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Epistemic injustice in healthcare professional practice: A scoping review

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ABSTRACT

Epistemic injustice, the unfair treatment of individuals in their capacity as knowers, has implications for the credibility, autonomy, and well-being of healthcare professionals. This scoping review addressed the following question: "What is known about epistemic injustice in healthcare professional practice as it relates to the experience of practitioners?". Guided by Arksey & O'Malley's methodology (2005), we searched eight databases for English and French language publications from 2007 to 2024. Of the 4186 records retrieved, 30 papers met the inclusion criteria. Fifteen papers originated in North America, with twenty-seven published between 2020 and 2024. Epistemic injustice was predominantly conceptualized through Miranda Fricker's constructs of testimonial and hermeneutical injustice, with numerous studies building on or extending Fricker's conceptualizations, and introducing other theorists and evolving concepts. The papers used qualitative research methodologies and theoretical analysis/commentary approaches; none used quantitative or mixed methods designs. Five themes related to epistemic injustice in healthcare professional practice were identified: (1) hierarchy of epistemic credibility, (2) epistemic politics, (3) constrained agency of healthcare practitioners, (4) pressures to modify professional self or identity, and (5) complex interplay of intersectional and social identities. A sixth cross-cutting theme highlighted (6) approaches aimed at mitigating epistemic injustice. The findings highlight the contextual, complex, and often obscure nature of epistemic injustice in the knowledge sharing practices of healthcare professionals. The review underscores the need for a more nuanced and justice-oriented conceptualization of these dynamics, greater visibility of their impact in everyday practice, and structural and educational reforms to foster more equitable knowledge sharing environments.

> *"The reality is that epistemic injustice is very easy to commit. In fact, it is extraordinarily difficult to avoid it."* (Dotson, 2012, p. 37)

1. Introduction

Healthcare professionals operate within complex environments, where they must integrate and navigate multiple forms of knowledge to inform their professional practice. These include biomedical, scientific,

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and evidence-based knowledge, alongside experiential, practice-based, ethical, and patient-centered knowledge. While healthcare systems increasingly recognize the importance of diverse knowledge forms, structural and epistemic hierarchies continue to undervalue certain forms of knowledge, thereby limiting the contributions practitioners can make to knowledge generation, sharing, and decision-making. The dismissal or undervaluing of practitioner knowledge has been reported to lead to ethical tensions, disciplinary role conflicts, and reduced autonomy in clinical and organizational settings (Ashby et al., 2013; Durocher et al., 2016; Durocher and Kinsella, 2021). The lack of recognition of practitioners' knowledge contributions has also been associated with diminished well-being, restricted ability to enact professional competencies, moral distress, and attrition from the health workforce (Mak et al., 2021; Sprow et al., 2021; Thomas et al., 2023; Rochette et al., 2020; Morley et al., 2022), ultimately impacting patient care.

Such challenges are further shaped by systemic and institutional structures that regulate healthcare practice. Though experiential, practice-based, and patient-centered knowledge are at the heart of what it means to be a healthcare practitioner (Caty et al., 2016; Kinsella, 2009), these aspects often conflict in contemporary practice contexts. Managerialist policies, regulatory expectations, and neoliberal governance models increasingly emphasize efficiency, standardization, and quantifiable outcomes, which may unintentionally constrain the epistemic agency of healthcare professionals (Bloom, 2017; Durocher et al., 2016; Drolet et al., 2020b). Tensions arise when practitioners must reconcile these systemic expectations with their clinical judgment, professional expertise, and ethical responsibilities. These tensions are not merely operational or bureaucratic but reflect deeper epistemic issues within healthcare structures, shaping who is seen as a credible knower and which knowledge is considered legitimate.

Epistemic injustice, as conceptualized by Miranda (Fricker (2007), is a valuable conceptual term for examining these tensions. It denotes the structural and interpersonal injustices that undermine individuals' or groups' ability to engage fully in knowledge practices. This form of injustice occurs when individuals are wronged, specifically in their capacity as knowers, thereby adversely affecting their credibility, authority, and ability to understand their own experiences. Fricker identifies two key types of epistemic injustice: testimonial injustice and hermeneutical injustice. *Testimonial injustice* occurs when an individual's knowledge or account is unfairly discounted due to the hearer's identity-based prejudice. For example, the accounts of someone might be ignored based on gender, race, class, disability, or their place in structural hierarchies. An instance is a nurse's observation about a patient's worsening condition being disregarded by the on-call physician despite the nurse's extensive experience and knowledge of the patient's usual state. This is an example of the nurses' credibility being unfairly diminished due to identity-prejudice, which may be linked to social identity or role in the structural hierarchy.

Hermeneutical injustice arises when individuals or groups are disadvantaged in their ability to interpret, communicate, or make their experiences comprehensible to others and themselves. This may occur because of a lack of a shared language or conceptual framework necessary to make their experiences understandable to others, often because those interpretive resources are absent or underdeveloped within dominant social groups. For instance, a clinician notices a pattern of subtle disrespect toward internationally trained colleagues but struggles to articulate the issue within existing workplace norms or policies.

To address these types of injustices, Fricker proposes a normative framework for cultivating ethical and intellectual virtues to advance *epistemic justice*. Two key virtues, *testimonial justice* and *hermeneutical justice*, are put forward as means to reduce and prevent unfair knowledge practices. Testimonial justice involves recognizing and granting appropriate credibility to individuals as knowers, especially in contexts where their input may otherwise be undervalued due to social bias or hierarchy. For example, when a nurse reports subtle but concerning changes in a patient's condition, and the on-call physician actively listens and takes the concern seriously, the physician affirms the nurse's epistemic authority.

Hermeneutic justice occurs when gaps in collective understanding are recognized, and people work to build the epistemic resources, such as vocabulary or language, needed to interpret marginalized experiences. It addresses situations where existing frameworks fail to capture certain social realities. For example, a neurodivergent nurse experiences daily microaggressions from colleagues because of her different way of understanding situations and interacting with others. Once the team realizes that they were being ableist towards this nurse (a system of oppression that they were unaware of), their relationship with her improved.

Within healthcare, epistemic injustice has been widely discussed in patient-provider interactions, where patients struggle to have their accounts of symptoms and experiences acknowledged as credible sources of knowledge (Kidd and Carel, 2017; LeBlanc-Omstead & Kinsella, 2023). While this recent scholarship has been influential, emerging literature indicates that healthcare providers may also experience inequities in knowledge practices. Reports have suggested that practitioners, particularly those from non-dominant social identities or disciplines, may also encounter epistemic exclusion, silencing, and credibility deficits within clinical and institutional contexts (Beagan et al., 2022; Llucmetkwe et al., 2023).

Epistemic injustices in practitioners can manifest in various ways, including the dismissal of clinical insights from certain disciplines, the undervaluing of tacit and experiential knowledge, and the absence of interpretive frameworks to describe ethical tensions and professional dilemmas (Cootes et al., 2022; Kok et al., 2022). Despite these emerging insights, scholarship on inequitable knowledge practices in healthcare remains fragmented, primarily focusing on patient experiences (Buchman et al., 2017; Byrne, 2020; Crichton et al., 2017; Heggen and Berg, 2021). There is limited attention to how epistemic injustice influences the roles and responsibilities of healthcare professionals across the full spectrum of knowledge practices, including creating, interpreting, sharing, and applying knowledge in professional contexts. Furthermore, existing research tends to be discipline-specific, lacking an overarching synthesis of how epistemic injustice is conceptualized and examined across different healthcare professions. Addressing this gap is essential to advancing our theoretical understanding of these injustices, uncovering systemic barriers to the production, sharing, and use of knowledge in decision-making, and guiding interventions that promote epistemic justice in healthcare. Our objective was to examine how epistemic injustice is understood and studied, focusing on the experiences and perspectives of healthcare practitioners, and to identify key insights and implications for professional practice.

2. Methods

In response to these issues, we conducted a scoping review to map the breadth and depth of the literature on epistemic injustice in healthcare professions. Scoping reviews map the existing literature to clarify a topic's key concepts, assess the scope of the available evidence, and synthesize findings from a wide range of studies (Thomas et al., 2017, 2020; Mak and Thomas, 2022a). They also determine gaps in the literature and can serve as a preliminary step toward conducting a systematic review (Mak and Thomas, 2022b). The current review is guided by Arksey and O'Malley (2005) six-stage methodological framework, supplemented by insights from Levac, Colquhoun, and O'Brien (2010) and the JBI review recommendations (Peters et al., 2020). The PRISMA-ScR was used to report the results (Peters et al., 2020).

2.1. Positionality statement

Our team approached the study from a social constructionist

epistemological perspective, recognizing that our social locations, professional experiences, and disciplinary backgrounds shape the study's focus and our interpretations of the findings. The project was informed by a shared interest in epistemic justice and knowledge practices in the health professions. We engaged in reflexive dialogue to consider how our positionalities shaped the review process. The team was comprised of: two PhD student/occupational therapists with decades of interdisciplinary professional practice experience, and interests in ethical tensions, practice-based knowledge, patient centered care, and healthcare equity; six professors with expertise in diverse health and social care professions (occupational therapy, speech language pathology, nursing), reflective/reflexive practices, evidence-based practice, practice-based knowledge, philosophy, including philosophy of professional knowledge, ethics, equity, diversity and inclusion, and epistemic injustice; and one medical education librarian with extensive expertise in conducting scoping reviews.

Step 1: Identifying research question(s)

The following overarching research question guided the review: What is known about epistemic injustice in healthcare professional practice as it relates to the experience of practitioners? Two subquestions were: (a) How is epistemic injustice conceptualized in this literature? and (b) How is epistemic injustice studied in this literature?

Step 2: Identifying relevant literature/papers

The first author (EHB), in collaboration with the research team and with the guidance of a health sciences librarian (AQ), developed and refined the search strategy through three pilot searches. The review focused on the concept of epistemic injustice. The search aimed to capture literature addressing epistemic injustice in relation to the experiences, practices, or perspectives of healthcare practitioners across diverse professional disciplines.

A comprehensive search was conducted on November 30, 2023, across eight databases: MEDLINE, CINAHL, Embase, Scopus, PsycINFO, Social Services Abstracts, Philosopher's Index, and Academic Search Complete. A combination of controlled vocabulary (such as MeSH) and keywords were used, including epistemic injustice, epistemic justice, testimonial injustice, testimonial justice, hermeneutical injustice, hermeneutical justice, epistemic silencing, and epistemic marginalization. Initial pilot searches using population or context-specific keywords yielded few relevant results, so these were excluded to ensure broader coverage across the health professions. Pilot searches indicated that even when alternative conceptualizations of epistemic injustice were used, the term epistemic injustice was still implied. Papers were included if they focused on epistemic injustice and addressed the experiences, practices, or perspectives of healthcare practitioners working in social work, psychology, occupational therapy, physical therapy, speech-language pathology, nursing, or medicine. The search was rerun and updated on October 25, 2024, to capture additional literature and added keywords' epistemic racism' and 'epistemic violence' based on insights from iterative data analysis. All records were imported and managed using Covidence. Full search strategies for all databases are found in Appendix 1 (Supplementary File 1).

Step 3: Paper selection

Our initial search strategy was intentionally broad, including literature from academic settings, global health, and learners in the healthcare professions. However, during the review process, the scope was narrowed to focus on the experiences of practicing healthcare professionals to maintain clarity and coherence in our analysis. While the excluded literature, particularly papers referring to students and academic settings, raised issues related to epistemic injustice, these were ultimately deemed outside the primary scope of this review. Eligible papers needed to focus on epistemic injustice and/or epistemic justice, be situated in the contexts of clinical practice, healthcare management, or health professions education, and published in or after 2007. This date was chosen to align with the publication of Miranda Fricker (2007) seminal work on epistemic injustice. Both peer-reviewed and grey literature (government reports, policy statements, issues papers, conference proceedings, preprints, theses, research reports, maps, and other documents not formally published in books or journals) written in English or French were eligible for inclusion. The reference lists of included studies were hand-searched using a snowball sampling technique (Pham et al., 2014).

Studies were excluded if they focused on healthcare support workers or students, if their primary orientation was on epistemic injustice toward patients, or if they were not available in English or French due to translation resource constraints. Although earlier work, particularly from feminist and critical theory traditions, touches on ideas related to epistemic injustice (Pohlhaus Jr, 2017), the term was first mentioned in 1998 (Fricker, 1998). This review focuses on literature that builds on or responds to Fricker's well-theorized conceptualizations from 2007 onward. Drawing on the results of our pilot searches and consultations with a medical librarian, and to bound the scope of the review, we included alternative conceptualizations of epistemic injustice only when the term epistemic injustice was present or strongly implied within the paper.

To ensure consistency in study selection, two reviewers (EHB and AC) independently conducted a calibration exercise until they reached 90 % agreement on the studies to be included in the review. They then independently screened all titles and abstracts, with a third reviewer (EAK) resolving any conflicts. The same approach was used for full-text screening. When disagreements arose during screening or data extraction, other team members (EAK, AT, MJD, MEC, PL, AR) with relevant expertise were consulted to reach a consensus. Articles in French were reviewed by language-fluent team members (MEC, MJD).

Step 4: Charting the data

Guided by our research question, we developed a data extraction chart in Microsoft Excel. The data extraction form was tested for calibration by EHB and EAK using five papers through trial use and iterative discussions to ensure consistency and reliability. The lead author (EHB) performed the data extraction, with ongoing iterative dialogue with EAK and check-ins with the research team. The extraction chart included the following categories: publication date; author(s); title of the paper; journal; location of the paper/study; aim of the paper/study; article type; theoretical framework/methodology; methods; sample population; paper context; key instances relating to epistemic injustice; major discussion points; key vignettes/quotes; limitations; level of provenance of epistemic injustice, and implications.

Step 5: Collating and summarizing the data9

First, a descriptive numerical analysis was conducted to document the key characteristics of the included records. Second, the data were analyzed thematically to map the epistemic injustice identified in the literature concerning healthcare professionals' experiences, practices, or perspectives. An iterative approach was employed to identify themes. The first author (EHB) created a series of mind maps that detailed the themes and subthemes emerging from the data analysis. Mind mapping is a technique that explores associations and relationships between ideas and concepts using images, lines, and colors (Davies, 2011). The research team convened multiple times to review the extracted data, discuss the emerging findings, refine mind maps, themes, and subthemes, merge ideas, and collaboratively produce a thematic map of the results.

Step 6: Consulting stakeholders

Given its highly theoretical nature, stakeholder consultation was not deemed necessary for this review. This phase focused on conceptual clarity rather than immediate application or implementation. However, stakeholder engagement may be undertaken in future phases to support refinement, contextualization, and practical uptake of the findings.

3. Results

The search retrieved 10,864 articles, of which 6623 were removed as duplicates by Covidence and 56 were removed manually. Ultimately, the only grey literature identified in the search were dissertations. However, none of these met the inclusion criteria for the review. One article was identified through citation tracking, resulting in 4186 titles and abstracts being screened. After excluding 4096 articles, 90 full texts were reviewed, and 30 were included in the final dataset. Across both searches, reviewer conflicts were resolved by consensus, with input from additional team members when necessary. (See Fig. 1).

3.1. Descriptive analysis

The dataset comprised 30 publications: 27 peer-reviewed journal articles and 3 book chapters. These publications addressed practice-related (17), ethics-oriented (10), and policy-focused (3) topics. The included works represented a range of contexts: work (22), policy (5), education (1), and mixed (2). All journal articles underwent peer review, with the earliest published in 2015. The three book chapters were

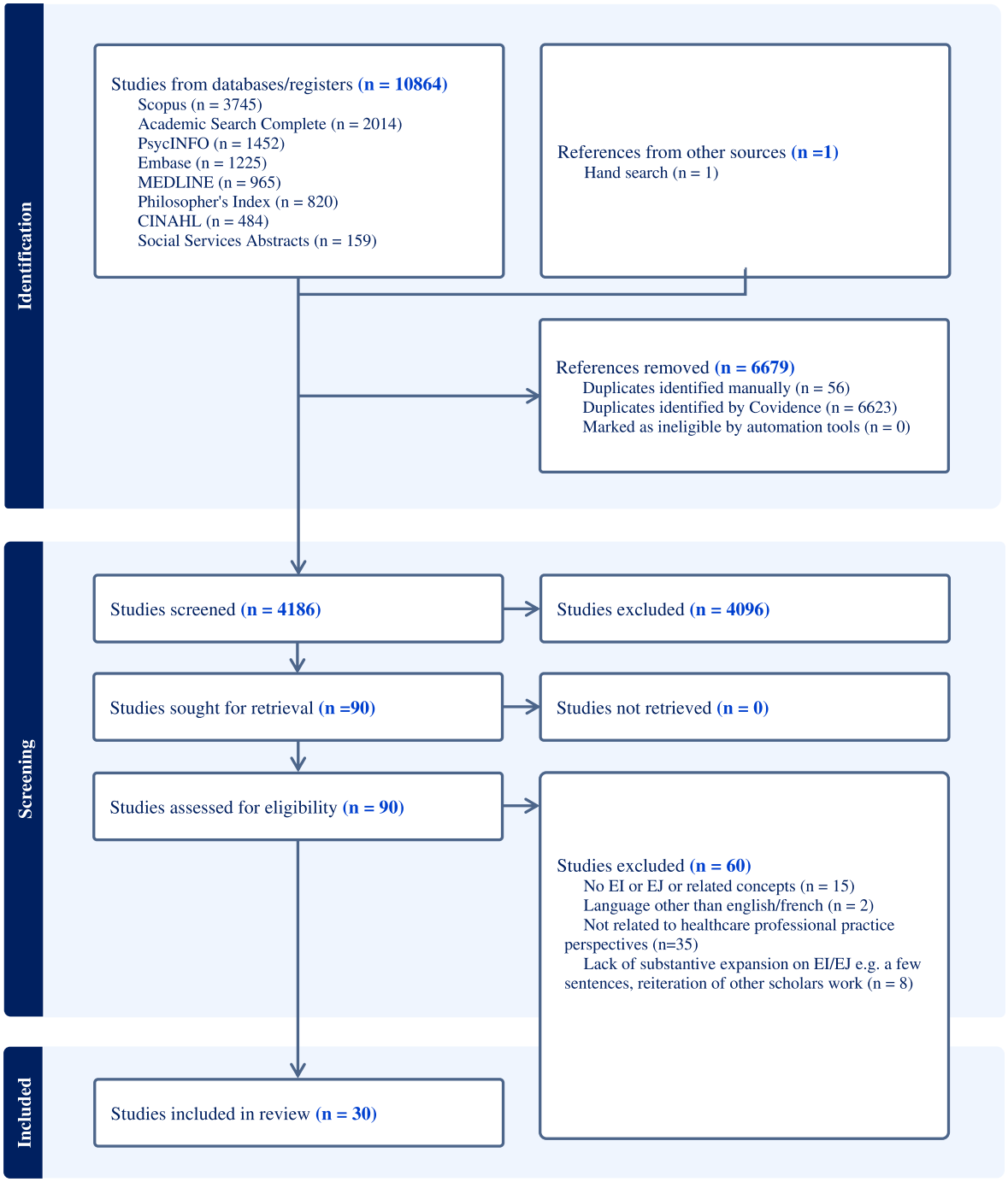

Fig. 1. PRISMA-ScR Flow diagram of the review.

included due to their substantive contributions to conceptual and theoretical understandings of the topic and were drawn from edited academic volumes. Fifteen of the 30 publications originated from North America, representing half of the dataset (Table 1). The studied populations included healthcare professionals from various disciplines and mixed professional groups. (Table 2).

The 30 articles were published between 2015 and 2024, with the majority (27) published between 2020 and 2024. Nearly two-thirds (19) were published between 2020 and 2022 (Table 2). Half of the articles utilized qualitative research methodologies (15), including descriptive, interpretive, and critical approaches (Table 2). The remainder were evenly split between theoretical (7) and commentary (7) pieces, along with one scoping review (1) (Table 2).

3.2. How is epistemic injustice conceptualized?

Across the papers, there were a range of conceptualizations of epistemic injustice and related concepts, with almost all the empirical papers drawing on Miranda Fricker's foundational work, and the theoretical and commentary papers engaging a broader range of conceptual thinkers. (See Table 2).

Among the sixteen empirical papers in the review, fifteen employed Miranda Fricker's conceptualizations of epistemic injustice, and one cited scholars who draw on Fricker (Beagan et al., 2024). Of these, twelve addressed testimonial and/or hermeneutical injustice. Several of these studies built on or extended Fricker's theoretical conceptualizations, incorporating concepts such as epistemic racism (2), credibility excess (3), epistemic politics (1), epistemic exclusion (1), and epistemologies of ignorance (2), while two introduced new conceptualizations of epistemic sabotage (1) and willful epistemic ableism (1). (See Table 2).

Among the fourteen theoretical and commentary papers in the review, ten engaged with Fricker's work on epistemic injustice, with four of these also incorporating related concepts from scholars such as Jose Medina, Ian Kidd, Havi Carel, Katarina Grim, Christopher Hookway, Alexis Shotwell, or Gaile Pohlhaus Jr. The remaining four theoretical/commentary papers used terms like epistemic, testimonial, or hermeneutical injustice, without referring to a specific scholar. A number of the theoretical and commentary papers discussed related concepts such as epistemic exclusion (1), epistemic privilege (1), epistemic violence (2), epistemic objectification (1), or epistemic dysfunction (1). (See Table 2).

3.3. How is epistemic injustice studied?

Epistemic injustice was most often studied through qualitative social research (15) employing methodological designs such as ethnography (6), phenomenology (3), grounded theory (1), discourse analysis (1), narrative analysis (1), and narrative inquiry in bioethics (1), as well as generic qualitative research designs described as critical interpretive (1), and thematic analysis (1). There was also one scoping review. We considered these as examples of empirical research, which, was defined for this review as any study that systematically collects and analyzes verifiable evidence, either from primary research or synthesized sources, through observation or experience, to answer a research question. None of the studies employed quantitative or mixed methods research designs. (See Table 2).

Table 1
Country of origin of included articles.

Included Articles	No. of articles (n = 30)
Country	
United States	8
Canada	7
United Kingdom	6
Australia	4
The Netherlands	3
Poland	1
Sweden	1

Epistemic injustice was also examined through theoretical analysis and commentaries, which engaged in reflective, critically reflective, or bioethical analysis (14). These approaches were used to critically examine how healthcare practitioners experience, make sense of, navigate, or resist inequities embedded within knowledge structures and practices across clinical, institutional, or educational contexts. (See Table 2).

3.4. Thematic analysis

Through thematic analysis six themes were identified. Five highlighted dimensions of epistemic injustice in healthcare professional practice, related to the experiences of practitioners: (1) hierarchy of epistemic credibility, (2) epistemic politics, (3) constrained agency of healthcare practitioners, (4) pressures to modify professional self or identity, (5) complex interplay of intersectional and social identities. A sixth theme was more of a cross-cutting theme focused on approaches aimed at (6) mitigating epistemic injustice (Fig. 2).

The thematic analysis maps how epistemic injustice was represented in the reviewed literature.

While the six themes are presented as distinct, we recognize the interwoven nature of our findings across categories. Further, it is important to acknowledge the conceptual and contextual complexity of situations of epistemic injustice, which extends beyond what this analysis can fully capture.

Theme 1: Hierarchy of epistemic credibility

A dominant theme in the reviewed articles highlighted epistemic injustices linked to hierarchies of credibility. These credibility hierarchies, involving communicative practices and disciplinary stature (Reed and Rishel, 2015; Morley et al., 2022; Wodzinski and Moskalewicz, 2023), were linked to the exclusion of knowledge contributions from practitioners in certain professional backgrounds. For instance, several studies pointed to epistemic injustice occurring when healthcare practitioners' knowledge was ignored, disrespected (Morley et al., 2022), or when disciplinary roles, responsibilities, or expertise were misunderstood, unrecognized, undervalued, or rendered invisible (Cootes et al., 2022; Morley et al., 2022; Kuijper et al., 2024). A theoretical paper by Reed (2015) reflected on how the knowledge of nurses may be devalued:

> Although there is a trend toward interprofessional collaboration and education, the hierarchy of knowledge and authority is still very prevalent in healthcare […] such that despite their expertise and intimate interactions with patients and families, bedside nurses are not regularly consulted and their knowledge is discounted. (p. 242)

Epistemic injustice associated with a hierarchy of credibility was also described when expert opinion (Porter et al., 2022; Wodzinski and Moskalewicz, 2023) outranked the knowledge of the clinicians providing care, or when information from front-line clinicians was excluded, deemed less valuable, or unfairly considered as biased (Drolet et al., 2020b; Poole et al., 2021; Porter et al., 2022; Michaels, 2021; Wodzinski and Moskalewicz, 2023). Some studies reported epistemic asymmetries arising in these situations, with power asymmetry (Cootes et al., 2022), epistemic dominance (Sibbald, 2021), and epistemic authority (Drolet et al., 2020a) linked to epistemic injustices. Michaels (2021, p. 420) invoked the term 'epistemological violence' (Coined by Shiva, 1987) to signal injustices that occur when a non-expert with essential knowledge is treated as a non-knower, even about practices for which they are responsible. Others referred to 'epistemic violence' as conflicts between groups of knowers that involve communicative breakdown or silencing (Fletcher and Clarke, 2020), as well as marginalization or exclusion (Llucmetkwe et al., 2023).

Table 2
Methodological and conceptual approaches to epistemic injustice.

Reference (First Author, (Year) (Alphabetical)	Paper Type	Methodological Approach	Sample Size and Population	Epistemic Injustice: Miranda Fricker's Approach Cited	Epistemic Injustice: Related Concepts & Scholars Cited
Beagan et al. (2022)	Empirical	Critical phenomenology	n = 10; Occupational Therapy	Testimonial Injustice (TI), Hermeneutical Injustice (HI)	Epistemic racism: Medina (2017), Mills (2007); Contributory justice, willful ignorance: Dotson (2012)
Beagan et al. (2024)	Empirical	Critical interpretive	n = 13; Medicine = 1; Nursing = 9; Occupational Therapy = 3		EI (implied): Dotson (2011, 2012, 2014), Mills (2007), Medina (2017), Pohlhaus Jr. (2017); Epistemic racism: Grosfoguel (2013), Paton et al. (2020), Zaidi et al. (2021), Dryden and Nnorom (2021)
Carlton et al. (2022)	Theoretical	Theoretical analysis	Medicine	Epistemic Injustice (EI)	Gender-based stereotypes and biases; Recognition theory: Honneth (1995)
Cherry (2021)	Theoretical	Bioethical analysis	Healthcare professional general		EI: theorist not specified
Cootes et al. (2022)	Empirical	Scoping review	Social Work	EI, TI	
Drolet et al. (2020a)	Empirical	Descriptive phenomenology	n = 11; Occupational Therapy	EI, TI, HI	Epistemic authority, occupational marginalization
Drolet et al. (2020b)	Commentary	Bioethical analysis	Healthcare professional general	EI, TI, HI	EI: Medina (2012)
Earp (2020)	Commentary	Bioethical analysis	Medicine		EI: theorist not specified; Systemic injustice, gender-based harms. Intersectionality: Scully (2020); Theory of patriarchy: Dembroff,
Egalite (2021)	Empirical	Narrative inquiry in bioethics	n = 12; Healthcare professionals not specified, narrative accounts	TI	Epistemic ignorance: Alcoff (2007); White ignorance: Mills (2007)
Fletcher (2020)	Empirical	Grounded theory	n = 23; Healthcare professionals; Interdisciplinary talk therapists & managers	EI	Epistemic violence: Dotson (2011)
Goldberg (2023)	Commentary	Critically reflective analysis	Social Work	EI, TI, HI	
Hunt (2024)	Empirical	Auto-ethnographic narrative	n = 1; Psychology	EI	Epistemologies of ignorance: Dotson (2012), Pohlhaus Jr. 2012, 2017), Medina (2013), Mills (2007); Willful hermeneutical ignorance: Pohlhaus Jr. (2012); Willful epistemic ableism: Hunt (2024)
Hutchison (2019)	Theoretical	Theoretical analysis	Medicine	EI	Epistemic dysfunction, epistemic labour exploitation, epistemic labour invalidation: Pohlhaus Jr. (2017); Knowledge-how: Hawley (2011), Shotwell (2017)
Hutchison (2020)	Empirical	Iterative thematic analysis	n = 46; Medicine	EI	Credibility excess: theorist not specified; Implicit bias: Brownstein (2016); Microinequity: Rowe (2008)
Kok et al. (2022)	Empirical	Ethnography	n = 73; Healthcare leaders, managers, interdisciplinary, health care professionals, service users, incident investigators	EI, TI, HI	Epistemic exclusion: Hookway (2010), Carel and Kidd (2014)
Kucmanic (2017)	Commentary	Bioethical analysis	Healthcare professional, general		Procedural fairness framework: Persad (2017); Epistemic objectification
Kuijper et al. (2024)	Empirical	Ethnography	n = 44 + 6 groups; Nursing, managers, experts, professors, association leaders	EI, TI, HI	Epistemic politics: Doing (2004), Beaulieu et al. (2012), Sørensen (2022)
Llucmetkwe et al. (2023)	Commentary	Critically reflective analysis	Nursing		EI: theorist not specified; Epistemic violence
Michaels (2021)	Theoretical	Bioethical analysis	Healthcare professional, general	EI, TI	Epistemic exclusion: Hookway (2010); Epistemic privilege: Carel and Kidd (2014); Epistemological violence: Shiva (1987)
Moes et al. (2020)	Empirical	Ethnography	n = Not specified; Medicine, policy officials, patients, insurers, hospitals, professional organizations	EI, TI, HI	Credibility deficit/Intelligibility deficit: Coady (2010); Epistemic authority: Carel and Kidd (2014); Epistemic participation: Hookway (2010)
Morley et al. (2022)	Empirical	Interpretive phenomenology	n = 21; Nursing	EI, TI, HI	Credibility excess: Medina (2013)
Percival et al. (2024b)	Commentary	Reflective analysis	Medicine	EI, TI, HI	

(*continued on next page*)

Table 2 (*continued*)

Reference (First Author, (Year) (Alphabetical)	Paper Type	Methodological Approach	Sample Size and Population	Epistemic Injustice: Miranda Fricker's Approach Cited	Epistemic Injustice: Related Concepts & Scholars Cited
Pistone et al. (2022)	Empirical	Ethnography	n = Not specified; Frontline social workers, managers, quality coordinators, and organisational/policy officials (national, regional, municipal levels)	EI, TI	
Poole et al. (2021)	Empirical	Institutional ethnography	n = 14; Nursing, Social Work	EI, TI, HI	Credibility deficit: Medina (2012)
Porter et al. (2022)	Empirical	Descriptive, thematic, and discursive analysis	n = 50; Claimant participants & policy documents; Analysis directed at claimants, healthcare professionals; assessors	EI, TI, HI	Epistemic sabotage: Porter et al. (2022)
Reed et al. (2015)	Theoretical	Critically reflective analysis	Nursing	EI, TI, HI	
Reed (2024)	Theoretical	Critically reflective analysis	Nursing	EI, TI, HI	Moral distress: Jameton (1984, 1993); Moral heuristics: Kahneman (2011)
(Sibbald (2021))	Empirical	Narrative analysis	n = 4; mixed: Medicine, Occupational Therapy, Physical Therapy, Social Work	EI, TI, HI	Credibility excess: Medina (2011)
Victor (2020)	Commentary	Critically reflective analysis	Psychology	HI	
Wodzinski et al. (2023)	Theoretical	Conceptual analysis	Medicine	EI, TI, HI	EI: Grim et al. (2019)

Legend: EI = Epistemic Injustice. TI=Testimonial Injustice. HI=Hermeneutical Injustice.

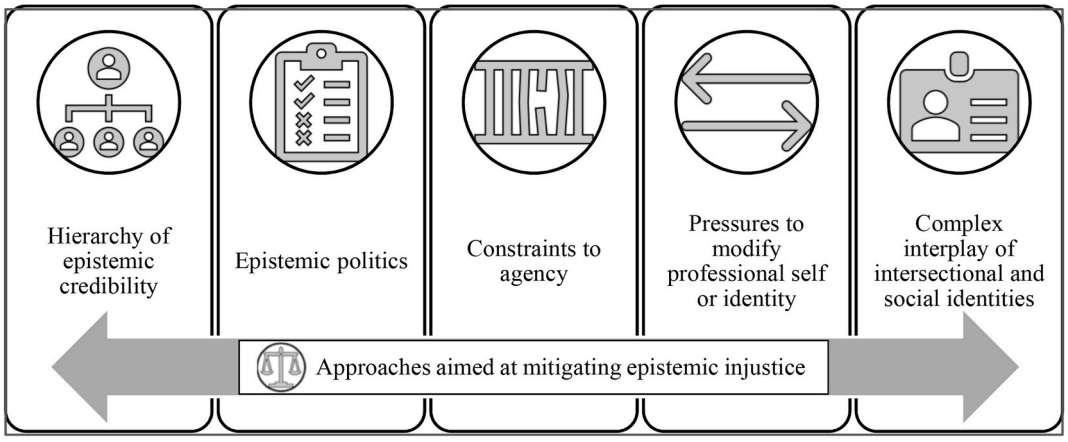

Fig. 2. Themes.

Hierarchical healthcare structures were also noted to contribute to epistemic injustice relating to recognition of credibility. Some scholars critiqued policies and processes that elevated the epistemic privilege of high-status disciplines, managers, policymakers, incident investigators, and administrators. These scholars noted a lack of fairness in the epistemic exclusion, silencing, or lack of recognition of the knowledge contributions of front-line practitioners, especially from non-high-status professions (Drolet et al., 2020a, 2020b; Kok et al., 2022; Michaels, 2021; Moes et al., 2020; Percival et al., 2024b; Wodzinski and Moskalewicz, 2023). A study by Drolet et al. (2020a) observed, "the word of the lecturer and clinicians in general is devalued compared to that of the professor, especially the professor-researcher" (p. 30).

Theme 2: Epistemic politics

Dominant knowledge structures, such as paradigms and models, and knowledge practices deemed legitimate in healthcare practice were linked to examples of epistemic injustice or what Kuijper et al. (2024) termed, 'epistemic politics' ("processes through which knowledge and expertise are constructed, challenged, and legitimized in policies and practice" [p. 2]). The medical paradigm (Cootes et al., 2022; Drolet et al., 2020b; Morley et al., 2022; Victor, 2020; Wodzinski and Moskalewicz, 2023) and the evidence-based practice model (Cootes et al., 2022; Michaels, 2021; Moes et al., 2020; Kuijper et al., 2024) were critiqued in several papers for providing an overly narrow scope and emphasizing numerical accountability.

These attributes were described as contributing to the epistemic exclusion and low credibility of other forms of knowledge, such as experiential, contextual, and humanistic approaches (Cootes et al., 2022; Drolet et al., 2020b; Michaels, 2021; Moes et al., 2020; Kuijper et al., 2024). For instance, a study by Kuijper et al. (2024) observed both testimonial and hermeneutical injustice: "The ongoing epistemic politics in nursing reform efforts […] tend to perpetuate forms of epistemic injustice […] by favouring certain knowledge and knowledge production methods in healthcare organizations over others" (p. 8). A study by Moes et al. (2020) noted the potential silencing of physicians' contextual knowledge "when the protocolled and quantified medical knowledge of performance metrics aligns to match the logic of the insurers' market" (p. 7).

Other studies have identified that when knowledge needs to fit a certain format or type of evidence, the potential for knowledge sharing or knowledge creating practices with groups of knowers is limited

(Cootes et al., 2022; Kok et al., 2022; Moes et al., 2020; Sibbald, 2021; Kuijper et al., 2024). As Michaels (2021) discussed:

> Expert evidence of healthcare practitioners is seen as being at the lower end of the evidence hierarchy, so professionals working in certain disciplines may suffer a credibility deficit. Such disciplines include those where there is a less established tradition of positivist scientific research and greater dependence on interpersonal and qualitative aspects of healthcare. (p. 418)

Some scholars have highlighted how the limited diversity in types of knowledge used in decision-making potentially creates a division between objective and subjective, propositional and tacit, and scientific and humanistic knowledge sources. Further, they suggested that this division risks excluding or limiting the breadth of potential knowledge sources available to inform decision-making (Moes et al., 2020; Wodzinski and Moskalewicz, 2023; Kuijper et al., 2024). For example, Wodzinski and Moskalewicz (2023) described a form of intuitive decision-making that practitioners may hide to align with dominant epistemological frames.

> Since current psychiatric diagnoses must be reliable, psychiatrists cannot openly speak of their intuitions, which would likely undermine their professional credibility. Instead, this sometimes vital aspect of the diagnostic process must remain publicly hidden. The psychiatrists' testimony regarding the source of their knowledge is, therefore, unjustly silenced by the dominant discourse of diagnostic tools operating within the "ticking boxes" framework […] In both cases, others do not recognize or value the expertise.
>
> (p. 7)

The exclusion of experiential practice-based knowledge was commonly discussed as a form of epistemic injustice, whereby practitioner knowledge was discounted or devalued in healthcare work (Cootes et al., 2022; Drolet et al., 2020b; Kok et al., 2022; Reed and Rishel, 2015; Wodzinski and Moskalewicz, 2023; Porter et al., 2022). The prioritization of forms of knowledge that were objective, measurable, or empirical was problematized as contributing to the marginalization of important contextual, tacit, embodied, and experiential forms of knowledge (Michaels, 2021; Moes et al., 2020; Reed and Rishel, 2015; Wodzinski and Moskalewicz, 2023; Kuijper et al., 2024).

Such epistemic exclusions were highlighted by Kok et al. (2022) as problematic in incident investigations:

> Providing testimony does not always mean that this testimony is heard, understood or valued. What's more, who is […] seen as holding relevant information for the incident investigation is not a 'given.' Rather, this is determined by incident investigators and the institutionalized structures in which these investigators work. (p. 268)

Likewise, in disability claims, Porter et al. (2022) discussed how insurance companies discounted practitioners' testimonies:

> Having limited the scope of claimants' own health professionals to testify to the functional limitations of their patients, here the credibility of that testimony is undermined for being clinically focused and not addressing disability. (p. 1180)

Similar challenges were identified in policy development (Michaels, 2021; Moes et al., 2020) and pilot projects in nursing practice, where measurements were reported to overshadow practitioners' knowledge contributions. Kuijper et al. (2024) discussed that:

> Although the potential benefits of measurements should not be disregarded, the board's emphasis on numbers and evidence-based evaluation overshadowed the contributions of the nurses and the experimenting approach used, and silenced the nurses. (p.7)

Theme 3: Constrained agency of healthcare practitioners

Constraints to the agency of healthcare practitioners arose as a prevalent theme in forms of epistemic injustice. Examples included a loss of practitioner autonomy due to authoritarian procedures and processes (Drolet et al., 2020b), as well as standardized protocols that challenged professionals' judgment (Moes et al., 2020). Neoliberalism and managerialism were argued to contribute to constraints on practitioner agency through metrics as measures of disciplinary outcomes (Cootes et al., 2022), the devaluing of practitioner knowledge (Beagan et al., 2022; Cootes et al., 2022; Poole et al., 2021), regulatory surveillance, control, and governance (Cherry, 2021; Poole et al., 2021), as well as systemic constraints (Drolet et al., 2020b). Hunt (2024) described exclusion practices in disability experiences as a form of neoliberal ableism. This concept integrates neoliberalism, which promotes values of productivity and individualism, with ableism, which constructs able-bodied and able-minded individuals as the normative ideal (Goodley, 2014). Together, these frameworks contribute to a cultural perspective that interprets disability as personal deficiency rather than recognizing the role of systemic barriers.

As an example, Poole's (2021) study of healthcare practitioners with mental-ill health found:

> When they [health care practitioners] were disciplined or reported to their regulatory colleges for sharing their distress or diagnosis, they were subjected to epistemic injustice; they were depicted as lacking in credibility, competence and 'fitness to practice' by hearers who had *already decided* that they – or people 'like them' – were dangerous and a threat to public safety. It does not matter what participants did or said, or what evidence they provided to the contrary […] they had already been found epistemically untrustworthy, epistemically disposable and extraneous. (pp. 186–187)

Porter et al.'s (2022) study described constraints to practice as a potential source of what they refer to as 'epistemic sabotage'. They describe epistemic sabotage as involving systemic disqualification of certain knowledge claims, and instances of disqualification of the knowledge of epistemic agents, in which professionals' roles and knowledge are restricted and silenced. Constraints on practitioner agency were also linked to being prevented from realizing full disciplinary potential (Wodzinski and Moskalewicz, 2023), viewed as a type of occupational marginalization or occupational injustice (Drolet et al., 2020a), as contributing to moral distress (Cherry, 2021; Morley et al., 2022), and leading to diminished moral well-being (Reed and Rishel, 2015). Constraints to practitioners' agency also appeared as instances where knowledge was used or credited to others (Beagan et al., 2022; Egalite, 2021). For instance, Beagan et al. (2024) showed that racialized healthcare professionals "were questioned and undermined, their contributions ignored and/or appropriated" (p. 210) when knowledge presented by one practitioner was dismissed, only to be later used or credited to someone else.

In many of these instances of epistemic sabotage, healthcare professionals struggled to find words to describe their experiences of constrained agency (Reed and Rishel, 2015; Wodzinski and Moskalewicz, 2023; Kuijper et al., 2024), noting the absence of a name for such experiences (Sibbald, 2021; Victor, 2020). The authors of an ethnographic nursing study on innovative practice, in interpreting findings from their research, posited that "nurses often lack the interpretative resources to articulate and make sense of the knowledge and expertise that underpins their experimenting in terms that dominant authorities would recognize as legitimate" (Kuijper et al., 2024, p. 8).

Constraints to agency were also theorized as experiences of epistemic objectification, whereby practitioners are treated as 'objects' rather than 'subjects' in processes that passively extract their knowledge (Wodzinski and Moskalewicz, 2023; Kucmanic and Sheon, 2017). One paper observed that practitioners are often unaware of the underlying epistemic frameworks, such as evidence-based practice, that shape their

decisions (Michaels, 2021). Michaels (2021) identified hidden value assumptions in EBP, arguing that it privileges certain types of evidence, such as randomized control trials, and cost-effectiveness metrics that contain implicit value judgments about what outcomes matter. Pistone et al. (2022) similarly note that practitioners may not recognize when they are operating within a management-by-knowledge framework. However, they frame this as an implicit 'nudge' or soft governance that guides practitioners through embedded practices, rather than constraining practitioner autonomy.

Related to constrained agency, one paper theorized that moral distress serves as a moral heuristic (a simplified shortcut for moral reasoning) for epistemic injustice, contributing to the internalization of self-blame (Reed, 2024). Morley et al. (2022) suggested nurses "do not enter the healthcare environment viewing their role or knowledge contribution as of lower value, but develop that understanding because of repeated failed attempts to infiltrate the hierarchy" (p. 1316). Some papers highlighted the negative impacts of constrained agency on healthcare professionals' self-confidence (Morley et al., 2022; Kok et al., 2022; Hutchison, 2020; Reed and Rishel, 2015). Epistemic asymmetries related to power and constrained agency were noted in the way practitioners' testimony was dismissed or devalued in workplace conversations and communicative practices (Hutchison, 2020; Kok et al., 2022; Morley et al., 2022; Reed and Rishel, 2015; Kuijper et al., 2024). These dynamics were further discussed as supporting the credibility excesses of other disciplines (Morley et al., 2022).

Constraints to agency were also observed in discrimination experiences. Examples included the exclusion of marginalized groups from disciplinary knowledge production processes (Sibbald, 2021; Hunt, 2024). For example, Hunt (2024) elucidated a 'willful epistemic ableism' as "ongoing epistemic and social exclusions" (p. 1) of disabled people from participating in or being recognized within knowledge systems, as existing in psychology professions. In other instances, practitioners from marginalized groups were told to leave the profession or field if unable to handle practice demands (Cherry, 2021; Poole et al., 2021). Some studies observed that power asymmetries were linked to stigma and lower disciplinary status (Cootes et al., 2022), as well as with stigma avoidance, such as withholding information to evade negative stereotypes related to mental ill-health (Poole et al., 2021). Lastly, healthcare professionals' rights were discussed as caught in tension between enacting disability and regulatory legislation (Poole et al., 2021) alongside tensions between how disciplines were expected to treat service users and how they were treated (Reed, 2024).

Theme 4: Pressures to modify professional self or identity

Pressures on practitioners to alter their professional selves or identities were another form of epistemic injustice and involved assimilation, acquiescence, or resistance. It could also involve shaping knowledge sharing practices to preserve professional identities and appearances. Beagan et al. (2022) identified that "therapists faced a constrained choice between professional assimilation and resistance" (p. 8) in response to tacit messages about who can be a legitimate knower. Examples of assimilation activities included modifying physical appearances through 'power dressing' (Hutchison, 2020, p. 240) and making efforts to look like or engage in the social activities of dominant groups. Another example consists of changing one's social presentation or adapting one's speaking and emotive style to fit within the perceived comfort of the dominant group (Beagan et al., 2022). Healthcare professionals were also reported to change their professional introductions, starting with credentials or authoritative positions, versus less formal titles (Hutchison, 2020), or ensuring their name tag with credentials was visible (Beagan et al., 2022). Behaviors such as modifying appearance or speaking in certain ways, were reported as means to pre-empt or mitigate perceived credibility deficits.

Some papers have also described the acquiescence of healthcare professionals as an instance of epistemic injustice. Acquiescence occurred through passive acceptance of the devaluation of disciplinary knowledge practices, or unquestioned 'trust' in established hierarchical knowledge structures (Cootes et al., 2022; Morley et al., 2022). Related to acquiescence, the championing of practitioner resilience to manage problematic practices and systems was challenged by Goldberg (2023), who suggested that while valuable, it also has the potential to obscure the underlying devaluation of practitioners' knowledge:

> When an idealized understanding of resilience is centered and interpreted as successful adaptation to systems, processes, and structures that perpetuate inequity and oppression of both social workers and those whom we serve. Through my teaching and practice of resilience, I may forget to question what we are being resilient against and forget that resilience is the backup plan—not one's first choice. (p. 251)

Resistance to pressures to modify one's disciplinary, professional, or situated identities was likewise discussed. In a couple of studies, resistance was identified in acts to challenge 'epistemic exclusion' (Cootes et al., 2022), such as when practitioners take supplementary training to increase credibility, seek and build beneficial inter and intra-professional relationships, or take measures to assert their professional worth by speaking out (Beagan et al., 2022; Cootes et al., 2022). Resistance was also noted in calls to deconstruct colonial knowledge systems and to resist and change the ways disciplinary practices reproduce the subjugation of knowledge (Beagan et al., 2022; Llucmetkwe et al., 2023). As an example, a commentary by Llucmetkwe et al. (2023) advocated that "nurses must acknowledge that our professional discipline exists as a key factor in perpetuating colonization and facilitating the subjugation and exploitation of Indigenous Peoples' knowledge systems" (p. 38).

In some theoretical papers, scholars called for 'civil disobedience' (Cherry, 2021) or a 'managerial revolution' (Drolet et al., 2020b) as forms of practitioner resistance. A few studies highlighted the burdens of performing these invisible practices and the extra labor required to counter credibility deficits in healthcare professional settings (Hutchison, 2019, 2020; Beagan et al., 2024).

Several papers discussed how healthcare professionals navigated knowledge sharing practices to preserve professional identities and appearances. For instance, knowledge sharing practices were frequently identified as context-dependent, ranging across a continuum of silence, shaping, diluting, diminishing, or fully sharing aspects of a practitioner's knowledge. Examples were provided of knowledge being deliberately withheld when it did not align with objective, quantitative, or EBM sources of knowledge; established processes, rules, or regulations (Wodzinski and Moskalewicz, 2023; Sibbald, 2021; Morley et al., 2022); or dominant cultural norms (Beagan et al., 2022; Goldberg, 2023). For example, Goldberg (2023) commented on how practitioners sometimes compartmentalize experiential racial knowledge from their own cultural and ethnic groups, as they work in healthcare roles. One study reported 'epistemic shifting' (Kuijper et al., 2024, p. 7), whereby nurses "shift to different epistemic repertoires in situations of uncertainty and in attempts to maintain and safeguard legitimacy among their peers and in those areas of healthcare organizations where, traditionally, they had less voice" (p. 8).

Social and professional identities were strategically shaped to fit dominant knowledge frameworks, such as evidence-based practice (Beagan et al., 2022, 2024). A study by Beagan et al. (2024) reported that racialized healthcare providers "learned to couch their contributions in ways that gave them added authority" (p. 209). For example, an occupational therapist discussed how she learned to mobilize the language of "evidence-based practice" as a way "to gain credibility for her contributions" (Beagan et al., 2024, p. 209). Other knowledge, for instance, about one's mental health, was selectively shared (Sibbald, 2021) or downplayed in specific contexts (Beagan et al., 2022; Egalite, 2021; Victor, 2020; Llucmetkwe et al., 2023; Goldberg, 2023). One paper stood apart, suggesting that practitioners experienced fluid,

dynamic, knowledge sharing, and creating practices, integrated into dominant, managed knowledge practices (Pistone et al., 2022).

Theme 5: Complex interplay of intersectional and social identities

This theme highlights the complex interplay of intersectional and social identities, suggesting that race, gender, mental health, (dis)ability, age, religious beliefs, and social status contribute to experiences of epistemic injustice. Examples were provided of how these intersectional identities were at times implicated in: a) attributions of credibility deficits, b) challenges to practitioners' expertise, c) dismissal of practitioner knowledge (Beagan et al., 2022, 2024; Egalite, 2021; Hutchison, 2019), and d) lack of acceptance of diverse knowledge (Cherry, 2021; Llucmetkwe et al., 2023; Egalite, 2021; Sibbald, 2021; Victor, 2020; Beagan et al., 2022).

Several authors discussed racism as deeply embedded (Llucmetkwe et al., 2023) and intervening in knowledge practices (Egalite, 2021). Some studies discussed 'epistemic racism' as "a particular form of systemic racism, in which the ways of knowing and forms of knowledge considered legitimate are those of a dominant group, rendering all others inferior" (Beagan et al., 2022, p. 1), whereby credibility deficits were attributed to race, and practitioners were cast as "deficient knower [s]" (Egalite, 2021, p. 262) or "epistemological misfits" (Beagan et al., 2022, p. 11). For example, Beagan et al. (2024) in their study of practitioners, described examples of epistemic racism, wherein racialized persons "may not be perceived as legitimate knowers, authorities, even when holding professional credentials and even when addressing realities with which they have direct first-hand experience" (p. 210). Egalite (2021) further discusses how racialized practitioners' accumulated experiences of racism, which constitute a form of experiential knowledge, are often dismissed rather than seen as epistemically valued. This devaluation of lived memory, alongside the marginalization of culturally embodied experiences (Victor, 2020) and the disregard for cultural practices (Beagan et al., 2022) and cultural knowledge of minorities (Beagan et al., 2024), was suggested to potentially contribute to testimonial injustice.

Epistemic injustice related to gender was also addressed. Earp (2020) described how patriarchal gender systems perpetuate structural disadvantage across intersecting social identities. Gender was linked to role misrecognition and credibility deficits, with prejudgments affecting perceptions of practitioners' competence (Hutchison, 2019, 2020). Disruptions to the 'knowledge encounter' also included the sexualization of the professional–patient relationship (Hutchison, 2019, p. 186). Intersections with race (Egalite, 2021) and age (Hutchison, 2019) have been shown to exacerbate credibility deficits (Beagan et al., 2022, 2024). For example, Hutchison (2019) noted that surgeons sometimes questioned whether credibility challenges stemmed from youth, gender, or the entanglement of both: "I don't want to see you because you're too young, or you're a female" (p. 197).

Epistemic injustices linked to gender were also related to care work. Carlton and Hutchison (2022) theorized that viewing care through the additional lens of recognition theory reveals more nuanced harms:

> [C]are work is routinely genderized as a naturalised female competence […] Once it is characterised as a naturalised competence, it is (ideologically) deemed less worthy of recognition than say other acquired or developed skills. The contribution of care to society is thus under-recognised and the provider of care misrecognised because the social valuation of care is distorted by an identity prejudice shaped by ideological gender stereotyping. (p. 344)

Drolet et al. (2020b) highlighted how unjust knowledge practices in care work disproportionately affect women healthcare practitioners. Similarly, Hutchison (2019) described the epistemic exploitation of women's care work—where communication and empathy were expected yet unacknowledged, and excellence remained materially undervalued. The invisibility of care work was also emphasized, with attributes that render it unseen (Carlton and Hutchison, 2022), professions described as "nearly invisible" (Reed and Rishel, 2015, p. 241) or framed as an "invisible trade" (Cootes et al., 2022, p. 260), routinely overlooked by colleagues, patients, and the broader healthcare system.

Mental ill-health was also associated with epistemic injustice through negative identity prejudices. Poole et al. (2021) referred to this as "sane supremacy" (p. 187), whereby perceptions of practitioners as less competent undermined their credibility as capable knowers. Sibbald (2021) highlighted a gap in societal language and concepts regarding the ethical concerns of practitioners sharing personal experiences of mental ill health with service users:

> The knowledge that exists in the collective understanding of ethical tensions in clinical encounters exists because of the epistemic dominance of groups who find themselves at the center of the health professions. Concepts surrounding ethical tensions in the context of mental illness disclosure are, therefore, lacking. (p. 5)

Identities connected to disability were also linked to epistemic injustice. One study discussed physical and attitudinal barriers toward practitioners with disabilities within the psychology professions, and the lack of recognition of disability-affirmative knowledge (Hunt, 2024).

Lastly, healthcare professionals with identities informed by religious perspectives were discussed as facing discrimination in their approaches to care (Beagan et al., 2022; Cherry, 2021). Cherry (2021) described two forms of epistemic injustice linked to religion as "systematic bias against the moral knowledge and experiential lifeworld of entire classes of persons," and "demands that physicians and other healthcare practitioners leave their religious knowledge behind when they practice medicine" (p. 126).

Theme 6: Approaches aimed at mitigating epistemic injustice

A final theme highlighted approaches aimed at mitigating epistemic injustice across individual, organizational, disciplinary, or interdisciplinary practices, as well as policy and systems levels. Approaches at the individual level included recognition of the importance of positionality, relationality, and social connectedness, as well as an openness to listening to the experiences and perspectives of others (Morley et al., 2022; Kucmanic and Sheon, 2017). It also included raising awareness about how power, history, and societal structures shape epistemic credibility (Cherry, 2021; Earp, 2020; Goldberg, 2023; Llucmetkwe et al., 2023; Porter et al., 2022; Sibbald, 2021; Victor, 2020; Hutchison, 2020). Victor (2020) commented on culturally rooted recollections that carry epistemic significance, which can equip healthcare professionals to resist hermeneutical injustice and affirm their experiential knowledge:

> I suggest that we understand our memories as 'medicine memories' because it opens a space where the mechanisms of power and historical relationships can come forth for critical reflection. Doing so is one way to take back our lived experiences from our oppressors. We deserve the hermeneutical tools and resources that can counter the messages that designate minority cultures as weird, foreign, weak, shameful, inferior, worth harming, and even worth erasing. (p. 48)

Promoting changes in individual practices included bias training (Kok et al., 2022), reflective thinking (Kok et al., 2022), and critically reflective practices (Drolet et al., 2020b; Egalite, 2021; Kok et al., 2022; Victor, 2020; Hunt, 2024). It was repeatedly argued that collective action was required and that individual actions alone may not resolve systemic issues (Drolet et al., 2020b; Earp, 2020; Kok et al., 2022; Hutchison, 2020; Beagan et al., 2024).

Efforts to overcome epistemic injustice within organizations frequently focused on communicative and relational practices. Recommended practices included invited and collaborative dialogue (Drolet et al., 2020a; Kok et al., 2022; Morley et al., 2022; Reed and Rishel, 2015); building mutual relationships in community and institutions

(Llucmetkwe et al., 2023); caring (Poole et al., 2021); and solidarity (Carlton and Hutchison, 2022). For instance, Fletcher and Clarke (2020) suggested that healthcare professionals "need to be able to acknowledge each other's different positions and find ways to accommodate these in a spirit of mutual understanding, honesty and respect" (p. 735).

Others called for creating supportive epistemic spaces for belonging, credibility, and community (Beagan et al., 2022; Goldberg, 2023; Kok et al., 2022) as well as supporting healthcare professionals in sharing their experiences (Beagan et al., 2022; Morley et al., 2022) and the burdens of professional practice (Hutchison, 2019). Communication strategies included fostering interprofessional and inclusive communication (Reed and Rishel, 2015; Reed, 2024) and acknowledging, respecting, and accommodating different roles, positions, opinions, and unique disciplinary knowledge contributions (Fletcher and Clarke, 2020; Kucmanic and Sheon, 2017; Morley et al., 2022; Reed and Rishel, 2015).

Within disciplinary and interdisciplinary knowledge systems, scholars called for different models of evidence, enhanced dialogue, mutual respect, and inclusion in knowledge generation and in intra- and inter-professional practices (Drolet et al., 2020a; Fletcher and Clarke, 2020; Sibbald, 2021). One paper called for recognizing an epistemology of practice (Wodzinski and Moskalewicz, 2023). Beagan et al. (2022) called for critical reflexivity about health professions' roles in reproducing hegemony in knowledge practices, and for professions to make space for "epistemological multiplicity" and to "uphold professed commitments to social justice" (p. 17). Approaches to valuing and respecting knowledge from diverse people were noted in calls to practice 'epistemic humility' (Percival et al., 2024b), to improve recognition of different types of knowledge (Drolet et al., 2020a; Fletcher and Clarke, 2020), and to prevent testimonial injustice across the healthcare hierarchy (Kucmanic and Sheon, 2017). For example, Cootes et al. (2022) findings suggested that "epistemic confidence resonated from medical professionals, due to their 'credibility' as speakers"; in contrast, "social work was often depicted as a 'jack of all trades' lacking depth and mastery of knowledge" (p.267).

In a commentary, Llucmetkwe et al. (2023) discussed how epistemic justice requires an 'epistemic stance', or an intentional and equitable structuring of curriculum that affirms Indigenous knowledge sovereignty through decolonizing and distinction-based healthcare, recognizing the specific rights, identities, and lived experiences of diverse Indigenous peoples. Morley et al. (2022) empirically derived model of moral distress identifies epistemic injustice towards nurses as a contributing factor in their experiences of moral distress, offering a framework for guiding just practices through inclusive decision-making and ethics approaches.

At the institutional and systemic levels, numerous papers have called for reforms to address epistemic injustice, particularly through changes in governance and policies. Several authors urged attending to structural epistemic asymmetries (Kok et al., 2022), calling for an 'epistemic shift' (Beagan et al., 2024) and acknowledging and including diverse forms of knowledge (Michaels, 2021; Moes et al., 2020; Porter et al., 2022; Hunt, 2024). For instance, Kuijper et al. (2024) findings suggested:

> In local practice, alongside navigating power differences and professional hierarchies, the work of change agents becomes entwined with and influenced by conflicts stemming from competing institutional ideologies and epistemic paradigms within the context of quality improvement and healthcare innovation […] a major task and challenge for organizations is to legitimize different knowledges that inform nursing work. (p. 9)

Further suggestions included calls to: address hegemony in knowledge models (Michaels, 2021; Moes et al., 2020); de-hierarchize and legitimize experiential and practice-based knowledge (Wodzinski and Moskalewicz, 2023; Drolet et al., 2020a); critically evaluate systems, tools, and biases involved in evidence use and research processes (Kok et al., 2022; Michaels, 2021); develop policy frameworks that align with program design (Fletcher and Clarke, 2020), and elevate awareness of epistemic injustice possibilities involving agents and workplaces (Reed, 2024). For example, Reed (2024) discussed that in the nursing profession attention to the concept of moral distress has epistemic value, yet: "As a heuristic, it can obscure, if not sustain, the target problem (epistemic injustice), which in turn increases the moral distress (heuristic), and so on until moral distress becomes a normalized pattern of a nurse's work […] in a healthcare environment" (p. 234).

Attending to systemic biases related to race (Beagan et al., 2022; Egalite, 2021), gender (Hutchison, 2020), patriarchal influences (Earp, 2020), and colonial and Western epistemes (Beagan et al., 2022; Llucmetkwe et al., 2023) were suggested as additional ways to work toward epistemic justice.

4. Discussion

This scoping review maps current literature of epistemic injustice in the experiences of healthcare professionals and how epistemic injustice is conceptualized and studied. Five themes related to dimensions of epistemic injustice in healthcare professional practice, specifically in the experience of practitioners, were identified: hierarchies of epistemic credibility, epistemic politics, constrained agency, pressures to modify professional identity, and the intersection of social identities. A sixth theme was more of a cross-cutting theme, which highlighted approaches aimed at mitigating epistemic injustice.

The findings illuminate the complexity of knowledge practices in healthcare, suggesting that epistemic exclusion may persist despite efforts toward interprofessional collaboration, equitable knowledge sharing, and reflective practices. The findings of this review have implications for understanding how epistemic injustice is conceptualized, how it manifests in professional experience, how it is implicated in knowledge sharing practices, and highlights directions for future investigations.

4.1. Conceptual approaches to epistemic injustice

Almost all empirical studies and the majority of theoretical and commentary papers drew on Miranda Fricker (2007) foundational conceptualizations of epistemic injustice, particularly testimonial and hermeneutical injustice, highlighting her significant influence on this area of scholarship. Complementary contributions that expand or refine these core concepts were also identified (See Table 2). Notable other thinkers and conceptualizations included Medina's (2011, 2013) work on epistemic resistance and credibility excess; Hookway's (2010) participatory epistemic practices; Kidd and Carel's (2017) theorization of epistemic exclusion and privilege; and scholarship on epistemologies of ignorance (Dotson, 2011; Pohlhaus Jr, 2012, 2017; Medina, 2012; Mills, 2007). While these emergent perspectives offer valuable insights into the complexities of epistemic practices, their application in healthcare professional practice remains nascent, offering fertile ground for future inquiry.

Building on these contributions, some scholars contend that Fricker's focus on individual agency risks obscuring systemic and structural dimensions (Anderson, 2012; Medina, 2012). In response, constructs, such as epistemic violence, contributory injustice, willful hermeneutical ignorance, and willful epistemic ableism have emerged (Hornyak-Bell and Kinsella, 2026), reflecting the theory's openness and conceptual fluidity at this early stage (Dotson, 2012). This proliferation of concepts aligns with Fricker's (2017) call for ongoing conceptual evolution and with Pohlhaus's (2017) caution against essentializing the concept. Yet the diversity of definitions surrounding some of these emergent constructs also raises questions about conceptual clarity in the field.

As scholarly interest in epistemic injustice has expanded, concerns have emerged about the dangers of conceptual overreach, specifically, the tendency to attribute various harms to epistemic injustice without adequate theoretical grounding (Hornyak-Bell and Kinsella, 2026). Such

practices, critics argue, risk undermining both the analytic precision and the practical utility of the concept (Byrne, 2020; Kidd et al., 2022; Nielsen et al., 2025). This suggests that identifying an instance as testimonial or hermeneutical injustice requires attention to conceptual fidelity, specifically by linking credibility deficits or interpretive gaps to structural identity prejudice, rather than to general disagreement or disciplinary variation. While remaining attentive to these critiques, this review did not assess the conceptual fidelity of individual contributions. Instead, it aims to map how scholars are using the concept of epistemic injustice across diverse contexts.

These conversations highlight an enduring tension between preserving openness to theoretical evolution and maintaining conceptual coherence. Following Fricker (2017), claims of epistemic injustice should indicate how credibility deficits or interpretive gaps are shaped by structural identity prejudice, rather than by generalized disagreement or disciplinary tension. Clarifying such boundaries will be important for the conceptual and practical utility of future work.

4.2. Methodological approaches

The findings reveal that research on healthcare professionals as "objects of epistemic injustice" (Wodzinski and Moskalewicz, 2023) is relatively recent, with 27 of the 30 papers published since 2020. Across the reviewed literature, theoretical and qualitative empirical work was generally balanced; no quantitative or mixed methods research was identified. This pattern may reflect the theoretical roots of epistemic injustice at the intersection of epistemology and ethics, and in virtue ethics and social philosophy, where interpretive depth, conceptual nuance, and attention to lived experience are often prioritized over empirical generalizability. It may also reflect ongoing efforts to refine its conceptual foundations at this early stage of development. At the same time, difficulties in quantifying these issues may pose methodological barriers to advancing scholarship in this area, potentially explaining the scarcity of quantitative studies noted in this review.

Further exploration using mixed or integrative methods may help identify cross-contextual patterns and mechanisms, complement in-depth qualitative insights, and contribute to a more comprehensive understanding of how epistemic injustice operates in healthcare. These approaches could be especially useful for identifying epistemic behaviours, testing theoretical constructs, and examining how they translate into practice-based settings.

4.3. The complexity of epistemic injustice

Experiences of epistemic injustice are deeply contextual phenomena, shaped by the environments in which they occur. The reviewed literature reveals that knowledge practices among healthcare professionals are intricately interwoven with professional identity, institutional logics, and value-laden decision-making. These features closely align with the concept of wicked problems, which are characterized by complexity, contested values, and the absence of definitive solutions (Rittel and Webber, 1973; Greenhalgh et al., 2023). This complexity is reflected in how practitioners navigate competing expectations about what counts as legitimate knowledge and whose voice is granted authority. This includes contested cases where differing views exist about whether certain commitments should be considered epistemically relevant, for instance, practitioners' religious views within clinical practice (Cherry, 2021). Some report pressures to adjust their epistemic contributions to fit institutional norms, while others describe strategic practices to manage perceived credibility within hierarchical structures that afford credibility excess to some and constrain others (Hutchison, 2020; Michaels, 2021; Cootes et al., 2022).

It is also important to recognize the complexity of determining when epistemic justice is present. In some cases, enhanced credibility may be warranted for certain practitioners or forms of evidence due to knowledge, training, or experience, or the strength of validated evidence. Likewise, organizational constraints, such as budgetary limits, can reasonably restrict practitioners' autonomy without reflecting epistemic harm. These situations highlight circumstances in which differences in epistemic authority reflect reasonable and contextually appropriate allocation rather than injustice, shaped by institutional demands, professional standards, or pragmatic constraints.

Epistemic injustice, by contrast, arises not from all asymmetries but from patterned exclusions that silence or marginalize legitimate knowledge contributions. Rather than a binary condition, these dynamics can be understood along a continuum of credibility, ranging from exclusion or unintelligibility to selective privileging by prevailing norms. Across the reviewed papers, such dynamics appeared in practitioners being unaware of exclusion from decision-making, encountering epistemic gaps in shared interpretive resources, or adapting to dominant systems that unevenly distribute credibility (Reed and Rishel, 2015; Moes et al., 2020; Michaels, 2021; Sibbald, 2021; Cootes et al., 2022; Wodzinski and Moskalewicz, 2023; Beagan et al., 2024; Kuijper et al., 2024). Recognizing these patterned exclusions situates epistemic asymmetries within their broader structural and contextual conditions and contributes to a more nuanced understanding of epistemic life in healthcare.

Such complexity also highlights an important epistemological caution: not all claims to knowledge are equally credible. Following Fricker (2017) and Meehl (1973), attention to how credibility is assigned helps avoid conceptual drift and epistemic relativism, while supporting pluralistic conceptions of knowledge and analytic coherence. Recent systematic reviews of patient-focused epistemic justice initiatives (Côté, 2024) show that narrative engagement, partnership models, and structural reforms can help calibrate credibility and foster equity in knowledge practices without compromising epistemic standards.

4.4. The hidden nature of epistemic injustice in healthcare practice

The reviewed literature depicts epistemic injustice as often subtle and obscured in everyday professional life. Using a metaphor from art, Fricker (2007) proposes that attending to the 'negative spaces', the absences that define what is seen, can reveal understated relations of power and meaning. Applied to healthcare professional practice, this invites attention to what remains unseen: whose contributions are excluded, what interpretive resources are missing, and how structures obscure these dynamics. Such indiscernible power relations can contribute to exclusion, silencing, invisibility, and distorted representation (Spencer et al., 2025; Kidd et al., 2017). Lacking shared interpretive language, practitioners may find these experiences unintelligible, a form of conceptual invisibility (Dotson, 2012).

The literature suggests this obscurity stems from deeply entrenched epistemic structures that normalize the exclusion of certain types of knowledge and ways of knowing. The concept of 'epistemic politics' (Kuijper et al., 2024) points to how dominant knowledge paradigms actively shape and constrain what is recognized as legitimate knowledge. This creates conditions that may contribute to systematic epistemic exclusion, particularly for disciplines, professional roles, and knowledge forms that do not align with dominant frameworks or discourses. For instance, managerial practices based on mistrust of clinicians' knowledge may perpetuate authoritarian imposition of practice and visions, with limited regard for the knowledge accrued within disciplinary fields (Drolet et al., 2020b).

Additionally, epistemic exclusion was identified as operating through silencing and testimonial smothering (Dotson, 2011), where practitioners, aware that their knowledge will not gain uptake, may choose not to share it (Wodzinski and Moskalewicz, 2023). In these conditions, tacit and subjective knowledge, often essential in healthcare practice, may be undervalued or excluded (Reed and Rishel, 2015; Morley et al., 2022; Kuijper et al., 2024), so that know-how (Hawley, 2011) and non-propositional knowledge (Shotwell, 2011) go unrecognized. Across the literature, various forms of exclusion or silencing were

noted as sustaining an epistemic status quo that reinforced dominant knowledge practices. In contrast, alternative epistemic contributions were reportedly devalued or overlooked. Both individual transactional processes and broader social structures were noted to maintain these dynamics, potentially limiting possibilities for epistemic justice (Anderson, 2012).

According to Fricker (2007), these conditions give rise to primary and secondary harms: the former involving denial of one's credibility as a knower, the latter encompassing diminished confidence, erosion of professional identity, or reduced willingness to participate in knowledge practices. The literature suggests these harms can remain obscured within routine practices, not because they are invisible to those experiencing them, but because they are embedded in entrenched norms and institutional arrangements. They surface in reports of practitioners modifying or silencing aspects of identity to preserve perceived credibility (Hutchison, 2020; Beagan et al., 2024) or adapting passively to dominant systems that may obscure underlying injustices (Goldberg, 2023). These subtle and tacit harms merit further investigation (Freeman and Stewart, 2019).

4.5. Implications for knowledge practices in the health professions

The findings point to how disparities in epistemic recognition may have far-reaching consequences for how knowledge is produced, shared, and valued in healthcare, and may constrain professionals' ability to contribute meaningfully to decision-making. Practitioners may engage in epistemic self-censorship, modifying their knowledge sharing to align with dominant frameworks. Examples include 'epistemic shifting' (Kuijper et al., 2024), strategic use of terminology to assert credibility (Beagan et al., 2024), or withholding knowledge to avoid professional repercussions (Poole et al., 2021; Sibbald, 2021; Wodzinski and Moskalewicz, 2023).

The literature also noted how epistemic credibility may be influenced by social location and disciplinary hierarchy. Certain practitioners were depicted as holding epistemic privilege, while others experienced credibility deficits shaped by intersectional factors such as race, gender, and professional status (Beagan et al., 2022; Hutchison, 2020; Cootes et al., 2022). Several scholars described how these disparities create ongoing pressures for certain practitioners to build and maintain epistemic credibility. Over time, this may contribute to accumulated epistemic burdens and limit the incorporation of diverse sources of knowledge into decision-making, with potential implications for practitioners' confidence, well-being, and occupational fulfillment.

Many papers suggested that achieving just knowledge practices requires structural and cultural shifts. Structural changes might include reforming policies that reinforce epistemic hierarchies (Kok et al., 2022), adopting inclusive knowledge models (Michaels, 2021), and enhancing institutional accountability (Kuijper et al., 2024). While these issues were widely emphasized, one study did not report evidence of epistemic injustice and suggested that participatory practices and flexible structures may help mitigate such concerns (Pistone et al., 2022). Culturally, creating environments that value diverse epistemic contributions may support more inclusive participation across professional disciplines and backgrounds (Fletcher and Clarke, 2020; Beagan et al., 2022). Although individual training in bias awareness is important, the literature consistently emphasizes that such efforts alone are insufficient (Drolet et al., 2020b; Beagan et al., 2024).

Broader systemic changes appear necessary to address the structural and institutional factors sustaining unjust epistemic practices. Regulatory bodies may have a role in advancing equitable knowledge practices by revising policies that reinforce epistemic hierarchies and examining biases in disciplinary governance. The implications of epistemic injustice for practitioner mental health and well-being also remain underexplored. Future research might examine practitioners' lived experiences to clarify how epistemic practices contribute to well-being, retention, ethical tensions, burnout, or attrition. Additionally, studies could explore strategies that promote epistemic justice, such as participatory decision-making models, interprofessional epistemic dialogues, ethics education attentive to epistemic issues, and organizational frameworks that attend to collaborative knowledge sharing practices.

4.6. Implications for education

The findings carry critical implications for health professionals' education and ongoing professional development. The literature suggests that asymmetries in epistemic legitimacy are often internalized over time, shaping healthcare professionals' perceptions of their epistemic authority and value. Morley et al. (2022) highlighted that repeated failures to have one's knowledge recognized may diminish professionals' sense of worth.

Efforts to counter these dynamics may involve fostering epistemic justice, cultivating awareness of exclusionary knowledge practices, and integrating diverse epistemologies into curricula (Beagan et al., 2022; Llucmetkwe et al., 2023; Percival et al., 2024b). Reshaping curricula and pedagogical practices may also require more attention to the deliberate integration of situated, intersectional, and non-Western ways of knowing (Paton et al., 2020).

At the institutional level, ongoing educational opportunities within and across disciplines may include methods to recognize and challenge epistemic biases and exclusionary knowledge practices (Kok et al., 2022; Moes et al., 2020; Reed, 2024). This might also involve critically reviewing protocols, procedures, and policies that may contribute to unjust knowledge practices (Drolet et al., 2020b). Systems thinking (Earp, 2020) offers one avenue for critical reflection and can be incorporated into professional development, regulatory training, and updates to standards of practice and ethical guidelines. Overall, strategies at multiple levels may support practitioners' sense of epistemic value and autonomy and foster more inclusive and equitable learning and practice environments.

During the early phases of the review, we explored literature concerning inequalities in knowledge practices among healthcare professional students and in academic settings. Student-centered literature highlighted similar issues surrounding credibility, knowledge marginalization, and the negotiation of epistemic hierarchies, resonating with the themes identified in this review (Blalock and Leal, 2023; Percival et al., 2024a).

4.7. Strengths and limitations

This scoping review offers several strengths. By incorporating a wide range of literature, the study ensured a broad exploration of epistemic injustice across various healthcare contexts. Including multiple professional disciplines and contexts allowed for a more comprehensive screening of studies. Additionally, the expansive time frame enabled a deeper consideration of evolving themes in the literature. The findings offer valuable insights that can inform practice, policy, and education, while identifying gaps and guiding future research. Furthermore, this review provides an overview of the conceptualization of epistemic injustice across the papers, contributing to a field where these concepts have not been frequently addressed.

Despite its strengths, this review has some limitations. Relevant studies may have been missed, particularly those published in languages other than English or French. In addition, the specific terms used in the database search may have limited the range of literature identified. For instance, literature on related topics such as symbolic power, epistemic politics, and intersectional and social identities, among others, was not included. While broader search strategies may have identified other literature relevant to issues reflected in our findings, we intentionally limited inclusion to studies that explicitly engaged with 'epistemic injustice'. This approach helped to focus on core and related conceptual foundations in an emerging field of scholarship. Future reviews that expand the search strategies or related constructs may yield additional insights.

Some critiques of the epistemic injustice literature question the strength or type of evidence supporting its claims, particularly concerning conceptual fidelity or quantitative verification. Our review does not assess the conceptual fidelity or empirical rigour of the studies but instead aims to map how epistemic injustice has been operationalized in the health professions literature. This aligns with the methodological aims of scoping reviews to systematically map how a concept is employed in current scholarship and to establish a foundation for future theoretical and empirical development. Future research that critically interrogates how conceptual fidelity is maintained, assesses methodological rigour, and examines the potential for quantitative or mixed methods approaches to advance empirical insight is warranted. Nonetheless, this scoping review raises evocative insights about knowledge practices in the health professions and provides a focused foundation for future research in an emerging field.

5. Conclusion

This scoping review highlights the contextual, complex, and often obscure nature of epistemic injustice in the knowledge sharing practices of healthcare professionals. The findings underscore the need for a more nuanced and justice-oriented conceptualization of these dynamics, greater visibility of their impact in everyday practice, and structural and educational reforms to foster more equitable knowledge sharing environments. By addressing these gaps, healthcare systems can move toward more inclusive epistemic practices, ultimately enhancing the well-being and agency of healthcare professionals and improving patient care.

Ethics

No ethics approval required.

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CRediT authorship contribution statement

Elizabeth Hornyak-Bell: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Validation, Visualization, Writing – original draft, Writing – review & editing. **Aliki Thomas:** Conceptualization, Formal analysis, Funding acquisition, Methodology, Supervision, Writing – review & editing. **Allison Chrestensen:** Conceptualization, Formal analysis, Investigation, Methodology, Writing – review & editing. **Andrea Quaiattini:** Conceptualization, Data curation, Formal analysis, Validation, Writing – review & editing. **Patrick Lavoie:** Conceptualization, Formal analysis, Methodology, Writing – review & editing. **Marie-Ève Caty:** Conceptualization, Formal analysis, Methodology, Writing – review & editing. **Marie-Josée Drolet:** Conceptualization, Formal analysis, Methodology, Writing – review & editing. **Annie Rochette:** Conceptualization, Formal analysis, Methodology, Writing – review & editing. **Elizabeth Anne Kinsella:** Conceptualization, Formal analysis, Funding acquisition, Methodology, Project administration, Supervision, Visualization, Writing – original draft, Writing – review & editing.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.socscimed.2026.119040.

Data availability

Data will be made available on request.

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