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Kaan Mert Güven
Acibadem Mehmet Ali Aydınlar University
Melike Şahiner
Acibadem Mehmet Ali Aydınlar University
Mustafa Kemal Alimoğlu
Akdeniz University
İlhan Cem Sungur
Acibadem Mehmet Ali Aydınlar University
Levent Altıntaş
levent.altintas@acibadem.edu.tr

Acibadem Mehmet Ali Aydınlar University

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From student voice to visible influence: A mixed-methods needs analysis of medical student partnership engagement across Türkiye

Kaan Mert Güven[1]*, Melike Şahiner[1, 2], Mustafa Kemal Alimoğlu[3], İlhan Cem Sungur[2], Levent Altıntaş[1, 2]*

[1] Department of Medical Education, Graduate School of Health Sciences, Acibadem Mehmet Ali Aydınlar University, Istanbul, Türkiye

[2] Department of Medical Education, School of Medicine, Acibadem Mehmet Ali Aydınlar University, Istanbul, Türkiye

3 Department of Medical Education, Faculty of Medicine, Akdeniz University, Antalya, Türkiye

*Corresponding authors: Kaan Mert Güven, kaan.guven@acibadem.edu.tr ; Levent Altıntaş, levent.altintas@acibadem.edu.tr

Kaan Mert Güven - 0009-0005-8920-5081

Melike Şahiner - 0000-0001-6561-7675

Mustafa Kemal Alimoğlu - 0000-0002-0587-1177

İlhan Cem Sungur - 0000-0003-2191-8323

Levent Altıntaş - 0000-0002-4950-6956

Abstract

Background

Student engagement through partnership positions students as collaborators in educational design, research, governance, quality assurance, and community engagement. Although increasingly promoted in health professions education, less is known about how students experience partnership across national contexts or why some participation mechanisms produce influence while others remain symbolic. This study examined how medical students in Türkiye perceived and experienced engagement through partnership.

Methods

We conducted a nationwide, multiphase mixed-methods needs analysis. An online survey included five-point items, a five-level engagement continuum, and open-ended questions on facilitating and hindering factors. Medical education departments or units across Türkiye's seven geographical regions were asked to distribute the survey. Survey findings informed two student-only online focus groups. Quantitative data were analysed descriptively in R. Open-ended responses and focus-group transcripts were analysed using an iterative, team-based codebook thematic approach and integrated during theme development and interpretation.

Results

A total of 144 students completed the survey; 130 (90.3%) attended public universities, and 80 (55.6%) reported no role in student representation or organisations. Partnership was rated at least moderately important by 82.6%, and 90.9% perceived at least a moderate contribution to educational quality; 59.0% rated institutional support at the scale midpoint or above. Across four domains, 89.5%–92.3% rated partnership at least moderately important, whereas 59.7%–70.1% reported engagement at involvement or higher. The integrated qualitative dataset comprised 639 meaning units and generated five higher-order themes: from student voice to visible influence; from goodwill to institutionalised partnership; building safe, respectful, and fair relationships; protected capacity for sustainable partnership; and enacting partnership through shared practice. Representation, feedback, and formal structures could facilitate or hinder partnership depending on their enactment.

Conclusions

Students valued partnership but perceived an implementation gap between its educational importance and institutional practice. Meaningful partnership requires student voice to have visible influence through institutionalised processes, psychologically safe and equitable relationships, adequate capacity, and shared practice. Medical schools should prioritise feedback accountability, inclusive representation, role clarity, partnership literacy, psychological safety, and protected capacity rather than simply increasing opportunities to speak.

Keywords: student engagement; students as partners; medical education; student voice; mixed-methods research; psychological safety; Türkiye

Background

Student engagement has become central to higher education, contributing to learning, persistence, educational development, and student success. Engagement is not a single behavior or psychological state; it is a multidimensional and dynamic phenomenon shaped by what students do, think, and feel. Likewise, it is influenced by the opportunities, relationships, and institutional conditions provided by their education (1–3). This interaction between students and their educational environments also makes engagement relevant to institutional quality. Rather than functioning solely as a student outcome, engagement indicates whether institutions provide responsive, inclusive, and educationally meaningful conditions that facilitate participation (4).

Interest in student engagement has grown within health profession education (HPE), where students not only learn but also engage in teaching, research, program evaluation, governance, quality assurance, and community-oriented work. The AMEE Guide on student engagement conceptualizes engagement across behavioral, psychological, and sociocultural dimensions; partnership engagement is considered an important sphere of HPE practice (5). This framing extends engagement beyond individual motivation or classroom behavior, highlighting students' capacity to contribute to educational environments, institutional processes, and professional communities.

Within this broader field, partnership engagement represents a unique form of participation. Partnerships move students beyond the roles of recipients, respondents, or consultees, allowing them to engage as collaborators in identifying priorities, developing responses, implementing change, and evaluating educational practices. Partnerships are commonly characterized by reciprocity, mutual respect, and shared responsibility. Students and staff contribute different but equally legitimate forms of knowledge and experience to partnerships (6,7). Partnerships do not require identical roles, responsibilities, or authority in every situation. Instead, they require transparency about roles and limits, meaningful opportunities to contribute, and sufficient influence to ensure that student participation produces measurable outcomes.

This distinction matters because not all student participation constitutes engaging in a partnership. Students may attend committees, complete surveys, or provide feedback without influencing decisions or receiving any account of how their contributions were used. Similarly, students may be invited to participate in activities only after priorities have already been established and solutions reached. A formal participation mechanism, therefore, provides limited information about the quality of the underlying relationship. Beyond student participation, effective partnerships depend on whose voices are represented, how power and responsibility are negotiated, how disagreement is handled, and whether participation leads to learning, action, or institutional change (7,8).

Despite increasing interest in the topic, the literature is characterized by conceptual and operational ambiguity. Terms such as student engagement, student voice, student involvement, cocreation, student participation, and students as partners are used interchangeably. However, each implies different roles, degrees of influence, and assumptions about power-sharing (9). A scoping review of undergraduate medical education similarly found considerable heterogeneity in how engagement was conceptualized and measured, with much of the literature focusing on behavioral, cognitive, and emotional engagement in learning rather than students' contributions to educational systems (10). A subsequent review of measurement approaches found that agentic and sociocultural forms of engagement, including partnership engagement, remained comparatively underdeveloped (11).

Reports of local initiatives and individual programs have also dominated the partnership literature. Such studies show what partnerships can achieve but provide less insight into the institutional and relational conditions that

determine whether they become meaningful, inclusive, and sustainable across settings (8). Practical guidance has highlighted communication, student representation, faculty support, development opportunities, and institutional structures as key to partnership effectiveness (12). Nevertheless, context matters: the same committee, feedback system, or representative role may function differently depending on institutional culture, decision-making practices, resources, and power relationships.

This contextual challenge is especially salient in Türkiye's large and diverse medical education system. In 2022, Türkiye had 118 medical schools offering 143 programs across 61 provinces, with 112,058 medical students and 17,494 faculty members. Student-to-faculty ratios differed between public and foundation-university programs (13). Consequently, medical schools operate within varying governance arrangements, resource environments, curricular traditions, and cultures of student representation. These differences make it unlikely that a single participation mechanism will function uniformly across institutions and underscore the need for context-sensitive evidence grounded in students' experiences.

Little is known about how medical students across Türkiye understand partnership engagement, how they perceive existing institutional practices, or which conditions they view as most important for meaningful participation. A nationwide needs analysis could clarify these understandings by documenting the perceived gap between the value attributed to partnerships and their current implementation and by explaining the structural, relational, and practical mechanisms underlying that gap.

This study explored how medical students in Türkiye perceived, experienced, and envisioned student partnership engagement by addressing the following research questions:

1. How do medical students perceive the importance of partnership engagement?
2. How do students perceive institutional support and their current level of engagement?
3. Which factors facilitate or hinder meaningful partnership engagement?
4. What broader mechanisms explain why student participation becomes a meaningful partnership in some settings but remains symbolic in others?

Methods

Study design

We conducted a nationwide, multiphase mixed-methods needs analysis. The first phase used an online survey with quantitative items and two open-ended qualitative questions. The second phase comprised two online, student-only focus groups conducted after preliminary survey analysis. The survey established the broad pattern of students' perceptions, experiences, and priorities, while the focus groups were designed to explain, deepen, and contextualize those findings rather than to constitute a separate qualitative study.

The quantitative and qualitative survey strands were initially analyzed separately. The qualitative survey and focus group datasets were subsequently integrated using a unified codebook and the development of higher-order themes. We then connected quantitative and qualitative findings during interpretation using a joint display and an explanatory model. The survey addressed research questions 1, 2, and 3, while focus group interviews explored research questions 3 and 4.

Conceptual orientation

The study was informed by a relational and institutional understanding of student engagement. We drew on the HPE literature that conceptualizes engagement across education program provision, scholarly research, governance and quality assurance, and community activities (5), together with partnership scholarship that emphasizes reciprocity, shared responsibility, mutual respect, and meaningful influence (6,7). We did not assume that partnerships required identical roles or equal authority in every educational decision. Instead, we treated them as a context-dependent collaboration model in which students hold a legitimate role, understand the scope of their influence, and can observe how their contributions are considered.

Questionnaire development and piloting

The questionnaire was developed through an iterative process, drawing on a narrative review of student engagement (14) and the literature on partnership and engagement in higher education, the four partnership domains described in the AMEE Guide (5), discussions among members of the medical education research

team, and methodological guidance on questionnaires in medical education (15). An English-language version of the complete questionnaire, including its questions and response options, is provided in Additional file 1.

The draft instrument was piloted with seven medical students. After completing it, pilot participants took part in a group interview addressing the clarity of the definition and items, interpretation of response options, organization, usability, completion burden, and sensitivity of the information requested. Their feedback provided input for revising the instrument's wording, order, and presentation. Pilot participants preferred maximum anonymity because institutional identification might discourage critical responses; thus, the name of the university was removed. The seven pilot participants were excluded from the final sample.

Setting, recruitment, and survey administration

The target population comprised students enrolled in undergraduate medical education programs in Türkiye. During the spring and autumn terms of 2025, we contacted medical education departments or units in public and foundation universities across all seven geographical regions and asked them to distribute a Google Forms survey to their medical students. The sampling strategy prioritized geographical and institutional diversity over statistical representativeness.

Participation was voluntary. Institutional identifiers were not collected, which encouraged candid reporting but prevented determining the number of participating schools, calculating institution-specific response rates, and conducting institution-level comparisons. All survey items were mandatory, and the form was configured to permit one submission per participant. Consequently, the quantitative dataset contained no missing item-level data.

Survey content and measures

The final questionnaire was administered in Turkish. Before the substantive items, participants received a brief definition of partnership engagement and an explanation of the five-level engagement continuum. The quantitative items were study-specific descriptive measures; each item was analyzed separately, and no total score was calculated. (Table 1)

Table 1. Survey content and response formats

Section	Construct	Response format
Participant context	University type	Public university / Foundation university
Participant context	Program accreditation status as perceived by the student	Accredited / In the application process / Not accredited / Do not know
Participant context	Membership in a student representation structure or organization	Yes / No
Students' views	Overall importance of partnership engagement	Five-point rating
Students' views	Perceived influence on educational quality	Five-point rating
Students' views	Importance in each of the four domains	Five-point rating for each domain
Institutional context	Perceived institutional support for partnership	Five-point rating
Current engagement	Perceived engagement level in each domain	No engagement / Consultation / Involvement / Active participation / Partnership
Qualitative component	Three factors facilitating partnership	Open-ended response
Qualitative component	Three factors hinder the partnership	Open-ended response

The five-level engagement continuum was adapted from Healey et al.'s (7) partnership framework: no engagement, consultation, involvement, active participation, and partnership. Students rated importance and

current engagement across four domains: development and delivery of the education program; scholarly research; governance and quality assurance; and community engagement.

Quantitative data analysis

Quantitative data were analyzed in R. The analysis was descriptive rather than inferential. Frequencies and percentages were calculated for all categorical and ordinal responses. Because all questions were mandatory, the denominator for each reported percentage was 144.

For concise presentation, scores of 3–5 on the five-point importance and perceived impact items were grouped as indicating at least a moderate level of endorsement. For perceived institutional support, scores of 3–5 indicated the scale's midpoint or above. Engagement levels of involvement, active participation, and partnership were grouped as involvement or higher. These groups were specified for descriptive communication and were not treated as validated thresholds. No causal or population-level inference was intended.

Focus-group phase

Preliminary survey analysis identified a consistent difference between students' strong endorsement of partnerships and their lower ratings of institutional support and current engagement. To examine the mechanisms underlying this variation, we conducted two mixed-region, student-only focus groups with 11 participants via Zoom. KMG conducted the focus group meetings, which were audio-recorded with consent and transcribed verbatim in Turkish. MŞ used the audio recordings and transcriptions for the analysis.

Participants were medical student representatives from diverse institutions and regions. The semistructured focus-group interview guide was developed by the research team specifically for this study, informed by the preliminary survey findings, and has not been published previously. It explored what student engagement through partnership means in practice; what students expect from their institutions; what they would change to make partnerships more effective; and the key message that medical schools should hear from students. Follow-up prompts elicited concrete experiences, explanations of why practices succeeded or failed, and comparisons between institutional contexts. An English-language version of the complete semi-structured focus-group interview guide is provided in Additional file 2.

Qualitative data analysis

We used an iterative, team-based codebook thematic approach. KMG and MŞ independently coded the substantive open-ended survey responses and the focus group transcripts. They first divided responses and transcripts into meaning units and assigned initial codes close to participants' language. They then compared coding, discussed differences, consolidated overlapping codes, clarified code boundaries, and developed a shared codebook.

They compared focus group codes with the survey-derived codebook. They retained codes that represented a distinct meaning, condition, or mechanism, and they integrated overlapping codes. KMG and MŞ jointly reviewed the final code assignments, theme structure, and coded-unit counts. The full author team then reviewed and discussed the data, theme boundaries, mixed-methods integration, alternative interpretations, and explanatory claims developed from the analysis. This process generated 12 subthemes, which were organized into five higher-order themes around central organizing concepts.

The survey contributed 539 meaning units, and the focus groups contributed 100, producing an integrated dataset of 639 units. Noninformative entries or those unrelated to the research questions were excluded. Coded-unit counts were used descriptively to illustrate the distribution of qualitative content; they were not interpreted as prevalence estimates because participants could contribute multiple units, response length varied, and frequency alone did not determine qualitative importance.

Translation of themes and quotations

Data were generated and analyzed in Turkish. The team developed theme and subtheme labels in Turkish, translated them into English, and back-translated them into Turkish. The team discussed differences until the English labels preserved the intended conceptual meaning. The team translated selected quotes into English and checked them against the original Turkish transcripts. Participant identifiers indicate the focus group and participant number; names and institutions were removed.

220 **Mixed-method integration**

221 Integration occurred at three points. First, we developed the focus group guide in response to preliminary
222 survey patterns, especially the discrepancy between high perceived importance and lower institutional support.
223 Second, we integrated the qualitative survey and focus group datasets through codebook comparison and the
224 development of higher-order themes. Third, we compared quantitative patterns with qualitative explanations in
225 a joint display to identify convergence, complementarity, and domain-specific differences.

226 **Researcher positioning and reflexivity**

227 Our reflexive account follows the view that reflexivity should be continuous, collaborative, and attentive to
228 personal, interpersonal, methodological, and contextual influences rather than reduced to a short biographical
229 statement (16). All authors work in the field of medical education and are professionally committed to
230 improving student participation. KMG had extensive prior experience as a medical student representative and
231 had participated in multiple partnership initiatives. MŞ, MKA, İCS, and LA supported or led student
232 engagement initiatives and held institutional roles charged with strengthening student participation.

233 These experiences provided contextual sensitivity to the language and mechanisms of partnerships and could
234 also orient the team toward improvement-focused or partnership-supportive interpretations. We did not treat
235 these positions as bias to be eliminated. Instead, we made them explicit and examined them through
236 independent coding by KMG and MŞ, discussion of divergent interpretations, repeated return to the source
237 data, joint verification of the final code counts and themes, and full-team scrutiny of the integration and
238 interpretive model. The analysis deliberately retained both positive and negative enactments of the same
239 mechanisms, such as representation, feedback, and formal committees. Survey anonymity and student-only
240 focus groups supported critical accounts of institutions.

241 **Ethical considerations**

242 Ethical approval was granted by the Acıbadem University and Acıbadem Healthcare Institutions Medical
243 Research Ethics Committee (ATADEK; Approval No. 2024-12/522; 15 August 2024). All participants

provided informed consent before participation. All study procedures were conducted in accordance with the Declaration of Helsinki and relevant guidelines and regulations.

Results

Survey participant characteristics

A total of 144 medical students completed the survey. Most attended public universities (130, 90.3%). Program accreditation status was self-reported: 125 students (86.8%) reported that their program was accredited, 12 (8.3%) indicated their programs were in the application process, 2 (1.4%) reported that they were not accredited, and 5 (3.5%) did not know. Eighty students (55.6%) reported not being members of a student representation structure or organization, while 64 (44.4%) reported being involved. (Table 2)

Table 2. Characteristics of the survey participants

Characteristic	**Category**	**n**	**%**
University type	Public university	130	90.3
	Foundation university	14	9.7
Program accreditation status (student-reported)	Accredited	125	86.8
	In the application process	12	8.3
	Not accredited	2	1.4
	Unknown	5	3.5
Student representation or organization membership	Yes	64	44.4
	No	80	55.6

Students valued partnerships more highly than they perceived their implementation to be.

Students expressed strong support for partnership engagement. Overall, 82.6% rated it as at least moderately important, and 90.9% believed it could have at least a moderate positive influence on educational quality. By comparison, 59.0% rated institutional support at the scale's midpoint or above.

Partnerships were highly valued across all four domains. Of those participants who rated it at least moderately important, the percentages ranged from 89.5% for community engagement to 92.3% for education program development and delivery. Reported engagement at the involvement level or higher was lower in every domain, ranging from 59.7% in governance and quality assurance to 70.1% in community engagement. (Table 3.1) (Table 3.2)

Table 3.1. Perceived importance, institutional support, and current engagement

Outcome	Result
Rated partnership engagement as at least moderately important (≥3/5)	82.6%
Partnership could improve educational quality at least moderately (≥3/5)	90.9%
Rated institutional support at the scale midpoint or above (≥3/5)	59.0%

Table 3.2. Perceived importance, institutional support, and current engagement

Partnership domain	Rated important (≥3/5)	Reported involvement or higher
Education Program development and delivery	92.3%	61.1%
Scholarly research	90.9%	63.1%
Governance and quality assurance	90.9%	59.7%
Community engagement	89.5%	70.1%

These findings indicated an implementation gap: students assigned high value to partnerships and associated them with educational quality, while perceiving institutional support and current engagement as more limited. The qualitative analysis examined the mechanisms underlying this difference.

Qualitative findings

Development of the thematic structure

The integrated analysis generated 12 subthemes, which were organized into five higher-order themes. During the analysis, we realized that the same domain could facilitate or hinder partnerships depending on how it was enacted. For example, feedback could build trust or produce fatigue, representation could broaden or restrict student voice, and formal committees could institutionalize partnerships or reproduce symbolic participation. There is a dialectic structure in each higher-order theme and subtheme. (Table 4)

Table 4. Higher-order themes and constituent subthemes

Higher-order theme	Constituent subthemes	Included coded units
From student voice to visible influence	Communication and feedback loops; Student representation and collective organization	248
From goodwill to institutionalized partnership	Governance, processes, and participation mechanisms; Capacity building and partnership literacy	119
Building safe, respectful, and fair relationships	Faculty attitudes and support; Relational climate and values; Psychological safety; Hierarchy, fairness, and power relations	172
Protected capacity for sustainable partnership	Resources, infrastructure, and logistics; Time and workload	72

Higher-order theme	Constituent subthemes	Included coded units
Partnership through shared practice	Learning design and engagement in learning; Opportunities for research and community engagement	28
Total		639

Theme 1: From student voice to visible influence

Our data show that student voices became partnerships only when they were collectively articulated, communicated through legitimate and accessible channels, taken seriously, and translated into a visible institutional response or action. Communication shaped how student perspectives traveled among the student body, representatives, faculty members, and decision-makers. Representation influenced which views were included, how individual experiences were assembled into a collective account, and whether that account was perceived as legitimate.

Participants described open communication channels, regular dialogue, accessible leaders, student councils, committee membership, and collective reporting as mechanisms that could facilitate partnerships. Effective representatives were not simply messengers; they gathered and synthesized diverse views, translated student concerns into forms usable within institutional processes, explained institutional constraints to peers, and connected students with decision-making structures.

> *"I see myself in the middle of the loop, carrying students' views to faculty and bringing back what is happening in the background. For me, partnership means completing that cycle."* ***(FG1-P1)***

> *"Because only the representative is invited, students do not really know what happens in these meetings. But seeing every piece of feedback being read by faculty, and then being asked about it, makes me feel that there is a genuine effort to include students."* **(FG1-P3)**

297 However, representation could become exclusive when a few highly involved students were repeatedly invited,
298 without reliable mechanisms to consult the wider student body. Feedback followed a similar pattern.
299 Opportunities to express views were valued, but participation became meaningful only when institutions
300 communicated what had been considered, what would change, what could not change, and why.

301 *"We attend almost every meeting and our opinions are asked, but I do not think there has been much*
302 *change."* ***(*FG2-P3)**

303 *"Even when a change cannot be made, saying, "We considered your feedback, but current conditions*
304 *do not allow it," would change students' perception."* ***(FG1-P2)***

305 Repeated feedback requests without an observable response produced skepticism and participation fatigue.
306 While students did not expect every recommendation to be accepted, they did expect transparent consideration,
307 accountable communication, and a transparent route from expression to influence.

308 *Box 1: From student voice to visible influence: partnerships are not achieved when students are merely invited*
309 *to speak; they are achieved when their collective voices have a transparent pathway to achieving influence.*

310 **Theme 2: From goodwill to institutionalized partnership**

311 Students shared that a partnership became sustainable when it was embedded in formal structures with clear
312 roles, accountable procedures, institutional memory, and shared capabilities, rather than depending on the
313 goodwill of individual students, faculty members, or administrators. Participants valued formal committee
314 membership, scheduled meetings, explicit roles, documented decisions, transparent escalation pathways, and
315 institutional accountability for responding.

316 *"We have a Medical Education Student Committee with students from all six years. We meet every*
317 *month, discuss our current problems, and submit a report to the dean's office. It works actively because*
318 *it also brings us together. Through these mechanisms, we can participate in governance and actually*
319 *create change."* ***(*FG1-P3)**

320 Formal structures reduced dependence on individual personalities and allowed participation to continue through
321 leadership changes and student graduation. However, a committee alone did not constitute a partnership, as

students could attend without understanding their roles, receiving relevant information, contributing to agenda-setting, or knowing whether they could influence decision-making outcomes.

> *"As class representatives, we are usually consulted about committees, examinations, clerkships, and student-related issues. We are not really consulted about governance or regulations. When I discuss regulations, it tends to happen informally."* **(FG2-P1)**

Participants also identified a need for partnership literacy. Students, representatives, faculty members, and leaders could enter participation processes with different assumptions about purpose, authority, institutional constraints, and follow-up. Orientation and continuity mechanisms were therefore important, particularly because similar concerns persisted across changing cohorts.

> *"The same concerns return with every new cohort. If previous requests, responses, and the reasons behind them were included in orientation, the process could move forward instead of starting again."* ***(FG1-P1)***

Structures without partnership literacy risked becoming bureaucratic or tokenistic. At the same time, partnership literacy without formal structures left engagement dependent on individual enthusiasm and vulnerable to turnover. Sustainable partnerships required both.

Box 2: From goodwill to institutionalized partnership: Partnerships become sustainable when institutions, faculties, and students design, teach, document, and remain accountable together.

Theme 3: Building safe, respectful, and fair relationships

Students participated meaningfully when they were treated as legitimate contributors to relationships characterized by respect, accessibility, trust, fairness, and psychological safety. Faculty attitudes shaped whether students felt invited to contribute. Approachable, open-minded faculty reduced interpersonal distance and legitimized the student experience as educational knowledge.

> *"We expressed our views openly, and in the next clerkship we saw that those things had changed without experiencing any mobbing or anything similar. We benefited greatly from that."* **(FG1-P7)**

"Partnership reduces the distance between us; both sides become more human in each 's eyes." ***(FG1-P4)***

Participants described psychologically safe meetings as spaces where concerns could be expressed without ridicule, retaliation, or deterioration of educational relationships. Conversely, dismissive attitudes, intimidation, favoritism, or minimizing student concerns led to hesitation and self-censorship. Supportive or discouraging institutional responses also shaped whether students continued to engage.

"After our first student-led symposium, the response was so discouraging that both I and the other students largely withdrew from further engagement with the administration." ***(FG2-P2)***

"Sometimes faculty respond as if, 'Is that really a problem?' and minimize what we are experiencing. Or the attitude can be, 'We went through these things in our time, so you can cope with them too.'" ***(*FG1-P4)**

The analysis reveals relational pathways: faculty and leadership attitudes shaped the relational climate and enactment of power, in turn shaping psychological safety, which influenced students' willingness to participate. It was therefore not an isolated individual attribute but rather a feature of institutional relationships and practices.

Box 3: Building safe, respectful, and fair relationships: Students use opportunities for participation only when the relationships surrounding those opportunities make engagement both legitimate and safe.

Theme 4: Protected capacity for sustainable partnership

Commitment and goodwill alone were insufficient to sustain partnerships. They also required dedicated time, manageable workloads, sufficient staffing, accessible infrastructure, logistical support, and participation mechanisms designed for institutional scale. Dense curricula and clinical responsibilities constrained student involvement, while faculty members balanced educational, clinical, research, and administrative duties.

"The same few people in management and medical education run from one meeting to another. Meetings are rushed, and we cannot fully explain our concerns." ***(FG1-P4)***

370 *"Faculty members already see their workload as high and sometimes try to avoid taking on more work.*
371 *When that enters the process, it becomes difficult to move things forward."* ***(FG1-P3)***

372 Large cohorts posed further challenges. Processes developed for small groups could become inaccessible or
373 administratively unmanageable with larger groups, while insufficient staffing and fragmented authority delayed
374 responses. Time was an especially important, yet often invisible, resource. Attendance alone did not create
375 partnerships when meetings lacked sufficient time for discussion and follow-up.

376 *"Some faculty members do not even know that we have around four hundred students. There is a*
377 *communication gap between academics and students, and I think that has to be addressed."* ***(FG2-P3)***

378 *"When the meeting is limited to one hour even though many issues remain, it feels as if it is being*
379 *held because protocol requires it, not for our benefit."* ***(FG1-P3)***

380 Participation also required work that entailed gathering views, preparing for meetings, analyzing feedback,
381 communicating outcomes, and developing responses. When this work was added to existing workloads without
382 recognition or protected capacity, even well-designed structures became difficult to sustain.

383 *Box 4: Protected capacity for sustainable partnership: Partnership becomes sustainable only when institutions*
384 *recognize it as work and provide the capacity required.*

385 **Theme 5: Enacting partnership through shared practice**

386 Partnerships became tangible when students moved beyond commenting on education and participated
387 substantively in shared learning, inquiry, educational development, research, and community-oriented work.
388 Participants connected meaningful engagement with opportunities to assume responsibility, discuss and solve
389 problems, codevelop activities, participate across the research process, and contribute to visible outputs.
390 Partnership engagement also contributes to the sense of belonging to the institution.

391 *"Being involved in medical education processes from the first year gives us a sense of belonging to the*
392 *faculty. When you first start medical school, you are trying to understand where you have landed;*
393 *being included in these processes helps you adapt and also strengthens your communication with*
394 *faculty."* ***(FG1-P2)***

"Students remain very passive: we go to class, listen, and return. If students took initiative and felt like stakeholders in learning, they would also become more active in giving feedback." ***(FG1-P1)***

Active and learner-centered environments were considered preparation for partnerships because they helped students develop initiative, responsibility, collaborative skills, and confidence in articulating their reasoning. Research and community projects provided concrete spaces for shared purpose and visible contribution.

"Our faculty supports student clubs and social responsibility activities—for example, visits to nursing homes or primary care centers. In public health, we also prepare a survey and work with people in the community. I would like these opportunities in the field to be expanded." ***(FG2-P1)***

"Our faculty has a six-year research education program. Students say they complete several projects during medical school, and the institution supports those opportunities." ***(FG2-P3)***

Partnership development was hindered when students remained passive recipients of teaching, were restricted to superficial research roles, lacked information or support needed to initiate projects, or were invited only once major decisions had been made.

Box 5: Enacting partnership through shared practice: Partnership becomes real when students and faculty learn, investigate, design, and contribute together.

Facilitating and Hindering Factors

Our data show that each higher-order theme and each subtheme has a dual effect: facilitating or hindering student partnership engagement. Importantly, these factors were rarely inherently positive or negative. Rather, their effect depended on how they were enacted within the institutional context; for example, communication could strengthen trust or generate disengagement; representation could broaden students' voices or restrict them to a small group; formal governance structures could institutionalize partnerships or reproduce tokenism; and faculty–student relationships could enable participation or discourage students from speaking. This facilitating–hindering duality was evident across all five higher-order themes and 12 subthemes (Table 6).

Table 6. Facilitating and hindering patterns across higher-order themes and subthemes

Higher-order theme	Subtheme	Facilitating pattern	Hindering pattern
From Student Voice to Visible Influence	**Communication and Feedback Loops**	Accessible and regular communication channels allow students to raise concerns and contribute ideas. Closing the feedback loop by explaining what was considered, what changed, and why some changes were not possible demonstrates that student contributions have consequences and strengthens trust in future participation.	Feedback is collected without visible follow-up, decisions remain unexplained, or students repeatedly raise the same issues without receiving a response. Participation can consequently be perceived as ineffective, leading to skepticism, feedback fatigue, and reduced willingness to engage.
From Student Voice to Visible Influence	**Student Representation and Collective Organization**	Representatives actively consult the wider student body, synthesize different perspectives, communicate collective concerns to decision-makers, and report outcomes back to students. Organized student structures can provide legitimacy, continuity, and a collective route to influence.	Representation is concentrated among a small number of repeatedly involved students, representatives have limited connection with the wider student body, or students do not know how their views are being represented. Representation may then become narrow or symbolic rather than inclusive.
From Goodwill to Institutionalized	**Governance, Processes, and**	Formal student roles, regular meetings, transparent	Students may be formally present in committees while

Partnership	**Participation Mechanisms**	procedures, documented decisions, and clear pathways for escalating student contributions embed partnership within institutional practice and reduce dependence on individuals.	having limited access to information, agenda-setting, decision-making, or follow-up. Processes may also be fragmented, bureaucratic, irregular, or dependent on individual faculty members, making participation procedural rather than influential.
	Capacity Building and Partnership Literacy	Students, faculty members, and institutional leaders understand the purpose of partnership, their respective roles and responsibilities, the scope of student influence, and how to communicate, represent others, negotiate, and work collaboratively.	Unclear roles and differing expectations about partnership create confusion and frustration. Students may lack preparation for representative or governance roles, while faculty may interpret consultation as sufficient or remain uncertain about how responsibility and influence can be shared.
Building Safe, Respectful, and Fair Relationships	**Faculty Attitudes and Support**	Approachable, receptive, and supportive faculty members legitimize students' experiential knowledge, encourage contribution and disagreement,	Dismissive, closed, or discouraging faculty attitudes can minimize student concerns, undermine student initiatives, or convey that student

		explain decisions, and actively support student-led initiatives.	contributions are inconvenient or illegitimate, reducing motivation to participate.
	Relational Climate and Values	Mutual respect, trust, reciprocity, openness, and a shared commitment to improving education create a sense of belonging and enable students and faculty to understand each other's perspectives and constraints.	Distrust, adversarial relationships, limited mutual understanding, or perceptions that students and faculty are pursuing competing interests increase relational distance and weaken the possibility of collaboration.
	Psychological Safety in Student Participation and Representation	Students feel able to raise concerns, challenge existing practices, express disagreement, and contribute critical perspectives without fearing negative academic or interpersonal consequences.	Fear of being labeled, disadvantaged, ridiculed, exposed, or treated differently encourages self-censorship and withdrawal. Formal opportunities may therefore remain unused despite their availability.
	Hierarchy, Fairness, and Power Relations	Faculty members and leaders recognize the inherent power asymmetry in medical education and deliberately create fair and accessible opportunities for students to contribute despite differences in status and	Rigid hierarchy, excessive power distance, perceived favoritism, unfair treatment, or authority exercised in ways that discourage challenge can make students feel that questioning decisions is inappropriate,

		authority.	ineffective, or unsafe.
Protected Capacity for Sustainable Partnership	**Resources, Infrastructure, and Logistics**	Adequate staffing, administrative support, physical and digital spaces, communication systems, financial resources, and mechanisms for documenting and tracking student contributions make participation feasible and scalable.	Inadequate staffing, infrastructure, administrative support, or financial resources, together with fragmented or slow institutional procedures, can prevent meaningful follow-through even when students and faculty are willing to participate.
	Time and Workload	Partnership activities are recognized as legitimate work and supported through sufficient meeting time, feasible scheduling, preparation opportunities, and consideration of student and faculty workloads.	Dense curricula, clinical responsibilities, faculty workload, insufficient meeting time, and participation added on top of existing responsibilities restrict meaningful discussion and make engagement difficult to sustain.
Enacting Partnership Through Shared Practice	**Learning Design and Engagement in Learning**	Active and learner-centered educational approaches allow students to exercise responsibility, discuss problems, make decisions, and contribute ideas, thereby developing the confidence and agency needed	Predominantly passive educational experiences position students primarily as recipients of teaching, limiting opportunities to exercise initiative, responsibility, or influence and reinforcing a

		for a broader partnership.	passive student role.
	Opportunities for Research and Community Engagement	Students participate meaningfully with faculty in research, educational projects, community engagement, and social responsibility activities, assume substantive roles, and contribute to visible outputs and outcomes.	Opportunities may be poorly communicated, inaccessible, available only to a small number of students, unsupported by faculty, or limited to peripheral tasks after major decisions have already been made, resulting in superficial rather than collaborative participation.

For the five higher-order themes, this duality can be summarized as follows. Students' voices have a tangible influence when communication and representation connect students to institutional action; however, they become symbolic when contributions remain unaddressed. Institutional structures sustain partnerships when roles, processes, and capabilities are deliberately developed but can reproduce tokenism when participation is only procedural. Relationships enable partnerships when students are respected and feel psychologically safe, but they suppress them when hierarchy, dismissal, or perceived unfairness make speaking up risky. Capacity supports partnerships when sufficient time, staffing, infrastructure, and resources are protected, yet constrains them when participation is expected without recognizing the work involved. Finally, shared educational, scholarly, and community practice makes partnerships tangible when students assume meaningful roles and contribute to outcomes; in contrast, these practices are superficial when student participation is passive or peripheral.

The distinction between facilitating and hindering factors, therefore, is not due to their presence or absence bur rather to their quality. Committees, representative roles, feedback systems, faculty relationships, or collaborative opportunities do not constitute partnerships in and of themselves. Their contribution depends on

435 whether they enable inclusive voices, meaningful influence, reciprocal and safe relationships, adequate
436 institutional support, and tangible outcomes. This duality helps explain the quantitative–qualitative
437 implementation gap observed in this study: medical schools may provide formal opportunities for student
438 engagement; however, students still experience limited partnership when those opportunities do not translate
439 into meaningful influence.

440 *Box 6: Meaningful student partnership engagement arises when students' voices are connected to tangible*
441 *influence through institutionalized processes, enacted within safe and equitable relationships, supported by*
442 *adequate capacity, and realized through shared educational, scholarly, governance, and community practice.*

443 **Discussion**

444 **Principal findings**

445 This nationwide mixed-methods needs analysis found that medical students in Türkiye strongly valued
446 partnership engagement and believed such engagement contributed to educational quality. However, perceived
447 institutional support and reported engagement levels were consistently lower than the importance attributed to
448 partnerships. This pattern was observed across education program development, scholarly research, governance
449 and quality assurance, and community engagement.

450 The qualitative findings showed that the partnership implementation gap could not be attributed to a single
451 barrier or resolved by a single participation mechanism. Partnerships depend on the interaction of structural
452 conditions, relational conditions, and opportunities for shared practice. Legitimate and inclusive representation
453 was required for student voices to be effectively heard; representation required institutional pathways; formal
454 pathways required psychologically safe and fair relationships; and participation required sufficient time,
455 infrastructure, and labor. Partnership became visible when these conditions enabled students and faculty to
456 engage in meaningful work together.

457 **Moving from participation to partnership**

458 Partnerships are defined not solely by the presence of students in an activity but by the quality of the
459 relationship, the reciprocity of contributions, and the capacity to influence outcomes (6,7). Our findings extend

460 this distinction by showing how students recognized the difference between an invitation to participate and a
461 visible pathway to making a difference.

462 This distinction may help explain why formal indicators can overestimate meaningful engagement. A medical
463 school may report student members on committees, recurrent surveys, and representative systems without
464 demonstrating whether students have access to relevant information, contribute to agendas, influence decisions,
465 or communicate outcomes to the broader student body. Different types of student participation require
466 materially different roles and degrees of centrality (9). Treating them as interchangeable can obscure whether
467 students are consultees, contributors, codesigners, or partners.

468 The implementation gap is not simply a lack of opportunities. Increasing the number of surveys, meetings, or
469 representative positions without changing how contributions are considered may exacerbate participation
470 fatigue rather than strengthen partnerships.

471 **Closing feedback loops: from expression to accountable response**

472 The largest qualitative theme concerned the shift from students having a voice to achieving a tangible influence.
473 Students did not require every recommendation to be accepted; they expected evidence that their contribution
474 had entered an accountable process. Listening is difficult to distinguish from inaction unless institutions
475 communicate what they heard, how they considered it, what they decided, and why.

476 Therefore, feedback loops have both informational and relational functions. They provide information about
477 outcomes and signal whether the institution regards student contributions to be legitimate. Feedback
478 strengthened trust when it resulted in measurable action or a transparent explanation; conversely, it fostered
479 skepticism when students repeatedly provided information without receiving a response. This duality is
480 consistent with partnership frameworks that place reciprocity and shared responsibility at the center of student–
481 staff relationships (7,8).

482 An accountable response does not imply unrestricted student authority. Medical schools operate within
483 regulatory, financial, clinical, and curricular constraints. Transparent nonimplementation may nevertheless
484 preserve partnerships when institutions explain the constraints and what remains possible and establish whether
485 the issue will be reconsidered.

Representation as infrastructure rather than proof of partnership

Student representatives functioned as bridges, interpreters, and organizers of the collective student voice. They gathered perspectives, identified shared concerns, translated these into institutionally usable forms, and communicated decisions back to the students. However, their presence did not automatically guarantee inclusivity. Representative systems could privilege students who were already confident, connected, or organizationally active and could become detached from the wider student body when consultation, reporting, and handover were weak.

Thus, medical schools should recognize that representation requires design and maintenance, including transparent selection, regular consultation with peers, mechanisms for underrepresented students to contribute, documentation of concerns and responses, communication of outcomes, and transition processes between cohorts. The partnership literature similarly notes that initiatives may reproduce inequities when access is limited to a small, self-selecting group (8).

Institutionalizing partnerships without bureaucratization

Students valued formal structures because they allowed them continuity, accountability, and access to decision-making. A partnership based solely on supportive individuals was vulnerable to changes in leadership, staffing, and student graduation rates. In contrast, Formal roles, scheduled meetings, documented decisions, and escalation pathways could protect partnership participation from this instability.

Formalization also introduced risks, however. Committees could become procedural, roles could remain unclear, and attendance could be mistaken for influence. Institutionalization should therefore focus on the quality and accountability of participation rather than multiplying administrative structures.

This requires partnership literacy, defined as a shared understanding of why a partnership is being used, what students and staff contribute, which decisions are open to influence, what constraints apply, and how disagreement and follow-up will be managed. Peters et al. (12) highlighted preparation, clear expectations, institutional support, and recognition of contribution as required elements for effective partnerships. Partnership literacy should not be framed primarily as a student deficit; faculty members and leaders may also benefit from

511 developing listening skills, power awareness, inclusive facilitation, the ability to respond to challenge, and
512 knowledge of inclusive decision-making.

513 **Psychological safety and the relational production of participation**

514 Formal opportunities were used only when students considered the surrounding relationships safe. Hierarchy is
515 intrinsic to many dimensions of medical education: faculty assess students, supervise clinical work, provide
516 references, and influence access to opportunities. These relationships can support mentorship but may also
517 increase the perceived cost of criticism or disagreement.

518 Participants found dismissive attitudes, intimidation, favoritism, and discouraging responses to aggravate self-
519 censorship and withdrawal. Conversely, approachable faculty members who explained decisions and
520 encouraged disagreement legitimized student contributions. Psychological safety therefore appeared to mediate
521 the relationship between institutional opportunity and actual participation.

522 This finding supports relational and sociocultural conceptualizations of engagement. Kahu and Nelson (2)
523 located engagement at the educational interface where institutional and student factors interact. In our analysis,
524 psychological safety was shaped within this interface by how authority was exercised, how disagreement was
525 received, and whether institutional processes protected contributors. Medical schools should avoid interpreting
526 low levels of participation as apathy without first assessing the interpersonal and institutional risks of speaking.

527 **Partnership requires protected capacity.**

528 Time, workload, staffing, infrastructure, and logistics were not peripheral implementation details. Partnerships
529 involve extensive work, including gathering views, reviewing materials, attending meetings, communicating
530 outcomes, developing responses, and evaluating change. When this work is added to dense curricula and faculty
531 workloads without protected time or administrative support, even well-designed mechanisms can become
532 symbolic.

533 The findings caution against relying on enthusiasm as the primary resource for partnerships. Support should
534 also include protected time, workload allocation, administrative coordination, digital tracking systems, access to
535 information, and recognition of student contributions. Such support should be proportionate to the institutional

536 scale. A mechanism feasible in a small program may not function in a medical school with large cohorts and
537 dispersed clinical placements. The lack of time and resources, sustainability, and dependence on committed
538 individuals have also been identified as recurrent partnership challenges in higher education (8).

539 **Partnerships become visible through shared practice**

540 Students described their contributions becoming tangible through shared educational development, research,
541 quality improvement, peer education, and community work. These forms of shared practice moved students
542 from expressing preferences to participating in producing educational or social outcomes.

543 The higher levels of engagement reported in community activities may reflect the concrete and project-based
544 nature of these opportunities. Conversely, governance and quality assurance had the lowest reported
545 involvement and were described as comparatively inaccessible, bureaucratic, and power-sensitive. This finding
546 is provisional, however, because the study measured perceptions rather than directly observing institutional
547 practices. Nevertheless, the convergence of quantitative and qualitative findings suggests that decision
548 proximity and tangible outputs may influence how partnerships are experienced.

549 Research also illustrates why opportunity alone is insufficient. Students valued substantive involvement
550 throughout the process, from idea generation to dissemination. Similarly, the educational partnership was more
551 meaningful when students were involved before major decisions were made. These findings align with the four
552 partnership domains in the HPE engagement framework (5) and with higher-education models that show
553 curriculum design and research as important spaces for student–staff partnerships (7).

554 **Scaling partnership beyond the institution: national frameworks and quality assurance**

555 Our findings suggest that meaningful partnerships require more than the motivation or practices of individual
556 medical schools. System-level structures may help establish shared expectations, support institutional
557 development, and reduce reliance on local goodwill. A recent example from outside health professions
558 education is the Australian Framework for Student Empowerment (AFSE), developed through a collaborative,
559 research-informed process involving nationwide consultation with students, educators, school leaders,
560 policymakers, and other stakeholders (17). Although designed primarily for primary and secondary education,

561 the AFSE illustrates how the broad partnership engagement principles of student voice, agency, advocacy, and
562 partnership can be translated into a context-sensitive framework for reflection and improvement. Notably, the
563 framework rejects a one-size-fits-all approach, recognizes power and institutional constraints, identifies cultural
564 and contextual responsiveness as a guiding principle, and provides a benchmark tool for educational
565 organizations to assess their current practices. The AFSE is a reflective tool rather than a prescriptive blueprint.
566 This approach aligns with our finding that the same mechanism may facilitate or hinder partnerships depending
567 on how it is enacted. In medical education, national or sector-level frameworks may be most useful when they
568 establish shared principles and minimum expectations while allowing institutions to customize implementation
569 to their particular governance structures, student populations, organizational cultures, and available resources.

570 Quality assurance and accreditation are powerful mechanisms for institutionalizing such expectations. Naylor et
571 al. (18) argued that student engagement in governance and quality assurance can move students beyond the role
572 of evaluators toward that of participants, partners, and active agents. National policies and quality frameworks
573 were also found to help define the roles, capabilities, and scope of student involvement. This is particularly
574 relevant to our findings: governance and quality assurance were highly valued by participants, yet they had the
575 lowest proportion of students reporting engagement at the involvement level or higher. Türkiye's own
576 development of medical education quality assurance demonstrates how system-level processes may influence
577 institutional student engagement. National efforts to standardize and improve undergraduate medical education
578 included the first National Core Curriculum in 2001, followed by the establishment of the National
579 Accreditation Board for Medical Education (UTEAK) in 2008 (19). The subsequent accreditation organization,
580 Association for Evaluation and Accreditation of Medical Education Programs (TEPDAD), received national
581 recognition, was recognized by the World Federation for Medical Education in 2013, and was rerecognized in
582 2023 (20).

583 A recent RE-AIM evaluation of Türkiye's accreditation system shows that accreditation may strengthen the
584 institutional conditions supporting student engagement. Analysis of progress reports from medical schools in
585 their second or third accreditation cycles identified increased student representation as one of eight areas for
586 improvement associated with the accreditation process, including expanding student representation within
587 educational committees (20). At the system level, TEPDAD has also established a Medical Students

588 Commission and incorporated students within accreditation governance and evaluation structures. These
589 developments suggest that accreditation is both an educational quality assurance mechanism and a system-level
590 lever for legitimizing and institutionalizing student participation. However, the present findings suggest that
591 student representation should not automatically be equated with achieving partnership. Accreditation standards
592 may have greater developmental value when they foster participation with clear roles, inclusive representation,
593 psychological safety, closed feedback loops, and identifiable pathways for student contributions to make a
594 difference.

595 Taken together, these examples suggest a potential two-level strategy for strengthening partnership: national or
596 sector-level structures can establish expectations and enable institutional action, while individual medical
597 schools must translate these expectations into contextually appropriate relationships, processes, and practices.
598 National frameworks should therefore not prescribe a single partnership model. Rather, they should provide
599 shared principles, practical guidance, opportunities for self-evaluation, and mechanisms for continuous learning
600 while recognizing that meaningful partnership will develop differently across institutional contexts.

601 **Implications for medical schools and national stakeholders**

602 The findings suggest that moving from consultation toward a meaningful partnership requires coordinated
603 action at both the institutional and system levels. Medical schools must strengthen the structures, relationships,
604 and resources through which students participate. In contrast, accreditation agencies, national medical education
605 organizations, and other sector-level stakeholders can create enabling conditions that support consistency,
606 sustainability, and contextual adaptation.

607 **1. Establish accountable feedback loops.** Institutions should communicate the concerns students raised, how
608 their input was considered, what action will follow, what cannot currently be changed, why, and when further
609 review will take place. Closing the feedback loop is important for transparency and for sustaining students'
610 trust that participation can have meaningful influence.

611 **2. Clarify roles, responsibilities, and decision rights.** Students and faculty should understand the purpose of
612 each participation mechanism, the expected contribution of student members, which decisions are open to

613 student influence, where ultimate responsibility lies, and who is accountable for responding. Role clarity can
614 help distinguish a meaningful partnership from consultative or symbolic participation.

615 **3. Design representation for inclusivity, legitimacy, and continuity.** Student representatives should have
616 structured opportunities to consult the wider student body, incorporate perspectives beyond highly engaged
617 students, communicate decisions and outcomes, document ongoing concerns, and transfer knowledge between
618 cohorts. Therefore, representation should be treated as a relational and organizational process, not simply
619 student participation in committees.

620 **4. Build partnership literacy across stakeholder groups.** Students, faculty members, administrators, and
621 institutional leaders likely require preparation to participate effectively in partnerships. Development activities
622 should address communication, collective representation, constructive disagreement, shared decision-making,
623 institutional constraints, feedback processes, power relations, and psychological safety. Partnership literacy
624 should be understood as a shared institutional capability, not a competence expected only of students.

625 **5. Address hierarchy, fairness, and psychological safety deliberately.** Medical schools should recognize that
626 the power asymmetries inherent in medical education can influence whether students feel able to question
627 existing practices or express disagreement. Faculty development and leadership practices should address
628 dismissive behaviors, responses to challenge, fairness, accessibility, and the potential consequences of power
629 distance. Formal opportunities for participation are unlikely to be effective when students perceive speaking up
630 as personally or educationally risky.

631 **6. Protect the capacity required for partnership.** Meaningful engagement requires time and labor by students
632 and faculty. Institutions should provide realistic meeting schedules, adequate time for preparation and
633 discussion, administrative coordination, accessible physical and digital infrastructure, mechanisms for
634 documenting and tracking issues, and appropriate consideration of participation within student and faculty
635 workloads. Partnerships should be treated as legitimate educational work.

636 **7. Extend partnership into shared educational, scholarly, and community practice.** Student engagement
637 should not be confined to surveys, feedback processes, or committee representation. Medical schools can create
638 opportunities for students to meaningfully contribute to curriculum development, educational quality

639 improvement, scholarly research, peer education, community engagement, social responsibility activities, and
640 the evaluation of educational change. These shared practices represent tangible opportunities for students to
641 experience the consequences of their contribution.

642 **8. Use accreditation and national frameworks as enabling infrastructure.** Partnerships should not depend
643 solely on the practices of individual institutions or highly committed faculty members. Accreditation agencies,
644 national medical education organizations, and other sector-level bodies can establish shared expectations for
645 effective student involvement, provide developmental guidance and self-evaluation tools, disseminate best
646 practices, and create opportunities for students to make system-level contributions. National frameworks should
647 be context-sensitive, allowing for developing institutional-specific partnership models. Their focus should
648 extend beyond whether student representatives or feedback mechanisms are formally present to consider the
649 quality, inclusivity, safety, and influence of student participation.

650 These priorities should be understood as an interconnected strategy rather than a checklist of independent
651 interventions. A committee without meaningful influence, a feedback mechanism without follow-through,
652 representation without connection to the wider student body, or partnership training without protected capacity
653 is unlikely to produce sustained change. Similarly, national standards alone cannot create partnerships unless
654 they are translated into locally relevant institutional practices. Strengthening student partnership engagement
655 requires alignment between system-level expectations and institutional enactment while preserving sufficient
656 flexibility for medical schools to respond to their own organizational cultures, student populations, resources,
657 and educational contexts.

658 **Strengths and limitations**

659 This study sought participation through public and foundation medical schools across all seven geographical
660 regions and examined education, research, governance and quality assurance, and community engagement
661 partnerships. The mixed-methods design combined quantitative patterns with student-defined qualitative
662 priorities. The survey sample was not restricted to formal representatives: more than half reported no
663 membership in a representation structure or student organization. The anonymous survey reduced concerns that
664 institutions could identify critical responses. Sequential focus groups enabled students to explain the

mechanisms underlying the survey patterns, and integration using a shared codebook and joint display supported a coherent analytic account.

The study has several limitations that should inform interpretation. First, voluntary participation may have attracted students who were particularly interested in educational improvement, although the survey included both represented and nonrepresented students. Second, institutional identifiers were intentionally omitted. This protected anonymity but prevented calculating the response rate, verifying institutional coverage, and analyzing variation by school context.

Making all survey items mandatory eliminated missing quantitative data but may have encouraged some brief or low-information responses to the open-ended questions; noninformative content was excluded from the qualitative analysis. Written responses also varied in depth and did not allow immediate probing.

The focus groups included student representatives; as information-rich participants, they may have been more familiar with institutional processes than the wider student population. Group interaction and differences in experience or confidence may also have shaped what was expressed.

Coded-unit frequencies indicate the amount of qualitative content assigned to each theme rather than the number or proportion of students holding a view. They should not be interpreted as prevalence or as a hierarchy of theme importance.

Conclusions

Medical students in Türkiye strongly valued partnership engagement and viewed it as relevant to educational quality across education program development, scholarly research, governance and quality assurance, and community engagement. Their perceptions of institutional support and current engagement nevertheless revealed a consistent implementation gap.

The qualitative findings show that a single committee, survey, or representative role does not produce partnership. Student voice becomes a partnership when it is connected to visible influence through legitimate and inclusive representation, institutionalized and accountable processes, psychologically safe and fair relationships, protected capacity, and opportunities for shared practice.

690 The same mechanism can enable or impede this process. Feedback can strengthen trust or create fatigue.
691 Representation can widen the student voice or restrict it to a small group. Committees can create sustainable
692 access to decision-making or provide symbolic presence. The effect of the mechanisms depends on how they
693 are enacted and whether students can observe the consequences of their contribution.

694 Medical schools seeking to move from consultation toward partnership should therefore do more than create
695 additional opportunities for students to speak. They should close feedback loops, clarify roles and decision
696 rights, strengthen inclusive representation, address hierarchy, develop partnership capabilities, protect time and
697 resources, and enable students and faculty to undertake meaningful work together.

698

699 **List of abbreviations**

700 ATADEK: Acıbadem University and Acıbadem Healthcare Institutions Medical Research Ethics Committee
701 HPE: Health professions education
702 R: R statistical computing environment

703 UTEAK: National Accreditation Board for Medical Education

704 TEPDAD: Association for Evaluation and Accreditation of Medical Education Programs

705 **Declarations**

706 **Ethics approval and consent to participate**

707 Ethical approval was granted by the Acıbadem University and Acıbadem Healthcare Institutions Medical
708 Research Ethics Committee (Approval No. 2024-12/522; 15 August 2024). All participants provided informed
709 consent before participation. The study was conducted in accordance with applicable ethical principles and
710 institutional requirements.

711 **Consent for publication**

712 Not applicable. No directly identifiable participant information is included. Quotations are anonymized and
713 translated from Turkish.

Availability of data and materials

The de-identified quantitative dataset and anonymized focus-group transcripts are available from the corresponding authors upon reasonable request, subject to ethical and confidentiality considerations. The qualitative codebook and supporting analytic materials may also be made available on request. The data are not publicly available because contextual information in the qualitative accounts may increase the risk of participant or institutional identification. Original audio recordings will not be shared to protect participant confidentiality.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

KMG: Conceptualization, methodology, investigation, data curation, formal analysis, visualization, writing, and original draft. MŞ: Methodology, formal analysis, validation, and writing, review, and editing. MKA: Conceptualization, supervision, interpretation, and writing, review, and editing. İCS: Methodology, supervision, interpretation, and writing, review, and editing. LA: Conceptualization, methodology, supervision, project administration, and writing, review, and editing. All authors reviewed and approved the final manuscript.

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Additional files

Additional file 1. Study questionnaire: English-language version.

Additional file 2. Semistructured focus-group interview guide: English-language version.

References

1. Kahu ER. Framing student engagement in higher education. Studies in Higher Education. 2013 Jun;38(5):758–73. doi:10.1080/03075079.2011.598505
2. Kahu ER, Nelson K. Student engagement in the educational interface: understanding the mechanisms of student success. Higher Education Research and Development. 2018 Jan 2;37(1):58–71. doi:10.1080/07294360.2017.1344197
3. Trowler V. Student Engagement Literature Review. 2010.
4. Coates H. The value of student engagement for higher education quality assurance. Quality in Higher Education. 2005. p. 25–36. doi:10.1080/13538320500074915
5. Kassab SE, Taylor D, Hamdy H. Student engagement in health professions education: AMEE Guide No. 152. Med Teach. 2023;45(9):949–65. doi:10.1080/0142159X.2022.2137018 PubMed PMID: 36306374.
6. Cook-Sather A, Bovill C, Felten P. Engaging students as partners in learning and teaching: A guide for faculty. 2014.
7. Healey M, Flint A, Harrington K. Engagement through partnership: students as partners in learning and teaching in higher education. 2014.
8. Mercer-Mapstone L, Dvorakova SL, Matthews KE, Abbot S, Cheng B, Felten P, et al. A Systematic Literature Review of Students as Partners in Higher Education. International Journal for Students as Partners. 2017.
9. Martens SE, Meeuwissen SNE, Dolmans DHJM, Bovill C, Könings KD. Student participation in the design of learning and teaching: Disentangling the terminology and approaches. Med Teach. 2019 Oct 3;41(10):1203–5. doi:10.1080/0142159X.2019.1615610 PubMed PMID: 31131654.
10. Kassab SE, El-Sayed W, Hamdy H. Student engagement in undergraduate medical education: A scoping review. Medical Education. John Wiley and Sons Inc; 2022. p. 703–15. doi:10.1111/medu.14799 PubMed PMID: 35285052.
11. Kassab SE, Al-Eraky M, El-Sayed W, Hamdy H, Schmidt H. Measurement of student engagement in health professions education: a review of literature. BMC Medical Education. BioMed Central Ltd; 2023. doi:10.1186/s12909-023-04344-8 PubMed PMID: 37210491.
12. Peters H, Zdravkovic M, João Costa M, Celenza A, Ghias K, Klamen D, et al. Twelve tips for enhancing student engagement. Med Teach. 2019 Jun 3;41(6):632–7. doi:10.1080/0142159X.2018.1459530 PubMed PMID: 29683024.
13. ODABAŞI O. Türkiye Tıp Fakülteleri 2023. STED / Sürekli Tıp Eğitimi Dergisi. 2023 Mar 6. doi:10.17942/sted.1259646
14. Güven KM, Altıntaş L. TIP EĞİTİMİNDE ÖĞRENCİ KATILIMI: DERLEME. Toplum ve Hekim [Internet]. 2025 Mar [cited 2026 Sep 3];2(40):142–50. Available from: https://www.belgelik.dr.tr/ToplumHekim/kayit_goster.php?Id=3252
15. Tombs M, Strange H. Using Qualitative Questionnaires in Medical Education Research. Perspect Med Educ. 2024;13(1):280–7. doi:10.5334/pme.1102 PubMed PMID: 38737397.
16. Olmos-Vega FM, Stalmeijer RE, Varpio L, Kahlke R. A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. Med Teach. 2023;45(3):241–51. doi:10.1080/0142159X.2022.2057287

17. Australian Council for Student Voice. The Australian Framework for Student Empowerment (AFSE) [Internet]. 2025 May [cited 2026 Sep 3]. Available from: https://www.studentvoice.org.au/learn/resources/afse/

18. Naylor R, Dollinger M, Mahat M, Khawaja M. Students as customers versus as active agents: conceptualising the student role in governance and quality assurance. Higher Education Research and Development. 2020;1–14. doi:10.1080/07294360.2020.1792850

19. Aysel BAŞER Ege Üniversitesi Tıp Fakültesi Tıp Eğitimi Anabilim Dalı Doktora Öğrencisi U, Şemikler Aile Sağlığı Merkezi N, Şahin Ege Üniversitesi Tıp Fakültesi Tıp Eğitimi Anabilim Dalı H. ATATÜRK'TEN GÜNÜMÜZE TIP EĞİTİMİ MEDICAL EDUCATION FROM ATATURK TO PRESENT.

20. Altıntaş L, Alimoğlu MK, Şenol Y, Durak Hİ, Sayek İ. RE-AIM evaluation of accreditation process in Turkey. BMC Med Educ. 2024 Dec 1;24(1). doi:10.1186/s12909-024-06143-1 PubMed PMID: 39415178.

Supplementary Files

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- Additionalfile1FromstudentvoicetovisibleinfluenceAmixedmethodsneedsanalysisofmedicalstudentpartnershipengagementacrossTrkiye.docx
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