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Assessment of Patient-Partnered Approaches in Undergraduate and Graduate Medical Education: A Scoping Literature Review

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Abstract

Background

Patients bring experiential knowledge that can enrich medical education. However, how they are engaged as partners in undergraduate (UME) and graduate medical education (GME) remains unclear. This scoping review mapped patient-partnered approaches in UME and GME.

Methods

Following JBI methodology and PRISMA-ScR guidelines, PubMed and Scopus were searched for English-language literature published between 2000 and September 2026. Two reviewers independently screened 1,710 records.

Results

Eleven studies met the inclusion criteria. Most used qualitative designs (n = 10), and seven described pilot initiatives. Eight studies focused on UME and three on GME. Patient roles ranged from sharing lived experiences to participating in educational co-design. Approaches varied in duration, frequency, and continuity. Most occurred in faculty-directed educational experiences, with fewer examples of sustained patient partnership in curriculum co-design. GME studies were concentrated in internal medicine, and narrative medicine was commonly represented.

Conclusions

Patient-partnered approaches represent an established but heterogeneous practice, varying in design, implementation, educational objectives, and guiding frameworks. Their breadth suggests potential utility across educational contexts. Future research should examine how patient involvement aligns with educational objectives and outcomes and expand the evidence base across specialties, learner levels, and settings to support comparisons and inform best practices.

Background

In healthcare settings, patients, families, and caregivers offer experiential knowledge that complements clinical expertise and shapes how medical trainees understand illness, navigate systems, and deliver patient-centered care. Accordingly, medical education has increasingly incorporated patients into educational experiences, positioning them as teachers, storytellers, advisors, evaluators, and collaborators in preparing learners for patient-centered practice.[1–3] Interactions between patients and medical trainees have mutually beneficial effects, including trainees reporting increased empathy and a deeper understanding of patients' experiences, as well as a patients' sense of empowerment through

contributing to the education of future healthcare professionals.[4,5] This increased involvement reflects a growing recognition of patients as partners in their own healthcare and in the education and development of medical professionals.[2,6,7]

There are several titles a patient may assume within medical education, including patient educator, instructor, mentor, teacher, volunteer, and partner.[4,8,9] Dijk et al.[9] categorized patient involvement in undergraduate medical education into four roles: patient teacher, patient assessor, curriculum developer, and patient selection committee member. These roles illustrate the breadth of patient contributions across teaching, assessment, curriculum development, and student selection. However, the different labels assigned to patients do not necessarily indicate the extent to which they collaborate with learners and educators, contribute to educational decisions, or influence responses to healthcare challenges. Understanding patient partnership therefore requires attention to the roles patients occupy and to the nature and extent of their involvement.

Patient partnership builds on broader efforts to engage patients as active contributors to healthcare research and improvement. For example, the Patient-Centered Outcomes Research Institute (PCORI) emphasizes meaningful engagement of patients and other stakeholders as partners throughout the research process.[10] Although the principles of community-based participatory research are well established in patient-centered research,[11] their conceptualization and application to patient-partnered medical education continue to evolve. Towle et al.[7] describe active patient involvement in health professions education as drawing on individuals' expertise and lived experiences of health, illness, or disability, with patients recognizing that they have a designated educational role. This perspective recognizes patients as educators who contribute their lived experiences and personal expertise to medical education. Bokken et al.[12] describe this approach as an effective teaching method that offers a level of authenticity not typically present when human actors portray patients in standardized or simulated clinical encounters.

Building on these perspectives, we define *patient-partnered approaches* as collaborative approaches in which patients, family members, or caregivers are meaningfully and actively involved as valued partners alongside medical learners, contributing their lived experiences, perspectives, and expertise to one or more stages of identifying problems, generating solutions, designing interventions, implementing change, or evaluating outcomes related to healthcare, quality improvement, patient safety, redesign, innovation, or education. This definition encompasses diverse roles and activities rather than a single educational model or type of relationship. Patients may contribute as co-teachers, advisors, curriculum contributors, evaluators, co-designers, co-researchers, or improvement partners. The defining feature is not the title assigned to the patient or the format of the activity, but the meaningful contribution of the patients lived experiences, perspectives, and expertise alongside medical learners. Importantly, patient participation does not necessarily constitute partnership, as the nature and extent of patients' involvement, autonomy, and influence may vary across educational experiences.

Existing frameworks, including Towle et al.'s[7] *Spectrum of Involvement* and Bennett-Weston et al.'s[13] *Wheel of Patient Partnerships*, provide conceptual resources for understanding and supporting patient involvement in medical education. Similarly, the Cambridge framework organizes patient involvement around three dimensions: *the how, the what, and the where*, offering a way to consider how patients are involved, what they contribute to, and where involvement takes place.[4] In addition to conceptual frameworks, successful patient involvement requires intentional preparation and institutional support. Howe et al.[14] identified several considerations for improving patient participation, including establishing clear guidelines for patients, teachers, and students; allocating sufficient staff time and training; recruiting and preparing patients before educational encounters; preparing students to interact appropriately with patients and navigate challenging situations; and obtaining feedback on the effects of patient participation.[14] These perspectives highlight that meaningful patient involvement is dependent on how participation is conceptualized and how educational experiences are organized, supported, and evaluated.

It remains unclear how patient partnership is represented and operationalized across the published literature on undergraduate and graduate medical education (UME and GME). This includes the roles patients occupy, the educational contexts in which partnerships occur, and the approaches used to support their participation. Systematically mapping this literature can clarify how existing concepts of patient partnership are reflected in educational practice, characterize the range of approaches described, and identify gaps in the evidence and opportunities for further development. Addressing this gap also requires examining the educational theories and approaches that inform how patient-partnered experiences are designed and implemented. Educational theories and approaches can inform how patient-partnered learning experiences are designed and implemented, but they differ in how explicitly they address the nature of patient involvement and partnership. For example, human-centered design can position patients as collaborators in identifying problems and developing solutions,[15] whereas experiential learning theory helps explain how learners construct knowledge through experience and reflection.[16] The use of a particular theory or approach does not, by itself, establish the extent to which patients are meaningfully involved or how their perspectives influence educational decisions. Examining the educational approaches used alongside the roles and contributions of patients can therefore clarify how patient partnership is conceptualized and enacted.

This scoping review aims to characterize what is known about patient-partnered approaches in UME and GME. Specifically, we examine: (1) how patients are engaged as partners, including the roles they play and the nature and extent of their involvement; (2) the educational contexts and learner populations represented in the literature; and (3) how patient partnership is conceptualized and operationalized, including the theoretical frameworks, models, and educational approaches used to inform or support these experiences. By mapping the breadth and characteristics of patient-partnered approaches, this review seeks to clarify how patients contribute to medical education and identify opportunities for further development.

Methods

A scoping review methodology was selected to map the breadth of literature on patient-partnered approaches in UME and GME and characterize the range of approaches described. The review was guided by the JBI methodology for scoping reviews and reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews.[17]

Primary Research Question:

What is known about patient-partnered approaches in UME and GME?

Sub-questions:

1. 1. How are patients engaged as partners in medical education?
2. 2. What roles do patients play in these approaches?
3. 3. What levels of engagement or partnership are described?
4. 4. What educational contexts and learner populations are represented in the literature?

Eligibility Criteria

Eligibility criteria were developed using the Population, Concept, and Context framework recommended by JBI.[18] The population comprised UME students enrolled in U.S. medical schools accredited by the Liaison Committee on Medical Education (LCME) or GME trainees in residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). The concept of interest was patient-partnered learning opportunities involving meaningful and active contributions from patients, family members, or caregivers as valued partners in medical education. The context included UME and GME programs and their affiliated learning environments. Studies were eligible if they were published in English between 2000 and the search date and reported original research, an educational intervention, a program evaluation, or another eligible educational study.

Studies were excluded if they did not involve UME or GME learners, did not include meaningful patient partnership, or took place outside the specified educational context. Studies focused on standardized patients, simulation-based education, didactic sessions, or passive patient involvement were also excluded.

Information Sources and Search Strategy

A literature search was conducted in PubMed and Scopus. Search strategies combined three concept groups: (1) patient participation, involvement, partnership, and related roles and approaches; (2) medical education, medical students, residents, and medical training; and (3) systems-based practice, health

systems science, systems thinking, quality improvement, and patient safety. Controlled vocabulary, including Medical Subject Headings (MeSH), and free-text terms were used where appropriate to capture variations in terminology. Search strategies were adapted for each database to accommodate differences in indexing and search syntax. Searches were limited to English-language publications from 2000 onward. Complete database-specific search strategies are provided in Appendix A. Searches were conducted on September 1, 2026. Results were imported into Covidence systematic review software[18] for reference management, duplicate removal, and study selection. The full protocol for this search was published in Open Science Framework.[19]

Study Selection and Screening

Of the 1,744 records imported into Covidence, 34 duplicates were removed, leaving 1,710 records for title and abstract screening. Two reviewers (CS and NG) independently screened titles and abstracts against the predefined eligibility criteria. Following this screening, 1,683 records were excluded, and 27 articles proceeded to full-text review. Both reviewers independently assessed all 27 full-text articles. Disagreements at either stage were resolved through discussion and mutual agreement.

Following full-text assessment, 16 articles were excluded for the following reasons: Wrong study design (n = 9), not patient-partnered (n = 5), wrong population (n = 1), and wrong setting (n = 1). The remaining 11 studies met the eligibility criteria and were included in the review. The study selection process is summarized in the PRISMA flow diagram (Fig. 1).

Data Extraction

Data were charted from the included studies using a structured extraction approach in Covidence and were consistent with the descriptive aims of a scoping review. Extracted study characteristics included publication year, study institution, study design, whether the study was described as a pilot, and student demographics. Educational context variables included level of training, learner year, specialty, educational setting, and whether the educational experience was curricular or non-curricular. Patient partnership was characterized by documenting the populations of patient partners involved, the roles they assumed, and the extent of their active participation in the learning experience. Learner engagement was captured by documenting how learners interacted with patient partners. Additional data included key findings, evidence of intervention scale or sustainment, reported outcomes, implementation barriers, and study limitations. CS developed a structured data extraction table to facilitate comparison across studies and address the review questions. CS and NG independently extracted data from the included studies. Discrepancies were discussed and resolved by mutual agreement.

Data Synthesis

Data were synthesized descriptively to characterize the breadth and nature of patient-partnered approaches in UME and GME. Findings were organized around the review's sub-questions: how patients were engaged, the roles they assumed, the levels of engagement or partnership described, and the educational contexts and learner populations represented. Results were presented in tables to compare findings. The synthesis focused on mapping the available evidence and identifying patterns and gaps in the literature.

Results

Study Yield

Eleven studies met the eligibility criteria and were included in the scoping review. Table 1 represents the characteristics of included studies and their educational contexts.

Table 1
Characteristics of Included Studies and Educational Contexts

Author	Study Design	Pilot Study	Learner Population	Learner Stage (specialty)	Curricular Context
Berger & Harada[20]	Qualitative Research	No	UME	M1	Curricular
Bradley et. al.[21]	Qualitative Research	Yes	GME	PGY-1 (Internal Medicine)	Curricular
Busey et. al.[22]	Cross Sectional	Yes	UME	M1-M4	Curricular
Chou et. al. [23]	Qualitative Research	Yes	UME	M1-M2	Non-Curricular
Kaplan et. al.[24]	Qualitative Research	No	GME	PGY-1 – PGY-4 (Internal Medicine)	Non-Curricular
Miller et. al.[25]	Qualitative Research	Yes	UME	M1	Curricular
Muzyk et. al.[26]	Qualitative Research	Yes	UME	M1	Curricular
Schrimpf Davis et. al.[27]	Qualitative Research	No	UME	M1	Curricular
Tang et. al.[28]	Qualitative Research	Yes	UME	M1	Curricular
Taylor et. al.[29]	Qualitative Research	Yes	UME	N/A	Curricular
Wright et. al.[30]	Qualitative Research	Yes	GME	PGY-2 – PGY-3 (Internal Medicine)	Non-Curricular

Characteristics of Patient Partnership

Pilot Studies

Of the 11 studies included in this review, ten employed qualitative research methods, while one used a cross-sectional design.[22] Eight studies described their patient-partnered approaches as pilot studies,[21–23,25,26,28–30] indicating that much of the literature focused on the preliminary implementation or evaluation of these educational approaches. The remaining three studies described longitudinal or repeated educational experiences.[20,24,27] The extent to which these approaches were integrated into medical education varied, ranging from discrete educational activities[24,27] to experiences embedded across an extended period of training.[22,28,30] Additional characteristics of patient partnership can be found in Table 2. These findings demonstrate variation in duration and implementation.

Patient Role

Using Towle et al.'s[7] taxonomy, all studies primarily reflected patient involvement in which patients shared their lived experiences and perspectives with medical trainees within structured faculty-directed educational activities.

Stage of Involvement

Patient involvement occurred at different stages of the educational process. In all studies, patients contributed their experiences and perspectives to aid in trainees better understanding healthcare through the patient perspective. Three studies described patients as collaborators in the development of educational interventions and extended their involvement beyond sharing experiences to co-designing learning activities with students.[23,29,30]

Duration and frequency of partnership

The duration and frequency of patient-partnered activities varied across studies. Miller et al.[25] described the briefest engagement, consisting of one or two touchpoints lasting 5–10 minutes each. Schrimpf Davis et al.[27] and Chou et al.[23] reported half-day patient-partnered activities, while Berger & Harada[20] and Bradley et al.[21] each reported two half-day sessions. In contrast, other studies described longitudinal programs involving repeated trainee and patient interactions over several weeks,[29] several months,[28,30] or spanning the entire four-year UME experience.[22] The duration or frequency of patient engagement was not reported in two studies.[26,28]

Primary Concept

The primary educational concepts reflected a broad range of learning objectives. These included social determinants of health,[20,21] professional identity formation,[22] interprofessional education,[25] burnout reduction,[24] critical consciousness in substance use disorder education,[26] intergenerational communication,[27] empathy and patient-centered values,[28] patient empowerment and resilience,[29] engaging patients as partners in healthcare,[22] and goals-of-care conversations.[30]

Theory, Framework, Model, or Approach

The included studies reported a range of theories, frameworks, models, and educational approaches to guide or contextualize patient-partnered learning. These included experiential learning,[20] social and narrative medicine,[21,24] communities of practice,[26] professional identity formation,[22] transformative learning theory,[26] the Interprofessional Education Collaborative Core Competencies,[25] Human Histories,[21,27] quality improvement,[29] and cultural humility.[30]

Discussion

This scoping review highlights the varied ways patients contribute to UME and GME, and it raises questions about how patient partnership is conceptualized and enacted. Across the included studies, patients contributed lived experiences, perspectives, and expertise to educational activities, but the nature and extent of their participation varied significantly. The findings reveal a clear distinction between incorporating patients' experiences into medical education and involving patients in shaping educational activities and interventions. Examining these approaches through the lens of patient partnership provides an opportunity to characterize how patients contribute to learning. For sustained partnership, it is important to know how patient participation is structured and represented in the literature, and the variety of ways it might be supported within medical education. The following discussion examines the nature and extent of patient participation, the organization and continuity of patient engagement, and the educational contexts in which patient-partnered approaches have been reported. These findings characterize the current state of published literature and identify opportunities to strengthen the conceptualization, implementation, and reporting of patient partnership in medical education.

Theme 1: The Nature and Extent of Patient Participation

Across the included studies, patients commonly contributed to medical education by sharing their lived experiences and perspectives with learners through structured, faculty-directed educational activities. These activities included workshops,[23,25,26,28,29] classroom-based activities,[20,22,26,27,29] and intentional engagements within clinical environments.[20,21,25,28] Such approaches recognize patients as holders of experiential knowledge shaped by critical illness and disease, interactions with healthcare systems, and the broader social determinants that influence health and access to care. For example, Berger & Harada[20] described a multi-site engagement in which students initially met with survivors, who had at least one myocardial infarction, in a classroom setting and then later visited the patients' hometown to explore how their social and community contexts might shape their patients experiences of illness and healthcare. The patient was then brought back into a classroom setting to allow students to better understand the patient lived experience, which further enabled a patient-student partnership in identifying and discussing barriers to care. This experiential knowledge can complement clinical and academic perspectives by illuminating dimensions of healthcare that may be less visible through traditional educational methods.

However, the extent to which patients shaped the educational experiences in which they participated varied across studies. Some approaches involved brief encounters, such as those described by Kaplan et al.[24] in which patient interactions focused on humanism and were associated with increased well-being and meaning in medicine. Others involved longitudinal relationships, such as Patient Student Partnership (PSP) program, a four-year ongoing patient engagement described by Busey et al.,[22] which influenced medical students' professional identity formation. Although these approaches provided opportunities for learners to engage with patients' perspectives, the extent of patients' involvement in shaping the educational activities themselves was less consistent. Future research could explore how

curricular activities might move beyond incorporating patients' experiences toward more meaningful patient partnership, including opportunities for patients to help shape educational objectives, learning activities, and evaluation.

The identified studies demonstrate patients serving as educators in different ways. In Muzyk et al.'s[26] study, patients lived experiences informed a faculty-designed, person-centered care curriculum focused on patients with substance use disorders. This work helped foster pre-clerkship medical students' critical consciousness through facilitated discussion and personal reflection. In contrast, Chou et al.[23] described a model of narrative medicine training, community-based participatory narrative medicine, centered on shared narrative work between healthcare trainees and patients, in which patient involvement shaped the educational approach. These examples illustrate how patients occupying similar roles may have different opportunities to influence educational content and design. To further characterize patient partnership, descriptions of patient involvement should extend beyond role titles to clarify what patients did, how they contributed, and how their contributions informed the educational experience. Greater transparency regarding the expectations communicated to patients, the preparation or formal training provided, and the extent of their influence on curricular decisions would also help clarify how partnership was operationalized. These important details could help support the replication, dissemination, and scaling of patient-partnered approaches across educational settings and specialties.

The stages of involvement identified in this review provide a useful lens for examining patient participation. Although patients in many studies contributed experiential knowledge within educational activities, three studies explicitly described patients as collaborators in co-designing interventions. Co-design expands the recognition of patients as holders of experiential knowledge to patients as wielders of experiential expertise. This operationalization of patient partnership also implicitly acknowledges the role trainees can play in transforming care delivery, tightly coupling the processes of mutual learning and impact as opposed to more sequential learn first, act later approaches. Taylor et al.[29] engaged patients through telephone calls to inform a quality improvement initiative focused on patient empowerment and resilience during the COVID-19 pandemic, whereas Chou et al.[23] used workshops to develop a community-based participatory narrative medicine approach, and Wright et al.[30] used workshops to conduct an experience-based co-design study grounded in cultural humility to improve goals-of-care communication training for clinicians caring for Black patients in the United States. These examples illustrate a variety of formats through which patients can contribute to educational and improvement efforts as partners in learning, including opportunities to shape interventions rather than solely sharing their lived experiences. Interestingly, these examples of co-design primarily focus on improving patient-provider interactions, with less attention to broader factors that influence health, such as policy, health technologies, and the built environment.

The extent of patient partnership depends on the nature of patients' contributions, the activities they undertake, and the opportunities they have to influence decisions. This distinction aligns with the review's operational definition of patient-partnered approaches, which emphasizes the meaningful and

active involvement of patients, family members, or caregivers as valued partners in one or more stages of an educational or improvement process. Partnership does not require involvement across every stage, but the nature and extent of that partnership may vary depending on patients' roles and influence. The articles in this review reflect inconsistent reporting of patients' contributions, roles in decision-making, and influence over interventions limited the ability to characterize and compare partnership across the literature. Future studies should explicitly describe patients' roles, the activities in which they participate, and how their input informs decisions. These details would support more consistent characterization of patient partnership and enable comparisons across educational contexts and approaches.

Theme 2: The Organization and Continuity of Patient Engagement

Patient-partnered approaches varied in duration and frequency, ranging from brief educational encounters to longitudinal experiences extending across multiple months or years. These approaches illustrate how patient participation can be incorporated into discrete learning activities or sustained across multiple educational experiences. For example, Kaplan et al.[24] described humanism rounds in which Internal Medicine graduate trainees set aside intentional time to listen and learn directly from patient experiences. This experience helped create opportunities for patients to contribute perspectives beyond their medical histories and immediate reasons for seeking treatment. In contrast, Tang et al.[28] and Busey et al.[22] examined approaches involving longitudinal patient engagement. In Tang et al.'s[28] study, first-year medical students were randomized to either a patient-centered or traditional track during their longitudinal clinical experience. Findings highlighted the potential of longitudinal, patient-centered experiences to foster empathy, and patient-partnered values among preclinical students.[28] Similarly, Busey et al.[22] described the Patient Student Partnership (PSP), which integrates mentored, longitudinal patient-partnered relationships into a traditional block clerkship model. Through participating in the PSP, students reported several advantages including being able to connect classroom learning to clinical practice, contribute meaningfully to patient care, practice communication skills, and develop their professional identities.[22] These examples illustrate how repeated and intentional interactions may allow learners to build partnerships with patients, deepen their understanding of patient perspectives over time, and receive feedback as they develop. However, longitudinal engagement alone does not establish the extent of partnership. Opportunities for reciprocal learning and patient influence depend on how interactions are structured and the roles patients are afforded within them.

Understanding these differences requires distinguishing among program duration, the frequency of patient–learner interactions, and the continuity of individual relationships. This distinction reflects a quality-over-quantity consideration: program duration should not be interpreted as a proxy for the quality of partnership or educational effectiveness. Additionally, the overall duration of a program does not necessarily indicate how frequently patients and learners interact or whether their interactions foster partnership. Although most studies reported the duration of patient–learner engagement, the reported timeframes varied considerably, ranging from brief encounters of 5–10 minutes,[25] a half day,[23,24] two

half days,[20,21] several weeks,[29] and several months,[28,30] to engagement spanning the entire four-year UME experience.[22] Two studies did not report the duration or frequency of patient engagement.[24,26] More broadly, most studies provided limited detail about the structure of patient–learner engagement, making it difficult to determine how interactions were designed to foster partnership. Kaplan et al.'s[24] P.E.O.P.L.E.S. framework offers one example of a more structured approach, using interview questions focused on Place, Environment, Occupation, People, Likes, Entertainment, and Service to encourage connections and partnership between trainees and patients. Overall, limited reporting of how patient–learner interactions were structured to support partnership constrained the ability to compare approaches systematically and examine how engagement patterns related to the nature of patient participation. It was difficult to determine whether patients had opportunities to revisit earlier contributions, provide feedback, or influence subsequent educational activities.

Theme 3: The Breadth and Distribution of Patient-Partnership Approaches

The published literature on patient-partnered approaches is unevenly distributed across learner populations, specialties, and educational settings. Although the included studies represented both UME and GME, the former accounted for most studies.[22,23,26,28,29] The few GME studies included were coincidentally concentrated in the internal medicine specialty.[21,24,30] Within GME, studies illustrated different ways of integrating patient partnership into training. For example, *Healing Through History* (HTH), a social medicine consultation curriculum for PGY1–4 trainees that integrated social determinants of health narratives into clinical care for medically and socially complex patients.[20] Initial findings suggested that HTH offered a model for teaching co-production and partnership through social and narrative medicine consultations while fostering meaning in work. GME studies emphasized co-production at the bedside, illustrating how patient partnership can be integrated into the clinical learning environment.[20,24] In UME, patient-partnered approaches were more frequently incorporated into structured curricular experiences, most often in classroom settings, with fewer studies situated in clinical environments.[22,28,29] Although these studies demonstrate variation in how patient partnership can be incorporated into medical education, the uneven distribution of studies across learner populations, specialties, and educational settings limits comparisons across contexts. In particular, the concentration of GME studies in internal medicine leaves less evidence about how patient partnership is implemented in other specialties and clinical learning environments.

Across these contexts, the included studies addressed diverse educational objectives, including social determinants of health,[20,23] empathy,[28] patient partnership,[29,30] professional identity formation,[22] interprofessional education,[25] quality improvement,[29] and goals-of-care conversations.[30] The theories, frameworks, and educational approaches used to contextualize these experiences were similarly varied, although narrative medicine was the most frequently reported approach.[21,23,24,27] This diversity suggests that patient-partnered approaches have been applied across multiple educational domains rather than being confined to a single curricular purpose or theoretical orientation. This breadth presents challenges

for synthesizing the evidence, as differences in educational objectives, conceptual foundations, and intended outcomes complicate comparisons across approaches.

Limitations

This review has several limitations. Eligibility criteria restricted inclusion to English-language, peer-reviewed studies conducted in U.S. UME or GME settings, potentially excluding relevant approaches described in other countries or publication formats. Only 11 studies met the inclusion criteria, and variation in educational context, study design, and reporting detail limited comparisons across approaches and conclusions about educational outcomes. Inconsistent descriptions of patient roles, activities, and contributions to decision-making also limited the ability to consistently characterize the nature and extent of patient partnership across studies. As a scoping review, this study mapped the available literature rather than evaluating the effectiveness of individual approaches. The small number of identified studies may reflect limited research on patient partnership or perhaps the possibility that partnership occurs organically within medical education without being formally documented or reported in the published literature. These findings highlight the need for more comprehensive reporting and further research examining how patient partnership is conceptualized, implemented, and evaluated in medical education.

Conclusions and future research

Patient-partnered approaches in medical education varied in their roles, educational contexts, duration, and theoretical foundations. The most common form of partnership involved patients sharing lived experiences and perspectives through structured interactions with learners, particularly in UME. Other approaches included advising, curriculum development, evaluation, longitudinal engagement, and improvement-oriented activities. Although patients contributed to diverse educational objectives, fewer studies explicitly described their involvement in designing educational interventions or shaping educational decisions. These findings suggest that patient partnership is an established but heterogeneous approach, with variation in how it is conceptualized and enacted across medical education.

Future research should more explicitly report patient roles, contributions to decision-making, and involvement across stages of the educational process, including the duration, frequency, and continuity of engagement and how patient contributions inform subsequent activities. Connecting patient involvement to educational objectives and outcomes would support more meaningful comparisons across approaches without assuming that one form of participation is inherently more valuable than another. Research should also broaden the evidence base across specialties, learner levels, and educational settings, particularly clinical environments where patient participation is integrated into ongoing care, improvement, or education. Examining how curricular structures and conceptual frameworks shape patient roles and opportunities for influence may further clarify how partnership is enacted. Competency-based medical education offers a potential framework for investigating how patient partnership contributes to the development and assessment of specific competencies, including

Systems-Based Practice, and how patients' perspectives might inform definitions of competence and evaluations of learner performance. More consistent reporting of study design, implementation, patient contributions, and educational outcomes would strengthen the evidence base while preserving the contextual differences that characterize patient-partnered medical education.

Table 2
Characteristics of Patient Partnership

Author, Year	Patient Role	Stage of Involvement (Towle et al.[7])	Duration and frequency of partnership	Primary concept	Theory, framework, model, or approach
Berger & Harada[20]	Patient shares their experience with students with a faculty directed curriculum	Identify: Patient(s) helped to identify or define a problem with students	Two 1/2 day's	Social Determinants of Health	Experiential Learning
Bradley et. al.[21]	Patient shares their experience with students with a faculty directed curriculum	Identify: Patient(s) helped to identify or define a problem with students	Two 1/2 day's	Social Determinants of Health	Social and Narrative Medicine
Busey et. al.[22]	Patient shares their experience with students with a faculty directed curriculum	Identify: Patient(s) helped to identify or define a problem with students	Bi-weekly or Monthly touch points for 4 years	Professional Identity Formation	Experiential Learning; Professional Identity Formation
Chou et. al. [23]	Patient shares their experience with students with a faculty directed curriculum	Codesign: Patient(s) co-designed an educational intervention with students	One 1/2 day	Patient-as-partner approach	Narrative Medicine
Kaplan et. al.[24]	Patient shares their experience with students with a faculty directed curriculum	Identify: Patient(s) helped to identify or define a problem with students	Unknown	Reduce Burnout	Narrative Medicine

Author, Year	Patient Role	Stage of Involvement (Towle et al.[7])	Duration and frequency of partnership	Primary concept	Theory, framework, model, or approach
Miller et. al.[25]	Patient shares their experience with students with a faculty directed curriculum	Identify: Patient(s) helped to identify or define a problem with students	1–2 touchpoints, 5–10 minutes each	Interprofessional Education	Interprofessional Education
Muzyk et. al.[26]	Patient shares their experience with students with a faculty directed curriculum	Identify: Patient(s) helped to identify or define a problem with students	Unknown	Critical Consciousness (SUD Education)	Transformative Learning Theory; Community of Practice
Schrimpf Davis et. al.[27]	Patient shares their experience with students with a faculty directed curriculum	Identify: Patient(s) helped to identify or define a problem with students	One 1/2 day	Intergenerational Communication	Narrative Medicine
Tang et. al.[28]	Patient shares their experience with students with a faculty directed curriculum	Identify: Patient(s) helped to identify or define a problem with students	Longitudinal engagement over 9 months	Empathy; Patient-Centered Values	Patient-Centered Longitudinal Experience
Taylor et. al.[29]	Patient shares their experience with students with a faculty directed curriculum	Codesign: Patient(s) co-designed an educational intervention with students	Weeks-Long	Patient Empowerment & Resilience	Quality Improvement
Wright et. al.[30]	Patient shares their experience with	Codesign: Patient(s) co-designed an educational	Ongoing engagement across a 3–	Goals of Care Conversation	Critical reflection; Cultural Humility

Author, Year	Patient Role	Stage of Involvement (Towle et al.[7])	Duration and frequency of partnership	Primary concept	Theory, framework, model, or approach
	students with a faculty directed curriculum	intervention with students	6-month period		

Declarations

Disclosures

The authors have no relevant financial or non-financial interests to disclose.

Author Contribution

Author A developed the search strategy, created the search terms, conducted the literature search, and managed the Covidence review process. Authors A and B independently contributed to title and abstract screening, full-text review, and data extraction. Author A drafted the manuscript, and Author B critically reviewed and edited the manuscript. Both authors reviewed and approved the final manuscript.

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None

Data Availability

All data analyzed during this study are derived from previously published literature and are available in the cited articles. Data extracted for this scoping review are available from the corresponding author upon reasonable request.

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Figures

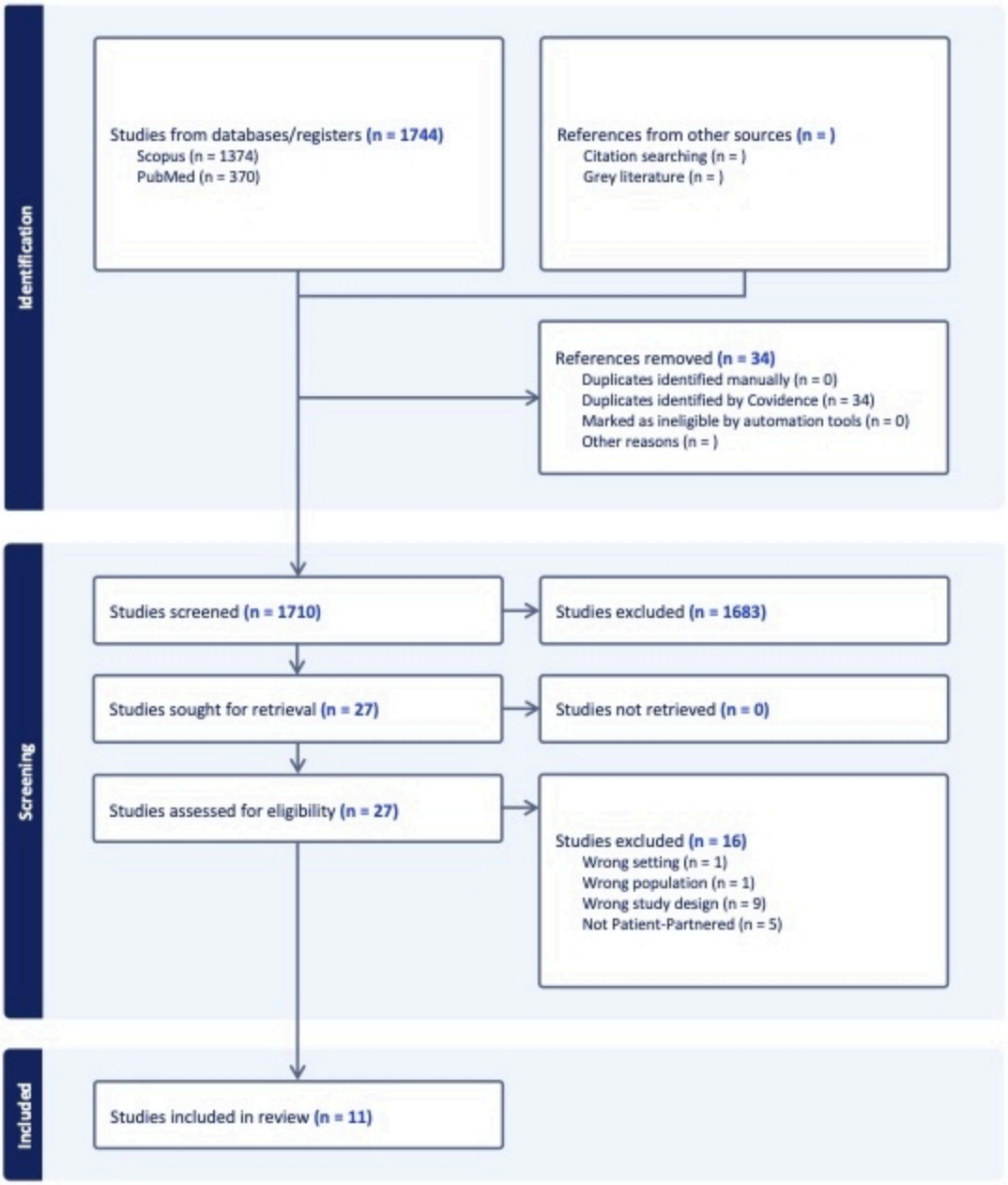

Figure 1

PRISMA flow diagram of Patient Partnered Approaches in Medical Education