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THE CLINICAL TEACHER ASME

Teaching reproductive justice

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1 | INTRODUCTION

Members of marginalised groups—whether by race, gender, ability and/or income—have faced disproportionate structural and sociopolitical barriers to the expression of their reproductive freedom and self-determination at the individual and community levels. Trainees may identify as members of marginalised groups, care for patients who identify as members, and may have experienced injustices or trauma of their own. Regardless of background or personal beliefs, clinicians must be prepared to listen to, understand and meet the needs of the people they care for. In this clinical teacher's toolbox, we use the pedagogical approach of transformative learning theory[1] to describe how educators can teach trainees about reproductive justice (RJ) specifically, and justice-centred, culturally humble care more generally. Transformative learning theory emphasises critical individual and shared reflection to unearth and confront assumptions and accepted 'status quos' and build alternative, informed thoughts and behaviours. Through this theory and method, educators will support trainees in (1) developing an understanding of historical injustices; (2) using reflective practice and critical assessment of bias; (3) practising the use of open inquiry; and (4) employing a co-production approach to care, a model that recognises the diverse knowledge, expertise, and perspectives of both patients and clinicians in healthcare decisions.

2 | WHAT IS REPRODUCTIVE JUSTICE?

RJ recognises the human right to decide if, when, and how to parent, and supports the ability to do so in safe communities. RJ seeks to support the creation of partnerships and systems that centre marginalised populations and return power over the expression of reproductive freedom to these individuals.[2]

3 | HOW SHOULD WE TEACH REPRODUCTIVE JUSTICE?

Originators of RJ describe the need for any curriculum to be centred on the lived experiences of those impacted by injustice, and to go beyond traditional debates on reproductive choice to examine the larger economic and environmental contexts that impact reproductive decision making.[3] Additionally, Loder et al.[4] have identified several components critical to any RJ curriculum:

1. Foundational knowledge of historical injustices
2. RJ definitions
3. Skills to critically analyse oppression, power and bias
4. Knowledge of contemporary law, justice and rights
5. Disparities and social determinants of health as they relate to reproductive health

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6. Cultural humility and respect for differences in cultural identity
7. Applications to patient care
8. Collaborative approaches to healthcare
9. Advocacy training

Existing published curricula on RJ use individual-level passive learning methods such as watching videos along with self-reflection questions[5] and case-based learning paired with a group discussion about historical and present injustices, previously observed behaviours in clinical spaces and potential future behaviours.[6] We believe that the added value of the transformative learning theory-informed approach presented here is in its use of self-examination and critical assessment of assumptions. Use of these tools powerfully supports the teaching of element (7) of Loder's framework, in addition to generalizable skills in person-centred reproductive health for any patient-facing individual in a range of health professions (medicine, nursing, ancillary health services and beyond). The principles described below also address elements (1), (2), (3), (6) and (8) of Loder's framework and address the differences between reproductive choice/rights, health and justice, addressing the experience of marginalised groups throughout.

3.1 | Principle 1: Ensure trainees are aware of historical and present-day injustices, identifying the value systems and consequent geographic, legislative, economic and interpersonal barriers that perpetuate them

Ensure trainees are aware of historical and present-day injustices.

Describing and learning to critically examine the histories of oppression and structural injustice and the impacts that they have on marginalised communities is the foundational step in a justice-centred curriculum. These histories serve as disorienting dilemmas that catalyse transformative learning. Trainees generally enter health professions with a desire to do good; disorienting dilemmas should challenge trainees' assumptions that medicine has been universally a force for good and bring them to a critical assessment of this assumption and the biases that underpin the historical context. In the case of reproductive health, there are numerous examples that serve as these disorienting dilemmas and can initiate a discussion around justice-focused care and centring patient autonomy. The disorienting dilemma should be examined through critical assessment to support an understanding of the forms and intersecting systems of oppression at work. We characterise these systems of oppression within a social ecological model[7] as health system barriers disproportionately impacting marginalised groups, restriction of services within communities, denial of information or consent, and interpersonal racism and bias. In Figure 1, we provide one example of how abortion access can serve as a disorienting dilemma and stimulate examination of intersecting oppressions. Educators may choose to use another injustice that is timely or geographically relevant to their learners, so long as they are equipped to support learner assessment of systems of oppression resulting in this injustice.

Describing and learning to critically examine the histories of oppression and structural injustice… is the foundational step in a justice-centred curriculum.

Laws restricting access to abortion care in the United States disproportionately affect people of colour. Black women are nearly three times more likely to experience unintended pregnancy than White women and nearly five times more likely to seek abortion care.[8] As a result, limitations in abortion access disproportionately affect Black women relative to their white peers and disproportionately deprive Black women of their human right to decide if or when to parent.

Social Ecological Model
Case Example: Barriers to Abortion Care in the United States

FIGURE 1 Disorienting dilemmas should challenge trainees' assumptions about medicine and explore various injustices in a historical context. These dilemmas can be explored using the social ecological model. The model can be used to understand the ways individuals, their relationships, the surrounding community, and societal forces impact health care and outcomes.

Community, neighbourhood, and societal factors also play a role in the environment that will support or hinder the safety, health, and success of children or parents who were not able to obtain abortion care due to legal or accessibility restrictions. Figure 1 illustrates the use of the social ecological model as a lens to explore how reproductive injustices are positioned within a structural context. Educators can use this figure as a framework for various case examples. The social ecological model serves as the foundation upon which a disorienting dilemma or specific case can layer over and examine the ways in which each layer of this model interacts with one another.

3.2 | Principle 2: Define justice-centred patient care as it differs from patient health, rights and autonomy

Define justice-centred patient care as it differs from patient health, rights and autonomy.

The term RJ was introduced by Black feminist scholars in response to the women's rights movement, which did not adequately address the barriers to accessible, full-spectrum reproductive healthcare faced by marginalised people. It is important to understand RJ as it relates to (and is different from) reproductive health and reproductive rights, and to recognise that its principles go beyond issues of individual choices to include both community and individual access to all choices. Table 1 illustrates these differences as they pertain to reproductive health, reproductive rights and RJ. In our setting, session leaders defined reproductive health, reproductive rights, reproductive autonomy and RJ to highlight the differences and interplay between these concepts. A table similar to rows one and two of Table 1 was reproduced (either as a slide, handout or on a whiteboard). Points for discussion by session leaders are noted below in the shaded section of the table.

3.3 | Principle 3: Support trainee reflection on individual positionality, power, values and biases and their impact on individual views about reproductive health, rights and justice

Support trainee reflection on individual positionality, power, values and biases.

To achieve person-centred care in the clinical phases of training (and beyond), trainees must also examine their own positionality and how their own values or biases impact their actions and, subsequently, the people they care for. Examining positionality and bias supports the

TABLE 1 Definitions and distinctions between related concepts of reproductive health, rights, autonomy and justice.

	Reproductive health	Reproductive rights	Reproductive autonomy	Reproductive justice
Definition	State of physical, mental and social well-being in all matters relating to the reproductive system and to its functions and processes. Not merely the absence of disease.[9]	Individual legal rights to decide whether or not to reproduce and the right to have reproductive health.	Having the power to decide and control contraceptive use, pregnancy and childbearing.	Human right to maintain bodily autonomy and decide if/when/how to parent and to do so in safe and sustainable communities.
Underlying frameworks	Biopsychosocial model of health and service delivery	Legislation	Human rights	Human rights, health equity and social justice movements
Points for discussion:	Acknowledges myriad of factors that lead to outcomes of reproductive health, but operates at individual level and therefore does not examine the legal rights and freedoms and structural barriers that can impact one's reproductive health.	Legally protects individual's rights, but does not ensure equitable access.	Human rights frameworks characterise human rights as universal, inalienable, indivisible (one right does not supersede another) and interdependent.	Faces similar challenges as other equity movements in our society, which are seeking to resist cultural norms, structural racism, explicit and implicit bias, and the complex intersectional nature of justice and equity.

steps of self-examination and critical assessment of assumptions from transformative learning theory.

To achieve person-centred care in the clinical phases of training (and beyond), trainees must also examine their own positionality.

We used a guided reflection to further explore individuals' viewpoints by asking trainees to consider their own beliefs and how these may impact patient care. To start, we used a focused reflection on individual positionality, power, values and biases through a positionality exercise. We asked trainees to spend 5 min writing down the identities that are most meaningful to them and reflecting on how these may influence how they experience the world and how patients may experience the patient–clinician relationship.[10] This may include race/ethnicity, gender, ability and other intersectional factors.

After considering their own values and identities, trainees could begin to consider how these may impact their opinions or counselling in patient care in a variety of scenarios. In our setting, participants reflected individually on the questions in Box 1.

BOX 1 Support trainee reflection

Guide reflection on individual positionality, power, values and biases

What identities are most meaningful to you?
How do they influence your experience of the world?
How might they affect your patients' experience of their interaction with you?

Guide reflection on the following statements

Unplanned pregnancy is a universally bad outcome.
Long-acting reversible contraceptive (LARC) methods such as IUDs and implants should always be first-line recommendations.
I would be comfortable with the decision if a patient were to decline contraception after an abortion.
Ambivalence about pregnancy needs to be resolved in order to provide the best care to people.

3.4 | Principle 4: Describe approaches to assessing patient goals that create psychological safety and honour autonomy

Assessing patient understanding and goals in a non-judgmental way is key to providing high-quality care. This begins with creating psychological safety in patient encounters and honouring patient autonomy in the clinical setting. Psychological safety is the belief that one is safe to 'take a risk' in a team setting without the fear of interpersonal consequences or being blamed, shamed or ignored by other team members.[11] In the context of patient care, this translates to creating a safe space for patients to ask questions, discuss concerns, or talk about their health without fear of judgement or negative consequences for the care they receive.

In addition to psychological safety, autonomy is a crucial component of patient-centred care, and cultural humility can be a starting point to practice this. Cultural humility is the "ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person]".[9] The concept of cultural humility provides a mental scaffolding for trainees to approach conversations and bridge the gap between clinical expertise and patients' expertise in their own lived experiences, values and preferences.[12] A culturally humble approach to care uses tools like the Explanatory Model to support inquiry about the patient's ideas, fears, and expectations around specific health issues through eight questions (Explanatory Model in Box 1).[13]

The concept of cultural humility provides a mental scaffolding for trainees to … bridge the gap between clinical expertise and patients' expertise in their own lived experiences, values, and preferences.

The Explanatory Model was designed to understand beliefs about disease. It is an excellent starting place for trainees to elicit patient beliefs, goals and expectations during times of illness but does not provide opportunities to explore knowledge, beliefs or values around reproductive health. In the setting of reproductive care, clinicians can use these same principles (common language, expectations, beliefs and goals) to develop an open-ended approach to discussion and ensure that a safe environment is created for patients to ask

questions. Humble and curious inquiry is essential for understanding patients' answers and how they align with patients' reproductive values and the subsequent care to be provided.[14]

In our context, we supported the 'planning a course of action' phase of transformative learning by presenting possible scripts and questions to demonstrate approaches to patient-centred reproductive counselling. These are reproduced in the 'Explanatory Model Applied to Reproductive Health' section of Box 2, and build upon several existing frameworks for discussing reproductive health and intention.[15,16]

BOX 2 Use of Explanatory Models and open-ended questions to support shared decision making in patient care

Explanatory Model of disease

1. What do you call your problem? What name does it have?
2. What do you think has caused your problem?
3. Why do you think it started when it did?
4. What do you think the sickness does? How does it work?
5. How severe is it? Will it have a long or a short course?
6. What do you fear most about your sickness?
7. What are the chief problems the sickness has caused for you?
8. What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment?

Explanatory Model applied to reproductive health

1. What questions do you have about fertility, pregnancy, sexual activity, or reproductive health?
2. Is there anyone you would like to include or exclude from this discussion?
3. How important is it to you to be able to plan or time (spacing between) your pregnancies?
4. Is there anyone in your life who is trying to influence your decisions about sexual activity, pregnancy or contraception?
5. What questions do you have about how contraceptive methods work or what they do to your body?
6. What is your understanding of how your medical issues might impact pregnancy (or contraceptive choice)?
7. What impact would a pregnancy now have on you?
8. What fears or concerns do you have about contraception, pregnancy or parenting?
9. What is the most important thing you want your contraceptive method to do for you?
10. What do you hope for your pregnancy (or for when you are a parent)?

3.5 | Principle 5: Provide trainees with case-based practice in co-production of care

Co-production of care refers to sharing power and involving patients in the design of services directed towards them. A co-production model can be used to support patient-centred care. To develop competence in the co-production of care, trainees require the opportunity to practice in safe, low-stakes spaces. Reflection on their own values can be a vulnerable experience to which trainees may not have had substantial exposure. Authentic practice in safe spaces can scaffold success in patient interactions. Below, we provide three clinical cases to support the later phases of transformative learning including planning a course of action, acquisition of knowledge or skills to carry out a new plan, and exploring and building self-efficacy (Table 2). Learners can practice using the elements of the cultural humility and RJ frameworks to co-produce patient-centred, culturally informed, and RJ-oriented reproductive counselling.

In our setting, we reviewed case one as a group, with a facilitator modelling the use of the following four questions being applied to that case and their own answers to guide reflection. For the two remaining cases, we had participants divide into small groups for self-guided discussion. For each case, participants addressed the following questions:

1. From a reproductive health standpoint, what are your concerns for this patient?
2. From an RJ standpoint, what are your concerns for this patient?
3. What questions could you ask this patient to explore these reproductive health and RJ concerns?
4. What personal or historical context might be relevant for you and for the patient in this case? What might be common or shared values for you and the patient?

The three additional cases and points for debriefing can be found in Table 2.

4 | LESSONS LEARNED

In our context, we learned that the discussions around reproductive health were straightforward and facile for attendees; however, discussions around RJ became more variable and novel for many. Participants came from a variety of backgrounds, including differing knowledge, experiences, values around RJ and cultural humility. The effect of transformative learning became apparent in the last of the four questions on personal context and shared values.

Although some of the cases may have benefitted from clinical knowledge of medical diseases, we found that facilitators could provide additional information (noted in the discussion points of Table 2)

TABLE 2 Cases and discussion points.

Case 1: 26-year-old East African woman with five living children has poorly controlled diabetes and experiences pressure to bear more children.	
From a reproductive health standpoint, what are your concerns for this patient?	For this patient, we might be concerned about the increased rate of complications for mother, fetus and pregnancy that poorly controlled diabetes confers.
From a reproductive justice standpoint, what are your concerns for this patient?	If we value individualistic decision making for ourselves, we might be concerned about reproductive coercion.
What questions could you ask this patient to explore these reproductive health and reproductive justice concerns?	To gauge her understanding of the impact of pregnancy on reproductive health, we might use the question from our explanatory model: 'What is your understanding about how your medical issues might affect pregnancy?' To explore our reproductive justice concerns, we might ask: 'Is there anyone in your life who is trying to influence your decisions about pregnancy?'
What personal or historical context might be relevant for you and for the patient in this case? What might be common or shared values for you and the patient?	
Case 2: 37-year-old East Asian woman experiencing homelessness, taking an ACE inhibitor for well-controlled hypertension, and ambivalent about pregnancy.	
From a reproductive health standpoint, what are your concerns for this patient?	We may be concerned about the impact of lisinopril on a developing pregnancy. At this point, we might consider asking 'What is your understanding about how your medications or medical issues might affect pregnancy?' We might also consider asking One Key Question® of all patients for whom we are initiating or refilling medications, to identify medications with favourable safety profiles in pregnancy, to support reproductive health for those who are neither pursuing nor preventing pregnancy.
From a reproductive justice standpoint, what are your concerns for this patient?	For this patient, we may wish to ensure that she feels supported in sitting with her ambivalence, and that she is aware of and has meaningful access to pregnancy prevention, termination, or prenatal services if and when she needs them.
What questions could you ask this patient to explore these reproductive health and reproductive justice concerns?	We might offer the questions 'What fears or concerns do you have about pregnancy or parenting?' and 'What do you hope for your pregnancy or when you are a parent?' Supported consideration and deliberation around these questions might identify ways in which we can support her in her ambivalence and provide care that accounts for the possibility of pregnancy now or later, while allowing access and removing barriers to emergency contraception or other forms contraception at any time.
What personal or historical context might be relevant for you and for the patient in this case? What might be common or shared values for you and the patient?	
Case 3: 41-year-old Black woman, a successful prominent attorney, does not desire pregnancy ever, has had negative experiences with the health care system, and is not open to contraceptive counselling.	
From a reproductive health standpoint, what are your concerns for this patient?	For this person of reproductive potential who is not interested in pregnancy, we might be conflicted about how best to support this goal in light of her disinterest in contraceptive counselling.
From a reproductive justice standpoint, what are your concerns for this patient?	This patient's negative experiences may reflect her own prior experiences or historical coercion and denial of reproductive autonomy for women of colour. We want to ensure that we respect autonomy and elicit means by which she feels we can support her reproductive goals.
What questions could you ask this patient to explore these reproductive health and reproductive justice concerns?	For this patient, we understand that she does not ever wish to be pregnant. However, we do not know how important pregnancy prevention is to her, or whether termination might be an equally

TABLE 2 (Continued)

Case 3: 41-year-old Black woman, a successful prominent attorney, does not desire pregnancy ever, has had negative experiences with the health care system, and is not open to contraceptive counselling.	
	acceptable option. Thus, we might consider asking 'How important is it to you prevent pregnancy?' We might also pursue an even broader question to identify what she views as most important in her reproductive health by asking 'What questions do you have about sexual activity and reproductive health?' These questions will help honour her autonomy and prior experiences, while building a trusting relationship, and underline that we wish to support her in her health goals as she defines them, no matter what they are. If this patient is expressing that they do not want to discuss pregnancy, sexual or reproductive health at all at this time, clinicians also need to honour that, while leaving the door open. A statement such as 'I hear that you are saying that you do not want to talk about this. I am always available to you and happy to talk more if you change your mind', may be appropriate.
What personal or historical context might be relevant for you and for the patient in this case? What might be common or shared values for you and the patient?	

that would allow for a sufficiently rich discussion of the tensions present in the scenario and the ability to practice skills related to inquiry without requiring a specific level of clinical knowledge. This approach allows materials to be used by any patient-facing healthcare professional.

Session leaders may consider including a content warning at the beginning of the curriculum, as hearing about the historical injustice in reproduction can be activating for some. Additionally, given the sensitivity and personal nature of the topic, we recommend allocating at least 90 min for the curriculum or having it spread out over the course of a few weeks/months. Participants may be encouraged to keep a journal on this topic to foster ongoing reflection as they continue in their clinical education to keep track of their transformative learning on this topic.

5 | CONCLUSION

Patients have expertise in their own lived experiences, including interactions with the healthcare system (whether through direct experience or experiences shared by members of their families or community). Clinicians have expertise in medical knowledge and their own lived experiences. In the overlap of these two is the space of a co-production model of patient care. The education of trainees in RJ-informed care provides an opportunity for trainees to explore key principles in the co-production of care, including cultural humility, cultural safety, and open-ended, non-judgmental inquiry.

The education of trainees in RJ-informed care provides an opportunity for trainees to explore key principles in the co-production of care, including cultural humility, cultural safety, and open-ended, non-judgmental inquiry.

AUTHOR CONTRIBUTIONS

Alexandra Bachorik: Conceptualization; project administration; writing—original draft; writing—review and editing. **Megha Shankar:** Conceptualization; resources; writing—original draft; writing—review and editing. **Meagan Williams:** Resources; writing—original draft; writing—review and editing. **Jessica Beaman:** Conceptualization; writing—original draft; writing - review and editing. **Adelaide H McClintock:** Conceptualization; project administration; resources; visualization; writing—original draft; writing—review and editing.

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