



# Patient involvement in health professionals' education: a meta-narrative review

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## Abstract

More than 100 years ago, Osler inspired educators to consider health professions education (HPE) as intricately reliant on patients. Since that time, patient involvement in HPE has taken on many different meanings. The result is a disparate body of literature that is challenging to search, making it difficult to determine how to continue to build knowledge in the field. To address this problem, we conducted a review of the literature on patient involvement in HPE using a meta-narrative approach. The aim of the review was to synthesize how questions of patient involvement in HPE have been considered across various research traditions and over time. In this paper, we focus on three scholarly communities concerned with various interpretations of patient involvement in HPE—patient as teachers, real patients as standardized patients, and bedside learning. Focus on these three research communities served as a way to draw out various meta-narratives in which patients are thought of in particular ways, specific rationales for involvement are offered, and different research traditions are put to use in the field. Attending to the intersections between these meta-narratives, we focus on the potentially incommensurate ways in which “active” patient engagement is considered within the broader field and the possible implications. We end by reflecting on these tensions and what they might mean for the future of patient involvement, specifically patient involvement as part of future iterations of competency based education.

**Keywords** Patient engagement · Meta-narrative · Patient and public involvement · Medical education · Competency based medical education

## Introduction

Patients—and their role in education—have always been of interest to educators, even as those patient activities may or may not have been in the direct purview of those designing and implementing curricula. Recently, the ways that patients are involved in health professions education has become more formalized in programs identified as “patient

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engagement”. There is a growing body of literature that seeks to address pragmatic, theoretical, and ethical questions about practices of patient engagement in professional education. However, in common with other health care fields that are also pursuing patient engagement agendas, (e.g. patient engagement in health research, policy, or health service design), the body of literature of patient engagement in education has been critiqued as under-theorized and disproportionately weighted towards ideological statements rather than empirical evidence (Regan de Bere and Nunn 2016). The result is a disparate body of literature, conflicting advice as to the purpose of patient engagement, and little consensus about how to build knowledge in the field.

A number of literature reviews have attempted to redress these conceptual problems (Jha et al. 2009a; Livingston and Cooper 2004; Repper and Breeze 2007; Spencer et al. 2000; Towle et al. 2010; Wykurz and Kelly 2002). Each of these reviews have noted the difficulty of the literature search process, as the field is characterized by an inconsistent array of definitions and terms (Towle et al. 2010). Previous literature reviews have sensibly addressed this difficulty by offering precise definitions of patient engagement as the involvement of patients (or their family members and/or caregivers) in at least one phase of the formal education process: curricular decision making, education program design, delivery of curriculum, assessment of learners and/or evaluation of programs (Jha et al. 2009a; Towle et al. 2010). These methodological decisions have resulted in literature reviews focused on patients as teachers, with important syntheses reporting on the effectiveness of patient involvement in education (Jha et al. 2009a, 2010; Towle et al. 2010; Wykurz and Kelly 2002). While the inclusion and exclusion criteria being applied in these previous reviews are both important and defensible, the focus on patients as teachers necessarily obfuscates alternative conceptualizations of patients’ involvement in health professions education. The result is that patient engagement in health professions education is conceptually reduced to just one possible iteration of patient involvement—patients as teachers—and is taken out of context of the other ways in which patients participate in processes of ongoing professional learning. As Bleakley (2014) puts it, there is a need to understand processes of learning with, from, and about patients as foundational to the entire health professions education enterprise. To focus on current iterations of patients as teachers risks an ahistorical approach, where recent iterations of patient engagement are taken to be “new and exciting roles” (Stockhausen 2009) that do not take into account the rich bodies of literature that could inform how these roles might actually be enacted. By putting patient engagement practices back into context of larger debates and dilemmas about patient involvement in health professions learning more broadly, new insight might be garnered about the role of patient engagement in education. This insight might be productively applied to practices of patient engagement as they currently operate, but also impending questions about patient involvement in future educational reforms, specifically reforms related to competency based education.

The objective of this review was to synthesize how questions of patient involvement in health professions education have been considered over time across various research traditions. We have chosen to focus on the broader concept of patient involvement in education, rather than restricting our interest to patient engagement. In particular, our focus was on the debates and dilemmas within the various research traditions that contribute a broader base of knowledge regarding patient involvement in health professions education. In this way, we did not aim to generate a comprehensive summation of all the patient involvement publications in the health professions literature. We generated a meaningful synthesis of various approaches taken to the study of patient involvement, including the various philosophical assumptions and world views that inform these approaches. The synthesis

was conducted using a meta-narrative review process (Greenhalgh et al. 2004, 2005, 2009; Wong et al. 2013). The rationale for the meta-narrative review is described in more detail below. In this paper, we report on our findings—highlighting three concurrent streams of research activity related to patient involvement in health professions education—and we discuss the various tensions between these streams of activity. The unique contribution of this particular review is the addition of a critical and interpretive perspective of the research activity related to patient involvement in health profession education. As meta-narrative reviews are relatively new forms of knowledge synthesis, we will describe and explain its methodology in detail prior to presenting our analysis.

## Methodology: meta-narrative review as knowledge synthesis

The meta-narrative review is designed specifically for topics that have been differently conceptualized and examined by different groups of researchers (Wong et al. 2013). Developed by Greenhalgh et al. in 2004 (Greenhalgh et al. 2005), the focus of meta-narrative reviews is on *how* research findings are produced (Gough 2013). Since 2004, meta-narrative approaches have been productively used to examine (among other things) the constructs of community (Jamal et al. 2013), the paradoxes and tensions in electronic patient records research (Greenhalgh et al. 2009), and the diffusion of innovations in service organizations (Greenhalgh et al. 2004).

A meta-narrative review has a pragmatic goal, intended to help individuals make sense of a conflicting body of literature (Wong et al. 2013). A meta-narrative review is concerned with how knowledge of a particular topic has been developed within and across research traditions (Greenhalgh et al. 2005). This is distinct from cataloging all the existing evidence about patient involvement in health professions education. Instead, this form of knowledge synthesis is concerned with the history, guiding assumptions, and key findings that exist within the different traditions that comprise the scholarly field. Here, a research tradition is considered to be a series of linked studies that are connected through shared assumptions and preferred methodologies (Wong et al. 2013). A meta-narrative review looks historically at how particular research traditions have unfolded over time, how these traditions have shaped the kinds of questions being asked, and the methods that are used to answer those questions (Wong et al. 2013). Thus, the outputs of meta-narrative reviews are maps of multi-level configurations of ideas and how these ideas have influenced what can be known about a topic.

Meta-narrative review was our methodology of choice for two reasons. First, from an early stage in this study it was evident that different research teams had conceptualized, studied and analyzed the topic in different ways. Second, our primary aim was to make sense of a conflicting literature that spanned many fields, and also look at how these fields have influenced one another. Given the need to understand patient involvement as a social innovation embedded in historical, political, and societal discourses, and following the international RAMESES guidelines on meta-narrative reviews (Wong et al. 2013), the meta-narrative review was selected as the methodology of choice. In engaging in a meta-narrative review, we sought to offer a critical synthesis, highlighting potential conceptual tensions and interpreting the implications of these tensions for how patient engagement might continue to be practiced and researched in the health professions education field.

In taking up the methodology of meta-narrative review, we also ascribed to the six guiding principles first introduced by Greenhalgh et al. (2005) and later summarized in

the RAMESES publication standards for meta-narrative reviews (Wong et al. 2013). These principles include: pragmatism, pluralism, historicity, contestation, reflexivity, and peer review.

## Collection procedures and analytical strategy

The procedures for this knowledge synthesis follow the guidelines published by RAMESES and evolved through three main phases: (1) collecting the archive, (2) analysis, and (3) interpreting intersections between higher order concepts. While these phases are presented in linear order, there was much overlap and interconnection between the phases such that stages of analysis informed the need for further development of the archive, interpretation between higher order concepts pointed towards the needs for further analysis and so on. Figure 1 displays the process of collection, screening, and analysis of the primary archive of texts included. The search process and resulting analytical procedures were informed through ongoing consultations with an expert advisory council that had been invited to participate in the review, adhering to the guiding principle of peer review. Members of the advisory council included patients, health professions educators, and social science researchers.

Our exclusion criteria were informed by the principle of pragmatism, namely that the review should be guided by what will be most useful to the intended audience(s), and what is most likely to promote sense-making (Wong et al. 2013). For this review, we excluded sources that were solely concerned with patient engagement in moments of clinical care and were not explicitly linked and/or theorized in relation to learning or education. For the purposes of containing this review, we also did not engage with the literature that is concerned with patient involvement in developing patient education. However, we did not choose to exclude sources based on an analysis of their methodological rigor. Our concern was less with cataloguing evidence across traditions, and more focused on what kinds of

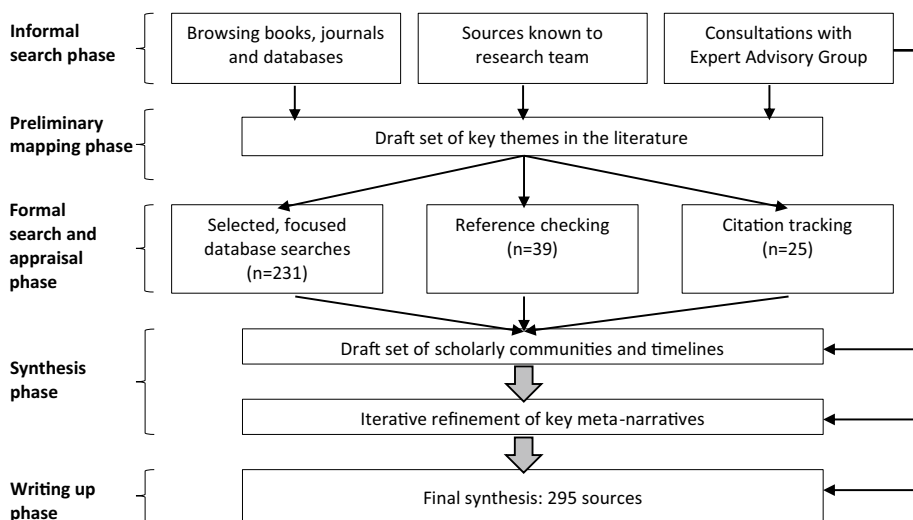


Fig. 1 Summary of phases of meta-narrative review

claims were possible to say at all. As such, if a source was considered to be influential within a particular field, it was included in our dataset as display of a particular way of thinking. The result may be that some of the sources included in our dataset may be contested within their own field. Those contestations are also of interest.

Early in the study, we also considered whether we should limit this review to one or two health professions, namely medicine and nursing. Given the prevalence of patient involvement that is emerging in the field of interprofessional education, we chose to not limit our search strategy by profession. While this decision allowed a certain kind of sense-making across the field of health professions education, it introduced other conceptual dilemmas that we address in the Limitations section of the manuscript.

Initial data collection included a mix of informal and formal search strategies. Starting in September of 2016, initial rounds of searches of Medline, PsycINFO, CINAHL, ERIC, Gender Studies Database, social studies abstracts and America history and life were performed using terms identified by the core research team and the advisory council, making use of the subject headings and tools available in each database to focus on the citations most likely to be relevant. Table 1 provides a high-level summary of the search terms used in the initial formal search, with various adaptations made for each database. Initial screening of titles and abstracts for relevance was conducted by two members of the research team (PR and SM). Following this initial screening, two of the investigators created thematic clusters to organize the remaining archive (see Table 2). These clusters were created through ongoing discussion and collaboration with the rest of the research team, and through consultation with the advisory council. Following consensus on the thematic clusters, each member of the research team (PR, SM, AKK, VS, SL) took leadership of a single cluster. In collaboration with the information specialist (MA), each member continued to search, summarize, and analyze sources that elaborated, informed, or complicated their particular thematic cluster. Data abstraction from each included source included: author(s), year, place of publication, main claims being made, and theorists/key sources cited. As part of this phase, each lead team member identified key researchers, seminal/highly cited sources, and authors that frequently published together. This was done in consultation with members of an Expert Advisory Panel who also provided advice on search terms and key sources. The connections were mapped out over time, following the principle of historicity. In this way, we started to elucidate key scholarly communities producing a range of research streams. Additional searches were performed as new terms and authors were identified. Table 1 summarizes these additional search terms.

As the review unfolded, it became clear that the phrase “nothing about me without me” had a great deal of historical and current salience. We therefore extended our search to help place the phrase in historical context. We used Google Ngram and Google Books to help track the phrase “nothing about me without me” over time. Formal database searches for “nothing about me without me” and variations were also performed in Embase, PsycINFO, Medline and ERIC. Finally, Web of Science was used to locate articles which were either written by key authors or which had cited key papers identified by the core research team. In agreement with Greenhalgh and Peacock (2005), we found our most fruitful searches were not in the formal databases, but were through snowballing, checking references lists, and citation searching.

Over the course of the year, our research team met for several analysis sessions. Given the diversity of concepts, research designs, and claims being made across the dataset, we engaged in narrative, rather than statistical analytical strategies. This decision to include multiple research traditions is consistent with the principle of pluralism. Through our analytical sessions, we identified the boundaries of various research communities. Informed

**Table 1** Database search terms

Databases		
Example Search terms and combinations		
Medline, PsychINFO, CINAHL, ERIC/America: History and Life, Gender Studies, Social Science Abstracts <sup>a</sup>	<p>Terms within columns combined with OR, terms between columns combined with AND</p> <p>Standardized patients                      Patient participation                      Patient or client or user led                      Cocreation                      Patient or client or user voice                      Patient representation                      Patient advisor                      bedside                      point of care                      exam room                      patient room                      disability                      narrative health                      narrative medicine                      patient advocate                      teaching associate                      patient proxies                      psychiatric survivor                      MAD studies</p>	<p>curriculum                      education                      learning                      teaching                      lesson                      training                      inservice</p> <p>medicine                      nursing                      health professionals                      nursing                      allied health professions                      therapy                      therapists                      pharmacy                      medical schools                      health professions students</p>

<sup>a</sup>Strategies varied by database, depending on topical focus and the subject headings and search tools available for each. Searches were run at different points over the course of a year. Individual terms such as “patient instructor”, “nothing about me without me”, “health mentors” and “patient as educator” were also searched

**Table 2** Original thematic clusters

Title of thematic cluster	Description	Number of sources <sup>a</sup>
Bedside learning	Students learning by virtue of being involved in patient care	94
"Nothing about me without me"	Concerned with the rights of patients to shape all arenas of health care, including health professions education	45
Patient narratives	Emphasis on patient narratives as a pedagogical approach	16
Real patients as standardized patients	A subset of the standardized patient literature, concerned with patients learning to display their illness/symptoms/condition in a standardized way	76

<sup>a</sup>Number of sources from original formal database searches

by the guiding principle of contestation, we used our analytical sessions to highlight connections and contentions between these various communities, key objects of consensus and various enduring debates occupying each of these communities. In this way, the four thematic streams provided an entry point into our interpretation. From this layer of mapping and interpretation, we began to articulate the higher order concepts—and the research traditions enlivening these concepts—as an explication of various meta-narratives comprising the field of patient involvement in health professions education. Thus, this involved a further interpretive maneuver, moving from themes in the literature (i.e. narrative medicine, bedside learning, “nothing about me without me”, and real patients as standardized patients) to meta-narratives that operate at the level of overarching paradigms. Concepts and conclusions held within each of the themes were put into context of these meta-narratives. Thus, our synthesis strategy operated at a high level of abstraction and required us to examine: (a) commonalities in underlying conceptual and theoretical assumptions, (b) differences across underlying conceptual and theoretical assumptions, (c) interplay and tensions between various paradigms, and (d) exploring patterns that span across various paradigms (Wong et al. 2013). This high level of abstraction necessarily loses some of the nuance that occupies each theme, but allowed us to put bodies of literature into conceptual contact in a way that would not have been otherwise possible.

Throughout the process, we were reflexive about our own position as researchers. The lead author is an organizational studies scholar who has explored constructs of patient engagement in other fields. Two members have spent many years developing and implementing patient engagement in health professions education programs, particularly making use of concepts of narrative and the patient role of Health Mentor. Two members were health professions students. One member also has experience of chronic illness, disability, and has volunteered as patient in various advisory and/or advocacy groups. Finally, our information specialist was a core member of the research team. Through our collaboration, we were required to make explicit our own assumptions about patient involvement (what it meant, why it was of interest, how it “should” be done, how it should be researched). For instance, one of our most fruitful analytical decisions was to release our assumptions about “active versus passive patient involvement” as an inclusion/exclusion criteria as part of the data collection, and instead engage with this dichotomy interpretively: how do the scholarly communities under consideration deal with this dichotomy of active versus passive patient involvement? Our final step of interpretation was to produce this manuscript. By

this we mean that we were required to choose meta-narratives to focus on, which tensions to illuminate, and to what depth given the word limits available to us.

## **Main findings: concurrent constructions of patient involvement in health professions education**

William Osler, the well-known Canadian medical educator, featured prominently in all scholarly communities concerned with patient involvement in health professions education. In particular, his famous address to the Academy of Medicine in New York was frequently cited, where he declared: “for the junior student in medicine and surgery, it is a safe rule to have no teaching without a patient for a text, and the best teaching is that taught by the patient himself” (cited in Towle and Godolphin 2011, p. 496). However, the ways in which researchers and educators subsequently took up that declaration—and the programs and institutions developed in association with those constructions—all reflect distinctions between scholarly communities. In the following section, we will demarcate just three of the ways in which patient involvement in health professions education is understood across academic disciplines and research traditions. Through the process, we will explore: (a) constructions of the notion of “patient”, (b) rationales for patient involvement in health professions education, and (c) research traditions associated with generating knowledge in the field. Throughout, we will highlight various debates and dilemmas occupying each of the scholarly communities.

### **Patient involvement as emergence of the “engaged patient”: democratic and emancipatory rationales**

In 2011, Towle and Godolphin usefully synthesized patient engagement in health professions literature, using the definition of patient engagement as *active* engagement in the design, delivery, and/or evaluation of curriculum. Through their synthesis, they presented a timeline of engagement, originating in Osler’s aforementioned famous declaration, evolving into “clinical teaching associates” (CTAs) in the 1970s, followed by a more politically active role for patient involvement in the 1990s, and culminating in a recent recognition of patient expertise as a legitimate source of knowledge that serves to move health professions education beyond the biomedical model. Our synthesis distilled around a similar timeline, which we have labelled as “the emergence of the engaged patient”.

In this body of work, the engaged patient took on particular meaning. First, there was much discussion about who to define as a “real” patient. Real patients were considered to be those that have direct lived experience with the illness and/or condition they sought to display. People who role-play patients to express symptoms or conditions they do not actually have were not considered “real” patients and thus excluded from this category (Towle et al. 2010). Thus, there was a distinction between patients and general members of the public. Further, in this research community, health professionals were often excluded, where real patients “are not constrained and influenced by professional value systems” (O’Neill et al. 2006, p. 27). Second, while there were no overt definitions that served to exclude particular illness experiences, much of this body of work was anchored in notions of “expert patients” that have taken hold within the chronic illness literature (Muir and Laxton 2012; O’Neill et al. 2006; Skog et al. 2000; Towle and Godolphin 2011) and the “nothing about me without me” rallying cry of critical disability studies and mental health



movements (Beecham 2005; Bollard et al. 2012; Charlton 1998). With the strong emphasis on chronic illness and patient expertise, it was not clear whether patients who had experienced acute illnesses that had subsequently resolved would be considered as “patients as teachers”. We draw attention to this demarcation, as it serves as a point of contrast to an alternate understanding of patient involvement discussed later in this manuscript.

This body of work is strongly influenced by democratic rationales for patient engagement in health professions education. Here, patient engagement was framed as the right of patients to teach about their own bodies and experiences (Beadle et al. 2012; Jha et al. 2010; Robertson et al. 2003; Silverman et al. 2012). This was further translated into the right to meaningfully influence educational priorities that will shape health professions of the future (Towle and Godolphin 2011). At times, this rationale took on an emancipatory tone, explicitly attempting to disrupt existing power relationships between health professionals through shifting curricular decision-making power to patients and/or role-modeling the abdication of power from educators to patients (Beecham 2005). Frequently cited theorists included Paulo Friere (Gutman et al. 2012; O’Neill et al. 2006), a Brazilian educator and philosopher famously concerned with critical pedagogies and their emancipatory potentials in society. Further, it was only in this body of work that there was reference to Arnstein’s ladder of community engagement (Beadle et al. 2012; McKeown et al. 2012). Originally developed to critique existing forms of community engagement in the 1960s and 1970s (Arnstein 1969), this ladder recommends higher levels of engagement characterized by increased power for decision-making being placed in the domain of community members themselves. Translated into the context of health professions education, moving up the ladder of engagement implies increased powers of curricular decision making allocated to patients, rather than remaining exclusively in the domain of faculty members.

The debates and dilemmas occupying this body of work reflect these democratic and emancipatory ideals. Thus, researchers and educators are concerned with questions of patient representation, authentic (as opposed to tokenistic) engagement, determining the amount of decision making afforded to patients, and patients’ experiences of these engagement opportunities (McKeown et al. 2012; Rowland and Kumagai 2018; Towle et al. 2010; Towle and Godolphin 2011, 2015; Vail et al. 1996). While researchers were also concerned with the learner experience of patient engagement, this learner experience tended to be considered in terms of either the learner’s enjoyment of the experience, the effects on health professionals’ level of empathy and/or impact on learners’ acquisition of clinical skills (Arenson et al. 2012; Duggan et al. 2010; Graham et al. 2014; Hope et al. 2007; Iezzoni and Long-Bellil 2012; Kumagai 2008). Other matters of concern included the therapeutic benefits experienced by patients (McCreddie 2002), the ethics of compensation for patients (Bollard et al. 2012), and the practical dilemmas of including patients who are experiencing various impairments (Hope et al. 2007). This body of work tended to be enacted through qualitative methodologies, with an emphasis on critical and/or interpretive approaches. It was only in this body of work where there was evidence of patients co-authoring publications with educators (see Agrawal and Edwards 2013).

### **Patient involvement, “real patients”, and standardized patients: technocratic rationales**

There is much overlap between the body of work that is concerned with “engaged patients” and that involved with “real patients as standardized patients”. The phrase “real patients as standardized patients” is somewhat challenging to unpack. In the literature, a distinction

was made between (a) members of the public who have received training in order to portray an illness or condition that *they do not actually have* and (b) patients who received training in order to portray *their illness or condition* in a standardized way. It is the latter that is referred to as “real patients as standardized patients” in this paper, even as we acknowledge the various paradoxes and dilemmas implied by such a label. In this review, we draw distinctions between research communities in order to illuminate disparate research traditions, attending to their various problem statements and their resultant conclusions. Therefore, those arguments related to standardized patients that share democratic and emancipatory concerns with decision-making, curricular design, and power sharing are considered in the preceding discussion. Indeed, there is a body of research concerned with how real patients could (and should) shape curricula as a result of their experience as standardized patients (Nestel et al. 2008; Plaksin et al. 2016). Further, there is much concern for the experience of patients acting in these roles, including their emotional and physical safety (Debyser et al. 2011; Krahn et al. 2002; Plaksin et al. 2016; Taylor 2011; Walters et al. 2003; Webster et al. 2012). However, taking those shared priorities aside, there are unique features of the “real patients as standardized patients” narrative that warrant discussion. It is to this body of work—real patients as standardized patients—that we turn to now.

Here we highlight the notion of *standardization* as a distinguishing concept. Putting this body of literature into historical context points to the 1960s works of Dr. Howard Barrows, a physician who first made use of simulated patients as a way to examine the clinical skills of medical students (Barrows 1993; Krahn et al. 2002). The introduction of simulated patients was to address some particular dilemmas of medical education, namely: the inability to ensure access to a suitable range of teaching cases as part of standard clinical education, the lack of consistency of learning opportunities across clinical cases, the potential lack of equity in the assessment of students given that unpredictability (Bates and Towle 2012), and the opportunity for students to receive meaningful patient feedback (Bokken et al. 2008). Thus, simulation was developed as a solution to a set of problems.

While the standardized patient literature holds historical roots within the field of simulated patients, we wish to highlight the concept of *standardization* as consequential. Within the concept of standardization, there is implied assurance that each student will encounter an exactly similar simulated patient scenario. This additional conceptual layer—of standardization not just simulation—was a further innovation applied to the paired problems of (1) fair distribution of learning opportunities and (2) transparency of the assessment process for learners (Barrows 1993). Of note, those problem statements were primarily defined from the standpoint of learners and educators.

The body of research that explores real patients as standardized patients continues to explore the boundaries and edges of these original problem statements, exploring suitable characteristics of standardized patients (Gall et al. 1984; Jha et al. 2010; Kroll et al. 2008; Long-Bellil et al. 2011; Stillman et al. 1980), appropriate ways to prepare patients for their role (Jha et al. 2009b), and novel ways to evaluate the impact of these standardized patients on student learning (Jha et al. 2009a). There is reference to “active” patient involvement in the “real patient as standardized patient” body of work, but this tends to refer to active roles in teaching, preferably in the absence of other teachers (Bokken et al. 2008). Jha et al. (2009b) found that educators and students value this active teaching role, but do not necessarily see a role for patients in curriculum design. Further, there are clear efforts to develop an evidence base for the utility of standardized patients, using research designs that are familiar within evidence-based medicine approaches. In this body of work, evidence is considered along the lines of lack of negative impact (for students), the presence of positive impacts (for students), and cost benefits (for the educational institution)

(Allen et al. 2011; Asprey et al. 2007; Bokken et al. 2008; Davidson et al. 2001). This is not to say that the studies are insensitive to standardized patients and their experiences. Further, there is a growing body of work that is concerned the politics of knowledge, questioning who decides—and how such decisions are made—about what content is addressed, how patients are constructed, what is being displayed about the patient experience (Taylor 2011). Despite these growing questions about power and decision-making, the concept of *evidence* seems largely to be reserved for the kinds of impacts experienced by learners, educators, and educational institutions. For example, Allen et al. (2011) compared learning outcomes for students receiving instruction from a standardized patient with rheumatoid arthritis and students receiving instruction from a rheumatologist. Davidson et al. (2001) also designed a concurrent controlled trial to compare two methods of teaching physical assessment: a traditional faculty-taught course and a course taught by specially trained standardized patients. Both sets of authors concluded that the learning outcomes were comparable, but the standardized patient model was far more cost effective. The use of cost comparisons and control trial research designs are unique to this body of research on patient involvement, as is the conceptualization of resource management, where “patient partners are managed for successful enduring engagement” (Barr et al. 2009, p. 599).

In the previous section on “the emergence of the engaged patient”, we drew attention to scholarly communities drawing on interpretive and sometimes critical paradigms. In contrast, there is a community of research in the field of standardized patients making use of instrumentalist notions of patient engagement, exploring the impacts of various interventions using positivist rationales and experimentalist designs. As already noted, there is overlap between these two research communities and their various assumptions. However, the distinctions are worth highlighting. In particular, the historical rationale for “real patients as standardized patients” as a technocratic response to a problem of access and standardization of learning opportunities remains consequential. These instrumentalist assumptions—not always explicitly stated—are visible in the great volume of concern displayed for the quality, reproducibility, and standardization of the learning experience. Accountability to present and future patients is inferred through a sense of responsibility for creating learning experiences that are authentic, meaningful, and equally dispersed for the learners.

### **Patient involvement as entanglements of care and learning: sociocultural learning**

Previous reviews of patient engagement in health professions education have excluded considerations of “bedside learning”—or “clinical learning”—defined here as the learning experienced (by students or patients) during moments of care (Monrouxe et al. 2009). Given that “active” patient involvement has been taken to mean active pursuit of some kind of teaching role (Towle et al. 2010), the exclusion of bedside learning from previous reviews is sensible. However, for the purpose of our review, we deemed it important to put our consideration of patient involvement in health professions education in conceptual contact with the large, long-standing, and historically influential body of work on bedside learning. This body of work is too expansive to be considered in depth in this particular review. Instead, we engaged with review papers, highly cited pieces of work, and enduring debates in the field. While the descriptor of bedside learning has persisted from the early 1900s to current times, there is recognition that much of learner-patient contact is no longer at the side of a bed, but also occurs in community and ambulatory settings (Coleman and Murray 2002). What is of interest to us in this review are those moments when

learning is considered in relation to moments of service provision. The point of distinction we made is not between “active” or “passive” patient involvement in learning, but between scenarios where patients have chosen to participate in learning and are aware of their teaching roles (e.g. as clinical teaching associates, curriculum committee members, standardized patients etc.) and scenarios where patients are seeking care and may also be participating in learning by virtue of student participation in those care relationships. This position also opens the possibility of learners and patients learning with, from, and about one another simultaneously, a concept explored by Bleakley and Bligh (2008). Further, considering moments of mutual learning also removes the necessity of patients having a particular kind of expertise in order to participate in a learning relationship with students. By this line of thinking, people experiencing illness for the first time are also in learning relationships. Learning relationships are not reserved for those patients with expertise by experience and/or chronic illness. Finally, by removing the assumption that active patient engagement in learning must equate to some level of curricular decision-making and/or direct teaching, we found a group of researchers conceptualizing active involvement of patients in various entanglements of care and learning at the (sometimes metaphorical) bedside.

Patient involvement in bedside learning is anchored in Osler’s famous *Aequanimitas*, taken to be the impetus for the institutionalization of the modern concept of a teaching hospital. The teaching hospital originally emerged as a ‘charity hospital’, where patients received medical care in exchange for participating in student learning (Ludmerer 1983). From this early manifestation of entanglements of care and learning, there are continued debates about whether patients have a duty to participate in the learning of health professionals (Waterbury 2001). Other enduring debates about the nature of bedside learning include: ethical concerns related to patient consent, declining student access to patients as learning opportunities, problematic role modeling of patient care from senior clinicians including the insidious effects of hidden curricula, and the various ethical dilemmas experienced by students attempting to balance their learning needs against patients’ care needs (Bashour et al. 2012; Celenza et al. 2011; Chiong 2007; Draper et al. 2008; Hubbeling 2008; Leinster 2004; Monrouxe et al. 2009; Paull 2006).

What is of particular interest to us in this review are the emerging ways in which bedside learning is being conceptualized. It is in this body of literature that we see constructionist theories of learning. This in contrast to earlier—and more dominant—approaches to bedside learning that would serve to objectify patients into teaching materials. In this alternate conceptualization of clinical learning, there is a focus on the interactional nuances during triadic encounters between learners, patient and instructors, using social theories of learning as a way to make sense of learning in these relational spaces (Bleakley 2014; Bleakley and Bligh 2008; Kumagai and Naidu 2015). It is this body of research that we wish to emphasize. Here we see the introduction of concepts of legitimate peripheral participation (Lave and Wenger 1991), communities of practice (Wenger 1998), Engeström’s notions of expansive learning in activity systems (Engeström 1999) and various iterations of actor-network theory (Latour 2007; Law 1999; Mol 2010). What these theoretical orientations share are a focus on the social, material, temporal, and contextual aspects of learning (Fenwick and Edwards 2010). This in contrast to theories of adult learning that have historically focused on learning as a cognitive accomplishment of an individual (Bleakley 2014). Instead of focusing on individuals, social learning theories draw on concepts such as shared knowledge, social identity development, and collective sense making as a means to explore learning not simply as acquisition of knowledge, but as an aspect of socialization, involving legitimate entry into a community of practice through the adoption of a particular identity (Bleakley 2012). In this theoretical framing, patients act along with health

care professionals in forming a network of activity, held together by a common object of interest. That is not to say that there are not tensions, debates and dilemmas about *how* to act within these networks, but explicating these tensions becomes part of understanding the phenomenon of learning (Fenwick and Edwards 2010). Research designs making use of these theoretical apparatuses tend to be qualitative, with in-depth observations and video-ethnographic studies predominating (Hamilton 2011).

In this summary, we emphasize just one stream of bedside learning literature: the body of work that focuses on constructivist theories of learning. We recognize that this particular scholarly community does not represent the whole of bedside learning—nor the experience of patients that find risk and rewards unevenly distributed between patients and trainees during moments of care. We highlight this one meta-narrative about bedside learning for the theoretical contributions being made and the juxtaposition from other scholarly communities sharing similar value statements, but approaching various research questions from a different theoretical stance.

## Meta-narratives: commonalities and tensions

Using an expansive and iterative process, we collected a wide range of literature concerned with patient involvement in health professions education. While we organized the presentation of our analysis along the lines of three scholarly communities—concerned with the engaged patient, real patients as standardized patients, and bedside learning—what is of primary interest in our synthesis are the over-arching storylines that animate each of these communities, particularly as those storylines (or meta-narratives) interact with one another. To that end, we discuss the primary research questions and dilemmas fuelling each scholarly tradition and the possibly incommensurate notions of active engagement. The shift from addressing narrative themes in the literature to articulating meta-narratives is conceptually significant. In outlining the aforementioned themes, we attended to various concepts and how they related to one another. To articulate meta-narratives requires attention to coherent bodies of work that share common sets of concepts, theories, methods and instruments (Kuhn 1996). This involves attending to boundaries and interconnections between the actual research communities over time and across various spaces and places. Whereas the narrative themes can be presented as ahistorical, to attend to meta-narratives necessitates attending to history, context, and connections. While the conceptual themes already explored do interact with one another, the meta-narratives we describe next are not simply mapped onto those themes. The meta-narratives described take into account those conceptual themes, but also layer in the boundaries between various research communities, what concepts are shared, what debates exist within communities and across them. Building from Greenhalgh et al's (2004, 2005) work, we asked questions such as: which of these researchers attend the same conferences, referee for each other's papers on journals, apply to the same grant-giving bodies? In doing so, we started to interlay narrative themes and research communities in order to tease out various meta-narratives that are informing the larger field of patient involvement in health professions education. Table 3 provides a high-level summary of the meta-narratives.

Anchored in the historical legacy of Osler, each stream of activity wrestled with the entanglements of care and learning. This was originally framed as a problem of learning for the students—and by extension, the faculty members—bringing into question where the most fruitful learning experiences were to be located. This is not to say that patient

**Table 3** Key meta-narratives in research into patient involvement in health professional education

Meta-narratives			
	Reproducible learning and assessment practices	Democratization of health professions education	Social understandings of learning in care contexts
Focus of field	Providing standardized learning and assessment opportunities	Involvement of patients in all aspects of teaching	Students learning within the contexts of patient care
Philosophical perspective	Post-positivist/objectivist	Critical-emancipatory	Constructivist
What is the purpose of involving patients in teaching?	Improving efficiency and reliability of the teaching process	Recognising the patient's right to influence education	Care and learning are entangled together
How is the "active" patient conceptualized?	Instrumentally: actively teaching	Politically: actively engaged in all levels of decision making	Theoretically: all bodies (and all objects) <i>act</i> in some way
What kind of research is valued?	Experimental trials	Participatory action research	Ethnographic studies
Debates and dilemmas	Reproducibility of learning	Patient voice, representation	Ethics and consent, student access to learning opportunities, effects of hidden curriculum

concerns were ignored, but that the avenue to better patient care was constructed to be mediated through better education. The bedside learning tradition addressed the learning dilemma by firmly locating learning within the care settings. The emphasis on bedside learning germinated a host of new institutions, still visible in modern day organization of the medical workforce within teaching hospitals. However, this decision caused other problems to arise, including ethical dilemmas related to patient consent and pragmatic concerns about student access to learning opportunities. Given the impossibility of disentangling care and learning at the bedside, research traditions developed that could explore the inherent social complexity in these spaces. For some, this situation has evolved into embracing social theories of learning that have originated outside of health care settings.

While educators and researchers that continued along the stream of bedside learning grappled with these dilemmas without destabilizing the foundational assumption of the value of learning within practice settings, a specific group of educators attempted to solve these problems by introducing a new educational resource: the simulated patient. For some, the simulated patient later evolved to become the standardized patient. Here, the problems to be solved were primarily the problems of students and educators, but this strategy also provided an avenue to manage the thorny dilemmas of patient consent through mechanisms of patient volunteerism. Having contained those particular ethical dilemmas and patient safety concerns, the focus could be placed on continuing to refine the practices and tools associated with creating a standardized resource that would bolster ever more educational activity related to competencies and competency development. Hence, an associated research tradition developed capable of answering questions related to the success of standardized patients as an educational resource.

However, the development of standardized patients was not occurring in a political vacuum. Coinciding movements outside of the academy also sought to provide alternatives to bedside learning, yet the problems to be solved were not necessarily those identified by students or faculty members. These problems were framed within a larger societal discourse of eroding trust in the professions, the rights of patients to shape health care systems, and a growing appreciation of lived patient experience as a form of expertise.

In Fig. 2, we display the meta-narratives as interacting with one another over time. We have presented these timelines in parallel to demonstrate their co-existence in high relief. This is in contrast to the distinctions displayed in Table 3, which suggests linear and clear separation between meta-narratives. Rather than a single teleological timeline that moves from passive to active engagement, there are multiple timelines with different trajectories. Each stream of activity shares the declared aim of improving patient care through enhanced learning experiences. However, the primary research questions and dilemmas—and the ways they are addressed—are different across the timelines. Further, the solutions to one set of problems invariably create a new set of problems, vigorously pursued by educators and researchers. The result is a set of boundaries between researchers that potentially crystallize into incommensurable concepts that may go unnoticed, particularly as they appear to share common language (Kuhn 1996).

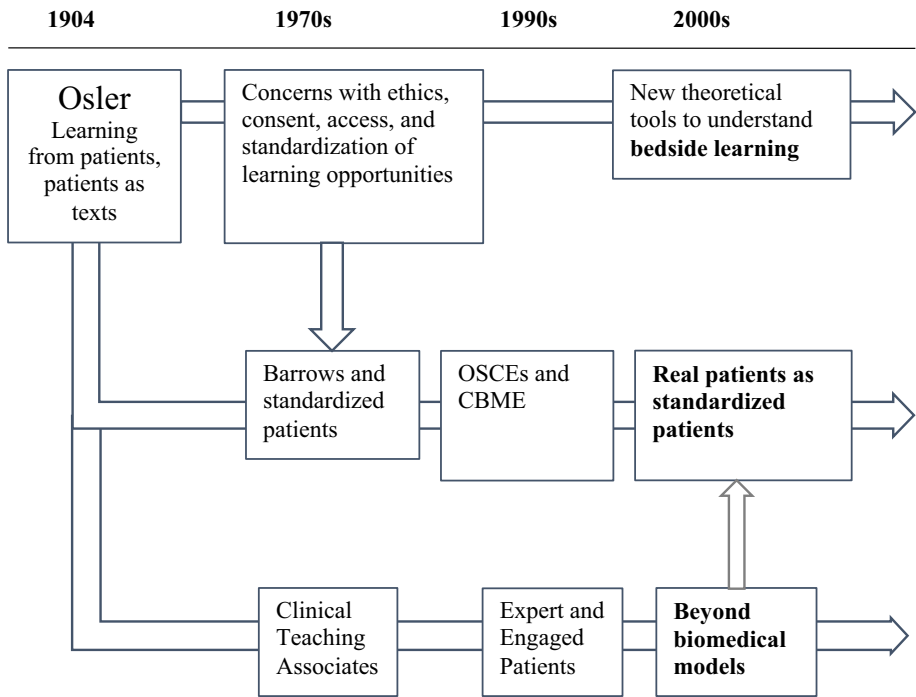


Fig. 2 Timelines of patient involvement in health professions education research

## Exploring incommensurabilities: constructing “active” patient engagement

One possible incommensurability is the notion of “active” patient engagement. Recent theorizations (Bleakley 2014; Bleakley and Bligh 2008) of bedside learning would position patients as part of social systems. The question of being “active” or “passive” may not be entirely relevant in these theorizations. This is not to say that these questions are not important, but that the concepts themselves may not hold the same kind of salience. In these theorizations, all actors within the system are implicated in learning. Whether the learning is desirable or detrimental is not predetermined, but the notion of passivity may not be the most fruitful way to pursue those questions. For example, in some social theories of learning, all animate and inanimate objects are active in some way (Latour 1999; Law 1999). In this kind of framing, patients, learners, teachers, desks, windows, policy statements, assessment protocols, patient gowns, short and long white coats are *all* active in some way. Thus, the ways in which objects act and interact, and to what effect these actions have, are empirical questions. In this sense, to say that some programs have active patients and some do not does not have the same kind of salience. This is not to say that these theorizations cannot be put to use as critique of existing practices (Latour 2004), but the nature of critique is not presumed prior to the investigation. The difference lies in the initial assumptions about the nature of engagement, requiring a bracketing of any assumptions about how it should be performed and instead focusing empirically on how practices are actually unfolding (Broer et al. 2014).



In contrast, the notion of active patient in some recent iterations of “patient as teacher” equates the active patient with holding decision-making power. Following the linear assumptions about power that animate Arnstein’s ladder (Tritter and McCallum 2006)—and all ladder-like models that might trace their conceptual lineage back to this particular model of engagement—any form of engagement that does not actively transfer meaningful decision-making power to patients risks being experienced as tokenistic. Here, the “active” patient is enrolled in the politics of healthcare, requiring a different set of theorizations to make sense of questions of impact. Social scientists have grappled with this linear conceptualization of power in other fields of patient engagement, raising questions about the unintended consequences of equating authentic engagement almost exclusively with visible forms of decision-making (Eakin 1984; Ocloo and Fulop 2012; Tritter 2009).

Finally, the standardized patient literature may overlap with the engaged patient literature in some decision-making spaces, but a substantive subset of the standardized patient literature assumes that “active engagement” equates to active teaching. This does not require any associated assumption about participating in decision-making and leaves the power balances between patients and educators relatively undisturbed. To address questions of impact of the “active” patient as teacher requires technocratic rationales that are amenable to experimentalist type thinking. To this end, there is a potential that communities of researchers are deploying the concept of “active” patient engagement with entirely different mental models of what “active” engagement entails.

Thus, the challenges of creating a meaningful synthesis of the literature on patient involvement in health professions education may not just be a problem of nomenclature. Instead, the difficulty of creating a useful synthesis may also reflect different conceptualizations about the nature of learning with, from, and about patients. Researchers and educators may be describing multiple conceptual objects (Mol 1999), where patient involvement is performed in multiple ways simultaneously. The outcomes between these various performances will invariably differ, as will their potential for unintended consequences. For example, where patient involvement performs as a democratic exercise, questions of patient voice, representation, and representativeness become relevant (Rowland and Kumagai 2018) but accountabilities to learners along the principles of explicit learning opportunities, transparent assessment practices, and equitable learning opportunities may be less visible. When patient involvement performs as a technical endeavour, accountabilities to learners may be more explicitly addressed, but unintended and unexplored paternalism towards patients may persist. When patient involvement performs as an emancipatory endeavour, the value of radical autonomy might be lived at the expense of realizing the full technical expertise of educators (Bleakley 2014), creating conditions of mutual powerlessness that have been explored in other fields of patient engagement (Broer et al. 2014).

Therefore, to continue to build knowledge in the field of patient involvement in health professions education requires recognition that the field is not homogeneous, and the differences will not be rendered smooth through efforts to create uniform nomenclature. Further, educators and researchers should be cautious about mixing incommensurate concepts, using parameters of impact that resonate in one paradigm to evaluate the impact of interventions designed in another. For example, it is questionable whether using an experimentalist design to determine the impact of dialogical intervention can truly satisfy either epistemic community. Instead of starting an inquiry with the question “does this patient engagement intervention work?”, perhaps it is wise to start by asking “what work does patient engagement do?”, “for whom?” and “how will we know?”. Thus, we are in agreement with Regan de Bere and Nunn as they call for more consideration of ontological and

epistemological matters in patient and public involvement scholarship and research in the field of health professions education (Regan de Bere and Nunn 2016).

## Limitations

For the purpose of this review, we sought high level abstractions to help educators to grasp—and wrestle with—various conceptualizations of patient involvement in health professions education. We opted to not limit our search to any particular health profession. As an astute reviewer pointed out, the differences between health professions are consequential, as are the impacts of these differences on the historical trajectories of patient involvement in education. It was beyond the scope of this particular paper to explore those differences, how they interact with one another, and how such an analysis might inform our over-arching interest in patient involvement. Future reviews could focus on these professional differences.

Further, in this particular paper, we have chosen to focus on high level abstractions and interactions among various meta-narratives. It was beyond the scope of a single manuscript to also address the various nuances within various meta-narratives: the contradictions, debates, and dilemmas that give each meta-narrative a sense of fluidity. As a result, we are aware that what we have presented in this paper is necessarily blunt. For example, we are aware that not all research in the standardized patient literature can be characterized as being concerned with efficiencies and reproducibility. As a further example, we appreciate the dilemmas of various social theories of learning that do not seem to adequately account for patients learning and/or membership in various communities of practice. There are certainly nuances and debates within each field introduced in this review. In this manuscript, we chose to put large and competing ideas on display in order to explore contrasts across the larger enterprise of patient involvement in education. Future papers might explore the nuances within paradigms with more depth than what can be accomplished here.

## Concluding thoughts: connecting to current educational imperatives

We conducted this review in order to synthesize how questions of patient involvement in health professions education have been considered across various research traditions and over time. In doing so, we sought to bring a critical perspective to how patient involvement is being considered in the literature more broadly and what are potential implications for the field. In this study, we focused on three scholarly communities—engaged “patients as teachers”, real patients as standardized patients, and bedside learning—as a way to draw out various meta-narratives in which patients are constructed in particular ways, rationales for patient involvement in health professions education are deployed, and research traditions associated with generating knowledge are put to use in the field. Attending to the intersections among the various meta-narratives, we focused on the potentially incommensurate ways in which “active” patient engagement is considered within the field and the potential implications of those incommensurabilities.

In coming to this conclusion, we return to the pragmatic aspirations of meta-narrative reviews (Wong et al. 2013). Along with many other countries, Canadian medical education is on the cusp of major reform, to be enacted through the principles of Competency Based Medical Education (CBME). We focus here on CBME as a particular example, but this example has salience for other health professions that are also mobilizing around

competency-based education. CBME seeks to reconfigure medical education towards an outcomes oriented model, relying heavily on practices of assessment as a way to enact those goals (Holmboe et al. 2010). The ways in which patients will be involved in this reform are largely yet to be seen. However, local conversations suggest that patient involvement might occur in any one of three arenas: patients as another stakeholder in the multiple stakeholder assessment process, as raters in Objective Structured Clinical Examinations (OSCEs), and/or as participants and decision makers in Competency Committees convened to make decisions about the advancement of learners. Each of these may be viable options. And yet, none of them are entirely new. Each option maps onto the timelines explicated in this synthesis: bedside learning, real patients as standardized patients, and engaged patients (particularly engaged patients as decision makers). As such, each option can be put into historical context, drawing attention to various assumptions, debates, and dilemmas that invariably carry forward into the present. Involving patients in workplace-based assessments of learners will require attending to questions of power, vulnerability, the ethics of consent, the potential burdens placed upon patients to participate, and the tensions that might be experienced as patients find themselves occupying multiple roles. Involving patients in Competency Committees will require much sensitivity to questions of power, credibility, legitimacy, expertise, and representation. Finally, all forms of patient involvement need to be understood in light of how they interact with the various assumptions, ideals, and aspirations that occupy CBME.

It continues to be true that health professions education does not exist without patients. Indeed, health professions themselves do not exist in the absence of patients. While that original claim remains salient, much has changed in the 100 years that have passed since Osler first inspired a generation of educators. As the field is poised for another transformation, the ways in which patients will be engaged, implicated, enrolled, involved, and followed warrant careful and collaborative thought.

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## Compliance with ethical standards

**Conflict of interest** The authors declare no conflict of interest.

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