SPECIAL ISSUE

What is "shared" in shared decision-making? Philosophical perspectives, epistemic justice, and implications for health professions education

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Handling Editor: Prof. Michael Loughlin

Abstract

Background: Drawing from the philosophical work of Hans-Georg Gadamer and the perspectives of theorists Mikhail Bakhtin and Kenneth Burke, the aim of this paper is to critically reflect on the meaning of the word "shared."

Method: The authors draw on the concept of epistemic justice, which they argue permeates the clinical encounter, to discuss how various forms of, and claims to, knowledge may influence the attainment of shared decision-making in health care contexts. The specific objectives are twofold: first, the authors draw key concepts from key Gadamerian, Burkean, and Bakhtinian philosophical perspectives to consider shared decision-making in relation to two types of epistemic injustice: testimonial and hermeneutic epistemic injustice. Second, building on philosopher Paulo Freire's critical pedagogy, the authors emphasize that major changes in educational structures and systems are required to promote the critical reflexivity required to address issues of epistemic justice, in the broader pursuit of authentic shared decision-making.

Results: They propose three main areas of focus for helath professions education: (a) changes in content (moving from a focus on biomedical knowledge to more content on social sciences) and methods of teaching (more dialogue and the creation of moments of dissonance); (b) a re-examination of teachers' role in promoting epistemic justice; and (c) inclusion of patients as partners.

Conclusions: Without major transformation in what, how, and with whom we teach, future clinicians may be unprepared to enact shared decision-making in a manner that does justice to the various ways of knowing.

KEYWORDS

education, epistemic justice, hermeneutics, philosophy, shared decision-making

1 | INTRODUCTION

In this paper, we argue that conceptualizations and enactment of shared decision-making (SDM) are deeply shaped by one's understanding of the term "shared." Drawing from the philosophical work of Hans-Georg Gadamer and educator Paulo Freire, as well as theoretical perspectives of Mikhail Bakhtin and Kenneth Burke, the overarching aim of this paper is to consider the challenges with the concept of shared in SDM in terms of epistemic injustice. Specifically, we draw on concepts of epistemic injustice[1] to highlight how the tensions between individual claims to knowledge and the historical, structural forces that determine the

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legitimacy of various forms of knowledge complicate any easy attainment of shared within health care settings. As Fricker underscores, it is helpful to think of the original use of epistemic injustice, with its roots at the margins of society, as discriminatory. Discriminatory epistemic injustice "carves out a space in which people are wronged in their status as a knower without that ever being a wrong done simply on purpose"[1] (p. 55). It is, she insists, not a matter of intention but "rather its absence"[1] (p. 54). Fricker explains that discriminatory epistemic injustice is not intentional, precisely because people are unaware of how they are unwittingly engaged in committing the injustice. She delineates two types: testimonial and hermeneutic. Testimonial injustice, in which someone else's knowledge is discredited, "happens by ingenuous misjudgement"[1] (p. 54) at the level of the interaction (eg, patientprofessional, technician-professional, professional-manager, doctorrehabilitation professional). As Carel and Kidd illustrate, in terms of the patient-professional interaction, stereotypes of the "ill patient" lead to a form of injustice whereby training, expertise, and formal knowledge are legitimized in the biomedical context and elevated to gold standard status, while the stories of patients are viewed as irrelevant, illogical, or unworthy.[2,3] Testimonial epistemic injustice often works on both interactional and structural levels (eg, see [4] in [1]). Hermeneutic epistemic injustice focuses attention on how the conceptual resources used during interpretive processes may not be shared. Hermeneutic injustice is particularly insidious in health care since the legitimized conceptual terms are entrenched and grounded in the natural sciences rather than the humanities (eg, see also[4]), while also often having different nuances of meaning within and across health care practices. Thus, this lack of shared concepts can only "…be somewhat mitigated by especially virtuous epistemic and communicative conduct on the part of any individual hearer"[1] (p. 55). The concept of sharing (in SDM), however, is quite a purposeful concept, which assumes that there is something that can be measured (ie, some dimension of shared) and that this measurement can be done in an equitable fashion. In this paper, we argue that epistemic injustice permeates the clinical encounter, threatening the possibility of authentic SDM in a double-hinged process from both patients' and providers' perspectives. The specific objectives of the paper are twofold: first, we will draw key concepts from different philosophical perspectives to consider SDM in relation to testimonial and hermeneutic epistemic injustice; second, we propose that changes in educational programs that foster critical reflexivity in learners as future health care professionals can help illuminate forms of epistemic injustice and, ultimately, empower clinicians to enact SDM in a more authentic manner. Thus, in addition to its theoretical contributions, this article suggests a starting point for health professions education (HPE) to lay the groundwork for questioning assumptions about SDM, providing tools for future providers to understand how health care practices can (unintentionally) perpetuate epistemic injustices and, thus, develop strategies and/or support structural changes to transform them. As such, we hope to shed light on the unique opportunity that the pedagogical environment offers for helping future health care professionals to embrace and develop the type of epistemic humility, which as Ho underlines, is both a disposition and requires commitment to the acknowledgement of one's own fallibility and limits of knowledge in addition to the actual and realistic assessment of those limits.[5] We do this to move us towards a greater appreciation of the subtleties and complexities of shared and how we need to consider all the experiences and perspectives that play into the decision-making process in both overt as well as implicit ways (eg, such as family members', providers', administrators' experience and perspectives in addition to the patient's).

1.1 | Authors' positionality

As an occupational therapist and rehabilitation scientist (A.T., first author), my research focus on how clinical experience and expertise impact clinicians' use of research evidence[6-10] has led me to explore how clinical decision-making occurs in complex systems of care, and to identify the factors that support or inhibit clinicians' use of scientific evidence in practice.[8,11,12] Two themes continue to arise in conversations with health care professionals that relate to their experience of both testimonial and hermeneutic epistemic injustice: (a) feelings of powerlessness and (b) a tension between meeting performance indicators and working with patients as unique individuals, with different aspirations, timelines, and priorities.

Health care professionals complain of having their "hands tied" in terms of lacking time to peruse, let alone reflect on the usefulness and relevance of research evidence in their daily practice. They feel devalued from what they refer to as "micromanagement" (of their daily responsibilities, of their schedules). Although professional associations and regulators stipulate that clinicians be client-centred[13] or patient-centered,[14] embrace, and adopt best practices, in addition to becoming agents of change through advocacy,[13-15] these mandates are at odds with the pervasive sense that there is not much they can actually do to transform the system.

I have also been struck by what appears to be a "silencing" of voices that extends beyond considerations of testimonial epistemic justice related to patients. Health care professionals' stories also reveal (a) the lack of value attributed to their intuition and professional acumen amassed though years of clinical experience; and (b) pressures for productivity that are experienced as unrealistic in current practice contexts (eg, growing caseloads and limited resources). Within these contexts, how can sharing be manifested? Is sharing between health care professional and patient possible in hierarchical systems of care that prioritize productivity and efficiency and value certain forms of knowledge above others? Whose knowledge matters? It is with these reflections on and interrogations of how SDM could take place within an era of evidence-based medicine (EBM) that I invited my three colleagues to discuss how an alternative epistemological lens could enrich our understanding of the limits and possibilities of shared in clinical practice and in SDM.

Our author team is composed of two occupational therapists (A.T., M.P.) and two physicians (A.K., B.C.Y.). Our disciplinary backgrounds include sociology, psychology, anthropology, education, philosophy, history, literature, and occupational science. Our practices as health care professionals, our experience as educators, and our research in EBM (A.K.,

A.T., B.C.Y.); patient-engagement, values-based practice, narrative reasoning and hermeneutics (M.P.); and personcentred care (A.K., B.C.Y.) have shaped our views of SDM. Our combined experiences as clinicians, educators, and scholars afforded us an opportunity to consider and question several taken-for-granted assumptions about SDM and, in particular, the meaning and oftenneglected importance of the qualifier "shared."

1.2 | From evidence-based medicine to shared decision-making

The impact of explicit structural factors (eg, institutional policies, missions, and mandates) and EBM on decision-making (clinician reflections on their personal values and beliefs about health care) is profound; they can exert a strong influence on enactment of core professional competencies and the extent to which clinicians have autonomy over the decisions they make, including, but not limited to, if, how, and when they give authority to the experiential knowledge of patients in their practice.

EBM emerged in the 1990s from the field of clinical epidemiology[16] and has since received abundant attention in the literature.[17] Since the introduction of EBM, critics have argued for more inclusive notions of evidence and the integration of various forms of knowledge derived from different ontologies and epistemologies.[6,18-21] Discussions have focussed on when and under what circumstances various forms of knowledge can be justifiably evoked and ultimately mobilized for clinical decision-making. Patients' involvement in their own care is recognized as necessary in health care systems that emphasize health promotion, prevention, and self-management.[22,23] Indeed, it is often taken for granted that the patient's knowledge of self, their lived experience of a health condition, and their wishes should guide the process of care.[24-29] Yet, the crux of many disputes about EBM rests on the legitimacy of various ways of knowing,[1,30-34] and, in particular, recognition (or lack of recognition) of the inherent value of patients' lived experiences.[35] Indeed, despite the growing discourse about the patient's role in EBM, critics have called into question the extent to which patients are (and can be) truly engaged in, and in control of their own care. To what extent can patients actively participate in making decisions about the services they receive? Such questions have been sparked by concerns regarding power imbalances between health care professionals and consumers of health care that may suppress the patient's voice (example of epistemic injustice), as well as the systemic and structural factors that emphasize efficiency, often to the detriment of person-centred care.[18,32,36]

Although the EBM movement appears to advocate for a shared perspective between the patient and the health care practitioner (emphasizing the patient's contribution in decision-making), its positivist legacy carries an underlying assumption that there is a truth to be known in every clinical situation and that "patient preferences" can be unproblematically weighed alongside research evidence and clinical expertise in the decision-making process.[37] But such a view risks mischaracterizing patient-provider interactions, which are fraught with power dynamics and require an awareness of the risk of epistemic injustice and the negotiation of different ways of knowing (experiential and technical knowledge). As Moes et al (2020) indicate "While the founding fathers of EBM claim that EBM entails the integration of the best epidemiological evidence with clinical expertise and patients' preferences,[38] critics are concerned that EBM and its focus on quantitative population-based research unintentionally undervalues both doctors and patients "as "knowers" capable of making judgements outside the confines of epidemiological evidence" (p.3). This mirrors the findings from a study on the legitimacy of user knowledge in decision-making in a SDM context by Grim et al, (2019) where patients highlighted relational issues such as being dependent on others, being dismissed, and choosing to edit their testimonies, whereas providers decribed workflow issues, users' lack of competency in decision-making, and their vulnerability to stress. Indeed, as Moes et al suggest, "Patients or medical professionals who are not duly recognized as credible and intelligible epistemic agents, subsequently, lack the social power to influence priority-setting practices. They are thus not merely frustrated in their capacity to be heard and make themselves understood, they are potentially deprived of a fair share in collective financial and medical resources" (p.1).

Though the earliest mention of SDM dates back to the early 1980s,[39] relative to EBM and its outgrowth from clinical epidemiology,[40] SDM has only recently garnered increasing attention in the literature, arising in part from tensions with fitting notions of patient preferences and actions into largely cliniciancentered models of decision-making developed by EBM. SDM, we argue, is a refined and current version of the decision-making approach at the core of EBM, which gives more explicit attention to the role that patients have, and are expected to play in the decision-making process. SDM is defined as "an approach whereby clinicians and patients share the best available evidence when making a decision, and where patients are supported to consider options and achieve informed preferences "[41] (p. 1361). Elwyn and colleagues proposed a three-step model that can help clinicians translate the conceptual descriptions of SDM into practice. Their work has focused on how to "do" SDM in everyday practice terms, in short to "integrate good communication skills with the use of patient decision support tools"[41] (p.1361). According to the SDM perspective, the patient is central to the decision-making process. It thus stands to reason that SDM often draws heavily on patientcentred care discourses.[42] SDM has been said to hold promise for protecting and promoting the health of individual patients and populations as well as for reducing health care expenditures.[43,44]

If EBM's epistemic ideal (favouring knowledge from population based studies and large scale clinical trials) represents a form of epistemic injustice, then an important question arises: what impact does this have on "shared" of SDM?[45] The different ways of knowing (eg, patient narratives, knowledge derived from population based studies, practical experience) enter into and influence the SDM process, and ultimately impact the patient-provider relationship. We contend that this phenomenon has been under-recognized and under-theorized, such that the meaning and value of the word "shared" within SDM remains opaque and in need of critical philosophical analysis.

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2 | PHILOSOPHICAL PERSPECTIVES AND KEY CONCEPTS

As our first objective, we draw on philosophical concepts from Gadamer, Bakhtin, and Burke to (a) consider challenges with the concept of shared in SDM in terms of hermeneutic and testimonial epistemic injustice, which can in turn, (b) illuminate communicative interactions—"complex processes" that cannot be measured by any particular skill or aptitude[46]—that we might call upon to create the conditions for clinical decision-making where "shared" is a possibility.

2.1.1. | Hans-Georg Gadamer (1900-2002): conditions of understanding

Hans-Georg Gadamer was a philosopher best known for his work in the philosophy of interpretation or hermeneutics. Gadamer's hermeneutic philosophy is concerned with the question of understanding— of how to reconcile two distinct perspectives, for example, text and reader, or as in our case, clinician and patient.[47] Gadamer emphasizes how interpretation is always situated, bringing with it "fore-conceptions" and prejudices which together constitute an interpreter's "horizon."[47] These fore-conceptions and prejudices come in part from "tradition," which can be understood as the various historical and structural knowledge that define a given epistemic community.

Gadamer's philosophy has implications for SDM, and indeed, he directly applied his hermeneutics to the clinician-patient relationship in his later essays published in The Enigma of Health.[48] Health professionals are all situated within traditions, each carrying its set of prejudices, embodied, for example, by the ways of knowing and knowledges privileged within a given professional community. Within the health professions, tradition takes on the form of the particular roles and ways of knowing that define specific professions in the health care institutions where they practice. Prejudice and tradition often carry negative connotations, and indeed can be limiting and misleading to an interpreter lacking critical reflexivity. For instance, the prejudice of a doctor may be to focus on what is perceived as "medically relevant" to a case, but this neglects psychosocial aspects or other contextual factors that are critical to the patient in a SDM context. While tradition can be constraining, Gadamer argued that it serves as an important guide to inquiry, helping to shape the conditions of understanding.

However, to achieve a "shared" understanding requires moving beyond tradition through a meeting of "life-worlds," which Gadamer termed a "fusion of horizons."[47] For Gadamer, this fusion of horizons is effected through dialogue, which constitutes the "area of common ground" that "breaks down the distance between [clinician and patient]."[48] Thus, a Gadamerian notion of shared in SDM requires that clinicians give priority to the question, which entails putting their prejudices "at risk" and to experience "the other's claim to truth," with the end in mind being shared understanding. Reflecting on the priority of the question in the clinical encounter creates an openness—to possibility, fallibility, and learning. This openness also necessitates epistemic humility in the recognition that interpretation is never final or complete. Through this hermeneutic approach, centered on the question, the health care professional can endeavour to meet with their patient's lived experience, and in dialogue, foster a shared understanding of health and illness. In this way, Gadamer's philosophy helps create conditions for hermeneutic epistemic justice, which can serve as the fundamental basis for achieving SDM in health care.

2.1.2. | Mikhail Bakhtin (1895-1975): dialogue and heteroglossia

The philosophical perspective of Russian theorist Mikhail Bakhtin helped inspire aspects of the poststructuralist movement, including the entanglement of agentic subjects with structures and the recognition that power acts on all of these. He was one of the early proponents of the linguistic turn in the social sciences, whereby meaning became understood to be co-constructed by a reader or listener rather than determined by the writer or speaker. For Bakhtin, "there is a constant interaction between meanings, all of which have the potential of conditioning others. Which will affect the other, how it will do so, and in what degree is what is actually settled at the moment of utterance."[49]

A dialogue for Bakhtin is an interaction in which there are multiple possibilities for communication between people that are not (and cannot) be exhausted in their exchange, resulting in "communication between simultaneous differences."[50] Such dialogues are polyphonic, meaning that the individuals who participate in them retain their distinct voices even as they join together to produce a shared understanding,[51] a phenomenon also referred to as heteroglossia. Within a dialogue, "the role of the others for whom the utterance is constructed is extremely great (p. 94). From the very beginning, the speaker expects a response from them, an active responsive understanding. The entire utterance is constructed, as it were, in anticipation of encountering this response."[49] In contrast, speech that is constructed in order to avoid a dialogical, agentic response—whether "a judge delivering a sentence in biblical terms, the Ten Commandments"[51] (p.198), or a physician asserting a definitive diagnosis—is termed monological. This power-mediated shift from dialogue to monologue is part of finalization, which "terminates dialogue, because the other is left with nothing to say; the other can be nothing more than what the finalization states he or she is."[51] Thus, the finalizing shift to the monological removes both agency within the relationship and the ability to co-construct meaning in the encounter. Indeed, such finalization that results from the monological is reinforced by the privileging of physician knowledge and its language (eg, biomedical) and, thus, doubles the mechanisms by which epistemic injustice occur at both interactional and structural levels.

Within Bakhtinian framing, SDM results from a dialogic encounter in which every participant speaks in his or her own distinct voice, with that multiplicity of voices combining to form a heteroglot whole wherein each speaker retains her "own intention, his own accent."[52] In a health care encounter, this requires constant reflexive mindfulness on the part of the provider not to slip into the monological mode that is characteristic of most medical and rehabilitation interactions— not just to solicit patient opinions

but to coconstruct the knowledge of the individual patient's disease and its treatment, including goals and objectives that are being made in the encounter. Further, it requires the type of deep listening to the patient's own knowledge of his or her illness, which may or may not be expressed in biomedical terms but in experiential ones. Since such dialogue is fundamentally nonhierarchical,[46] how, then, to embed heteroglossia within a system that values and sets up explicit and implicit structural barriers between patients and their providers?

2.1.3. | Kenneth Burke (1897-1993): dramatism

Kenneth Burke is recognized as a philosopher of language. His primary tenet, that humans are symbol users, abusers, and inventors of the negative, underlines human agency in the creation of knowledge: "I need but point out that, whether or not we are just things in motion, we think of one another (and especially of those with whom we are intimate) as persons. And the difference between a thing and a person is that the one merely moves whereas the other acts"[53] (p. 53). Yet, the focus on evidence and decision-making that occurs at one definitive point in time often requires just the opposite assumptions, placing the object (diagnosis, prognosis, and its predictive power) rather than the human actors (re-envisioning, and enacting hoped-for ending).[54] Even when patients and health care professionals seek to understand the attitudes that guide each other's actions in the face of the ambiguous experiences that can accompany illness, they may end up being caught in different stories that exasperate any sense of shared and lead to, as Frank noted, reactions such as "How can they act like that?".[55]

The symbolic acts in health contexts prioritize the gathering of facts and information, what Burke[56] would consider the privileging of the semantic over the poetic. He uses the phrase "Iowa is in New York" which is not semantically true but could be metaphorically so. In the context of decision-making, his delineation between the semantic and poetic meaning helps illustrate how both hermeneutic and testimonial epistemic injustice can be easily created in contexts which legitimize one type of meaning at the expense of another. For example, in a biomedical context, technical or procedural knowledge is the dominant resource for making decisions. Yet, person-centered and multiple perspective ethnographic research underscores how shared poetic resources (eg, metaphor, narrative)[54,57-59] alleviate hermeneutic epistemic injustice that occurs with the strict reliance on biomedical semantics and plays a significant role in SDM processes that lead to transformative experiences for patients and their families. However, since these poetic practices are most often underground and considered illegitimate,[60,61] they ultimately do very little to overturn the everyday acts of testimonial epistemic injustice when the stories of patients, family members, and even health care professionals are dismissed as inconsequential.

This raises questions then about how the lack of shared poetic hermeneutic resources during clinical decision-making leads to testimonial epistemic injustice and threatens to place persons who use them (whether patient, health care professional, or administrator) into positions of, what

Fricker called, hermeneutical marginalization. What is key here is how Fricker's conceptualization of discriminitatory epistemic injustice focuses attention on how the structural factors that shape what counts as legitimate knowledge is unintentional and, thus, can only be partially rectified by interpersonal strategies: "Any such virtuous listening will somewhat erode hermeneutical marginalization, because the more actively a hearer listens, the more the speaker's hermeneutical marginalization is thereby eroded— and they are thereby enabled to contribute more than before to the shared hermeneutical resource." Here, active of deep listening can "erode" marginalization. Simply by entering into the language (whether semantic, poetic, or both) of another, one can learn and authorize the meaning of the other, essentially legitimizing what then becomes a shared resource for future decision-making. However, there is a caveat: "…insofar as hermenuetical marginalization is a product of social powerlessness (and is a form of it), the actual eradication of this kind of injustice will require significantly more than such slight interpersonal hermeneutical empowerments…. [1](p. 55)." This then requires theoretical resources that can help us think through how we begin to create the type of equity in the very structures where the initial learning that informs decision-making take place.

3 | EMPOWERING AUTHENTIC SHARED DECISION-MAKING IN PEDAGOGICAL CONTEXTS

As learners in the health professions practice critical reflexivity, they may develop a deeper understanding of what may constrain authentic SDM and be better prepared to enact it in a manner that promotes a fusion of horizons, dialogue, agency, and the legitimacy of poetic resources. Our second objective is to suggest ways in which HPE could draw from philosopher Paulo Freire's Pedagogy of the Oppressed[62] to reflexively look at the structures that perpetuate epistemic injustice. We begin with a summary of the core tenets of Freire's critical pedagogy and then highlight how we might use these to cultivate authentic SDM competencies in our learners.

3.1.1. | Freirean concepts

Freire believed that education could not be dissociated from politics and from those who hold and exert power and influence.[62] The acts of teaching and learning are to be considered political acts in and of themselves. Freire emphasized that both the learner and teacher must acknowledge and be prepared to respond to political forces that influence education and practice (what is taught/practiced, how it is taught/practiced, and when it is taught/practiced); for example, they must be given the space and safety to reflect on their own, as well as others' political beliefs, on notions of power, and on systemic influences that could constrain more authentic SDM as they acquire the knowledge, skills, attitudes, and values within their practices. Freire's critical pedagogy aims to cultivate learners' critical reflexivity. Critical reflexivity is more than reflection or critical reflection.[63] Critical reflection, the "questioning of assumptions and power relations and

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how assumptions and relations shape practice"[64] (p. 5), leads to praxis, that is, critically informed action for social improvement.[65] Critical reflexivity, on the other hand, involves "acknowledging one's position in the world in order to understand the limitations of one's knowing and to better appreciate the social realities of others"[64] (p. 9). Freire's focus on cultivating critical reflexivity underscores the need to "flatten" hierarchies (structures) and give voice (hermeneutic justice) to the oppressed (whether that be the patient, learner, or clinician) through first turning the critical reflection to one's own situatedness within structures, the limits of one's knowledge, and the examination of the epistemologies underpinning one's actions. Freire's critical pedagogy compels us to learn new ways of knowing that may allow for more authentic sharing, while levelling power relationships associated with expected dichotomies between teacher/learner and practitioner/ patient. A Freirean approach to education for authentic SDM would aim to transform the ways in which SDM is understood and enacted, which will need to engage the learner as a future health care professional in a way that is liberating and emancipatory (allow them to question, to think differently about oppressive forces such as epistemic injustice) and not just to emulate what they are taught. It can also ultimately impact the patient as the learner gains new perspectives on knowledge and on patients as epistemic agents, which can then lead to new ways of interacting. Just like patients will need practitioners who truly include, engage, and give voice to patients, who acknowledge and value the patient experience, learners will need educators with whom they feel their voices will resonate, be listened to, and be heard—even if when they question taken-for-granted traditions, or historical or structural "givens" in curricular content or methods.

Freire adds that "those who authentically commit themselves to the people must re-examine themselves constantly."[66] Educators of learners in the health professions must question their own beliefs and values about what is shared and how, and acknowledge that many of their own taken-for-granted assumptions about knowledge sources, and the value of patient testimonials are derived from the "social and cultural structures in which they were raised and trained and/or currently live and work."[66] As Ng and colleagues suggest,[66] educators must call into question their own definition of SDM and ask who stands to gain from current conceptualizations of SDM, what type of knowledge it is assumed will be shared, which type(s) of knowledge will be privileged, and how stereotypes may lead to the discrediting of other type(s).

We introduced Paolo Freire's Pedagogy of the Oppressed[62] to argue that major changes need to occur in HPE and, subsequently, in clinical practice to move towards authentic SDM. In this final section, we ask what changes are required within educational systems to enact a critical pedagogy that can promote epistemic justice and set the conditions for authentic SDM. We offer suggestions for changes in three primary areas: (a) curricular content and methods of teaching; (b) reexamination of teachers' role in promoting epistemic justice; and (c) inclusion of patients as partners. These three main areas underscore a need for teachers and learners to become aware of each area's relationship to testimonial epistemic and hermeneutic epistemic justice.

3.1.2. | Curricular content and methods of teaching

Educators must commit to examining what (content) beyond what is included in traditional curricula which disproportionately focus on biomedical knowledge, and how (methods) learners need to know, in order to promote epistemic justice as well as embrace and enact authentic SDM. Kuper et al [67] identified 12 cross-cutting areas of nonbioscientific knowledge that are needed to support the training of physicians in the six CanMEDS roles (other than the medical expert). Epistemology was viewed as the foundational theme "without which the other themes could not be appropriately taught or understood" (p.162). Culture, justice, and power were the three interrelated anchoring themes. This research underscores the importance of designing curricula that consider content derived from social sciences and humanities that will "ensure that trainees become scholarly, compassionate professionals who collaborate well, communicate effectively, and advocate for individual patients and systems change"[67] (p. 159). Such curricula may help to redress testimonial epistemic injustices by bringing the value of other epistemologies to the surface and result in a reframing of stereotypes that professionals might have of their "ill patients."

We also propose a re-examination of HPE's goal of promoting competencies such as the change agent or health advocate without a critical eye to the inherent challenges of such roles. Although these professional roles represent major competencies in several health professions, our concern is that the manner in which they are taught misrepresents the multiple, interacting individual and structural factors that will either promote or hinder future health care professionals' ability to enact these roles. The message that learners may be getting is that they can transform, if not, "beat the system"—in some cases, with little more than sheer determination and passion. In this representation, learners may get a narrow and unrealistic perspective: the health care system needs mending, and with the right attitude and enough knowledge, a change agent can "move mountains." Explicit teaching about discriminatory epistemic injustice, such as testimonial and hermeneutic epistemic injustice in addition to other emergent definitions of epistemic injustice, could promote critical reflexivity on the factors that shape and reinforce oppressive systems in practice. This can be accomplished via narratives and case examples of clinicians' successful and failed efforts at navigating complex contextual factors to modify an existing practice or encourage a new one. Examples of epistemic injustice may be particularly informative, calling on learners to also come up with ways to imagine alternative possibilities and how they can enact those during SDM.

A focus on content alone is insufficient. Educators should consider using methods of instruction that help create moments of dissonance, or what Boler[68] calls a "pedagogy of discomfort," where learners can question their assumptions and interrogate their values in a system where epistemic injustices may render SDM challenging.[70-72-85] A pedagogy of discomfort can serve to counter epistemic injustice by disrupting assumptions of the primacy of medical ways of knowing. Kumagai and Lypson[69] suggest that although this can be done through dialogue with other learners in small groups, this strategy alone will not be enough to develop learners' critical

consciousness. In their work, "they have aimed to stimulate engaged, interactive, honest dialogue within small groups on potentially contentious social issues of relevance to the practice of medicine. These are groups in which individuals bring themselves—their identities, values, ideas, perspectives, backgrounds, and experiences—into collective (but not necessarily unified) expression to consider the basis of moral action" (p. 784). The pedagogy of discomfort is consistent with Freire's problem posing education, in which "the student is an active agent in his or her own learning and uses newly and collaboratively constructed knowledge to identify and act to solve problems and injustice in the world"[69](p. 784). Creating moments of dissonance requires authentic examples that will resonate with and be meaningful to learners.

3.1.3. | A re-examination of teachers' role in promoting epistemic justice

The teacher-as-expert model will need to move towards one where learners' experiential knowledge and worldviews are recognized, valued, and integrated into course content. This recognition of learners' experiential knowledge can serve as a powerful example of testimonial epistemic justice. Not only can this be used to help promote the critical reflexivity advocated by Freire, but also reinforces learners' experience of and, thus, ability to practice testimonial epistemic justice in the health care setting as providers with patients. For educators, this will necessitate a delicate balance of understanding, integrating, and remaining true to Freirean principles of emancipation and flattening of hierarchies, while scaffolding learners into acquiring and being asked to emulate discipline-specific knowledge and skills which are based upon normative rather than personal worldviews or experiences. For example, educators can begin by making explicit that learners' worldviews are necessary, valued, and provide the foundation upon which they can construct a new understanding, while also asking them to question their own taken-for-granted assumptions and those within their discipline specific knowledge. This can be done using rich and culturally detailed cases examples where learners are asked to critically reflect upon their values and worldviews and how these impact on interpretations of the case study examples, relative to those of their classmates and faculty. This will require that educators also critically reflect upon the tensions associated with revealing their own vulnerability and authenticity (or not) in relinquishing authority in teaching styles and/or pedagogical approaches.

Reframing the learner-teacher dialogue will be critical for fostering epistemic justice and authentic SDM amongst teachers and learners, as this interaction may serve as a model that may carry forward into clinical practice. Consistent with the principles of epistemic justice, there is no intended hierarchy of knowledge. In dialogical teaching, which draws from Bakhtin and Gadamer, Kumagai et al [46] underline that dialogical processes are key to developing the deep relationships between individuals that will lead to reflexivity, and clinicians who will practice with excellence, compassion, and justice. Such dialogues begin with the recognition of the validity of others' perspectives, particularly when they conflict or contrast with one's own. According to Kumagai et al,[46] discussion is a mode of communication that is goal oriented and presupposes a primarily cognitive process; as such, it is largely reductionist. As Kumagai et al[46] describe about dialogical teaching "the role of the faculty is to offer questions, paradoxes, and moral dilemmas in order to stimulate thinking, curiosity, reflection, and exchange; to highlight complexity, ambiguity, and uncertainty; to pose problems that ask for solutions; and to tell stories without endings in order to encourage learners to struggle with their own perspectives, values, and moral compasses" (p. 1780). In contrast to discussion that "appeals to a rational consideration of objective data and tends to preserve traditional differences in privilege, hierarchy, and power" (p. 1779), dialogue offers a way forward to enact the humility and compassion essential to patient-centred care in an era of EBM and rapid technological advancement.[79,80]

3.1.4. | Inclusion of patients as partners

To move learners towards a greater understanding of testimonial epistemic injustice, we recommend including patients as educational partners throughout the curriculum; this has the potential to promote person-centred practice, interprofessional collaboration, community involvement, and SDM.[70] Although inviting patients as "guest speakers" to share their stories in HPE has been taking place since the 1960s,[71-73] and although patients contribute to HPE in diverse ways, there has been little empirical research on learner and patient outcomes related to patient-teachers. Karazivan et al[74] describe a patient as partner initiative that was born out of a need to abolish paternalistic approaches to patient care, to create a partnership between care providers and patients, and to legitimize patient knowledge. Founded on the principle of patient-centred care, engaging the patient as partner acknowledges that patient experiences are vital to informing health care practice, which validates their membership as essential to clinical teams. We suggest that this also promotes the epistemic justice required for authentic SDM. Karazivan et al [74] also describe the impact of having patients as partners over time including "the growing influence of alternative forms of medicine that foster less asymmetrical power relationships between caregivers and patients and a greater consideration of patients' lived experiences and ways of knowing" [74] (p. 437).

Including patients as true partners in HPE will necessitate a major shift in both the clinical practice and HPE cultures. Early exposure to patient narratives and lived experiences—with an aim towards promoting a deeper understanding of testimonial and hermeneutical justice—and the relationship between patient (experiential) knowledge and health outcomes (as well as the reverse—when patient experience is not considered and poor health outcomes) can make explicit why SDM is central to, rather than peripheral to, procedural and/or technical forms of knowledge. For example, we propose that academic programs include and recognize persons with patient experiences—who could also be students— as official members of the pedagogical team and include them in all levels of the educational continuum (from admissions, to curriculum design, teaching, assessment, and program evaluation). Although including

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patients in HPE can make explicit an educational program's commitment and effort to encourage authentic SDM, promoting testimonial and hermeneutical justice will require a much deeper examination of curricular values, assumptions and current leadership structured by gold standards in medicine.

4 | CONCLUSION: AREAS FOR FUTURE CONSIDERATION AND EMPIRICAL RESEARCH

Drawing from three theoretical and philosophical perspectives, we critically examined the notions of epistemic hermeneutical and testimonial justice and the role that each one plays in SDM. We then proposed that the principles from Paolo Freire's critical pedagogy can be leveraged to create spaces wherein teaching practices include more than a focus on formal scientific knowledge. We suggested three main areas that may need to become the focus of concerted effort and empirical examination in the pursuit of authentic SDM as these may help break down hierarchies, promote sharing of perspectives, and encourage epistemic justice. Although these may appear radical and incongruent with current discourses in EBM and competency-based curricula, without a major transformation in what, how, and with whom we teach, our future clinicians may be unprepared to enact SDM in a manner that does justice to the patient voice.

CONFLICT OF INTEREST
None to declare.

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