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How does patients' knowledge become academically acceptable? A theoretical and empirical study in medical education

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Submission – Research

How does patients' knowledge become academically acceptable? A theoretical and empirical study in medical education

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ABSTRACT

Involving patients in medical education does not, in itself, make their knowledge academically acceptable. This study examines how such knowledge becomes, or fails to become, academically acceptable through pedagogical, epistemic and institutional processes. We conducted an embedded qualitative case study at a French faculty of medicine, encompassing a verbatim theatre performance (180 students), a thematic educational day (240 students) and an institutional process aimed at structuring patient partnership. The corpus comprised 139 immediate student questionnaires, 43 unpaired follow-up questionnaires, questionnaires completed by patient partners, performers and faculty members, field notes and institutional documents. An abductive analysis informed by Bernstein's theory of recontextualisation identified four configurations: strong mediatisation without explicit pedagogical recontextualisation; curricular framing without sustained engagement; documented pedagogical recontextualisation without observed use in clinical practice; and institutional formalisation without established stabilisation. These findings informed the reconstruction of a distributed space of recontextualisation in which mediatisation, pedagogical engagement with experiential knowledge, qualification and legitimation, and institutional consolidation were undertaken by actors occupying different positions across educational and institutional settings. The analysis conceptualised academic acceptability as a provisional and non-cumulative outcome of these configurations, while the extent to which emerging forms of recognition and institutional formalisation could support lasting curricular stabilisation remained uncertain. The proposed model provides an analytical framework for examining the conditions under which patients' knowledge can be transformed and recognised as knowledge for education. It also proposes a principle of evaluative coherence grounded in the epistemological alignment between the object of evaluation, the evidence collected and the inferences drawn.

KEYWORDS

Experiential knowledge; patient involvement; recontextualisation; academic recognition ; curriculum ; medical education

INTRODUCTION

Patient involvement in health professions education takes diverse forms, including testimonials, contributions to educational activities and institutional roles (Towle et al., 2010). These forms of involvement can be situated within the broader development of patient partnership, described in the Montreal Model as a continuum of patient engagement in healthcare, education, research and governance (Pomey et al., 2015). Previous studies have reported positive student responses and perceived benefits for empathy, understanding of illness experiences, communication and reflection (Dijk et al., 2020; Gordon et al., 2019). These forms of involvement raise questions about patient representation, identities and boundaries within educational settings (Rowland et al., 2018; Rowland & Kumagai, 2018; Bennett-Weston et al., 2025a). Previous research has also examined the ethical and epistemic tensions surrounding patients' storytelling, including the risk of reducing experiential knowledge to emotionally engaging narratives (LeBlanc-Omstead & Kinsella, 2023). Existing research has examined patient involvement and its institutional integration, but how experiential contributions are transformed, qualified and potentially institutionalised across educational and institutional settings remains insufficiently understood (Bennett-Weston et al., 2022; Bennett-Weston et al., 2025b; Gross & Ruelle, 2025). One question remains underexplored: how is knowledge derived from patients' experiences transformed when it is brought into university education? Addressing this question requires examining the trajectories of knowledge within educational settings, beyond the involvement of the actors who contribute it.

This shift in focus matters for three reasons. First, patient involvement does not necessarily confer authority on patients' accounts or epistemic legitimacy on their contributions. An account may be appreciated, emotionally engaging or perceived as authentic without being recognised as legitimate knowledge in an educational setting. Second, students' reported appropriation of knowledge does not demonstrate changes in clinical practice or its inclusion in curricular expectations. Third, the continuation of an educational activity does not necessarily mean that the knowledge conveyed has gained academic legitimacy. Reception, appropriation, legitimation and curricular integration are therefore distinct phenomena requiring different forms of evidence. From this perspective, patient involvement cannot be understood solely through the evaluation of educational interventions.

Patients' knowledge encompasses diverse forms, including embodied, monitoring, relational, cultural, navigation and medical knowledge (Dumez & L'Espérance, 2024). Experiential knowledge refers here to knowledge developed through lived experience and its elaboration through reflection, collective exchange and comparison. It is therefore not equivalent to an account of lived experience (Borkman, 1976; Castro et al., 2018; Halloy et al., 2022). These categories are not mutually exclusive: patients may develop and mobilise different forms of knowledge through their experiences. Moreover, articulating experiential knowledge transforms the experience from which it emerges (Gardien, 2025; Pols, 2013). Experiential knowledge cannot therefore be treated as fixed content that can simply be added to the curriculum.

Bernstein's (1996) theory of recontextualisation provides a framework for analysing these transformations. When discourse or knowledge moves from a social or practical context into an educational setting, it is selected and reorganised according to the rules of pedagogic practice (Bernstein, 1996; Singh, 2002). Recontextualisation involves

more than transmission. It distributes positions of authority, establishes boundaries between categories of knowledge and determines the forms in which knowledge can be taught or assessed. Within this framework, classification refers to the strength of boundaries between categories of knowledge and social positions, while framing concerns control over the selection, sequencing, pacing and criteria of pedagogic communication (Bernstein, 1996). These processes are also embedded in social relations that establish hierarchies between forms of knowledge and distribute authority over their production, validation and transmission unequally (Bourdieu, 1984). In academic medicine, different forms of knowledge do not enjoy equal legitimacy. Scientific and professional knowledge benefits from institutionalised authority, whereas knowledge derived from patients' experiences is recognised more conditionally (Carel & Kidd, 2014). This asymmetry may contribute to epistemic injustice when identity-based prejudice leads to a credibility deficit, or when shared interpretive resources are insufficient to make sense of certain experiences (Fricker, 2007). Research on patient partnership suggests that recognition often remains partial and dependent on the institutional arrangements through which participation is organised (Gross & Ruelle, 2025).

Understanding what happens to experiential knowledge in education therefore requires examining both the processes through which knowledge is transformed and the social relations that shape its legitimacy. We approach recontextualisation as a socio-epistemic process linking these two dimensions. Applied to patients' experiential knowledge, this perspective examines how contributions are legitimised and potentially incorporated into the curriculum. Previous research has shown how patients' experiences can contribute to the dialogic construction of professional knowledge (Renedo et al., 2018). Research on professional education has also shown that recontextualisation can occur across different settings and involve multiple actors (Hordern, 2014). However, how these processes interact in educational activities involving patients' experiential knowledge remains poorly documented. This study seeks to clarify these relationships.

In this article, academic acceptability refers to the possibility for a contribution derived from patients' experiences to be recognised and used as knowledge for education. This concept allows us to examine what happens to experiential knowledge without assuming that it has achieved institutional recognition or curricular stabilisation. Curricular stabilisation refers to the durable incorporation of experiential knowledge into educational practices and curricular structures, supported by institutional conditions that sustain its recognition and pedagogical use over time.

This study aimed to understand how knowledge derived from patients' experiences becomes, or fails to become, academically acceptable, and how academic acceptability relates to curricular stabilisation. Drawing on two educational activities and an institutional process examined within the same faculty, we propose an explanatory model of the processes contributing to academic acceptability and the conditions under which experiential knowledge may become stabilised within the curriculum.

METHODS

Study design

We conducted an embedded qualitative case study using an interpretive approach and abductive reasoning (Albarello, 2022; Yin, 2018; Timmermans & Tavory, 2012). The case concerned the introduction of patients' experiential knowledge into undergraduate medical education at Jean Monnet University, Saint-Étienne, France. During the study period, the Faculty of Medicine became the Faculty of Health, providing an evolving institutional context for the development of patient partnership. The study encompassed two educational activities with different pedagogical formats and an institutional process aimed at developing patient partnership. The reporting of the study was guided by the Standards for Reporting Qualitative Research (O'Brien et al., 2014).

The first activity, “A Storm of Life”, was a two-hour verbatim theatre performance held on 11 June 2025 for 180 sixth-year medical students. As part of a compulsory Health, Society and Humanities seminar, the performance presented a patient partner's experience of cancer through a theatrical production involving her company, without a structured collective debriefing afterwards. The second activity, organised on 9 January 2026 with the French Cancer League, involved 240 second-year medical students. This compulsory educational day combined a plenary session, small-group discussions with patient partners, forum theatre and a collective debriefing. The institutional process documented the development of a faculty-wide patient partnership programme between June 2025 and September 2026, including coordination, formalisation and governance activities. These were not the only educational activities involving patients within the faculty. They were selected for the availability of empirical data and their different pedagogical formats, allowing us to examine distinct configurations of experiential knowledge recontextualisation within a shared institutional context. The analysis did not aim to compare their effectiveness.

Corpus and data collection

The corpus comprised questionnaires containing closed- and open-ended questions, a recorded and transcribed group discussion, field notes, and educational and institutional documents (Table 1).

Student questionnaires were administered at two time points: immediately after each educational activity and at follow-up. For the verbatim theatre performance (180 students), 45 questionnaires were completed immediately after the activity (25.0%) and 19 at seven months (10.6%). For the thematic educational day (240 students), 94 questionnaires were completed immediately after the activity (39.2%) and 24 at two months (10.0%). In total, 139 immediate and 43 follow-up questionnaires were collected. Responses were anonymous and could not be linked across time points. The immediate questionnaires focused primarily on students' responses to the activities. The follow-up questionnaires, developed in relation to the analytical framework, explored reported uses of experiential knowledge, its perceived legitimacy and its place in medical education. Closed-ended questions provided descriptive data on respondents' perceptions and positions, while open-ended questions documented how experiential knowledge was appropriated, qualified and legitimised. For the thematic educational day, questionnaires were also completed by 11

patient partners involved in small-group discussions with students and two performers involved in forum theatre. Separately, 46 faculty members responded to a faculty-wide survey on patient partnership in education. These questionnaires documented perceptions of educational interactions, forms of participation and institutional conditions for patient partnership. A 55-minute group discussion with three members of the verbatim theatre company was audio-recorded and transcribed verbatim. It explored the artistic representation of experience and the intended messages of the performance. Field notes documented the activities, observable interactions and pedagogical framing. The institutional corpus, collected between June 2025 and September 2026, included documents from four meetings of the faculty's patient partnership steering committee, responsible for coordinating the development of patient partnership in education, as well as institutional correspondence, budget documents and planning documents. These sources supported the analysis of legitimation, coordination and institutional development of patient partnership. As part of the institutional process, a patient partner involved in developing the faculty's patient partnership programme also provided a reflective note on her prospective role within the emerging structure. This note documented tensions surrounding the recognition and institutionalisation of experiential knowledge.

Table 1 Composition of the corpus by case component

Case component	Participants or sources	Corpus included in the analysis
Verbatim theatre: "A Storm of Life"	Students (180 attending)	45 immediate and 19 follow-up questionnaires at seven months; closed- and open-ended responses
	Theatre company members	One 55-minute group discussion, audio-recorded and transcribed verbatim
	Observation and educational documentation	Field notes; educational and institutional documents
French Cancer League educational day	Students (240 attending)	94 immediate and 24 follow-up questionnaires at two months; closed- and open-ended responses
	Patient partners	11 questionnaires
	Performers	Two questionnaires
	Observation and educational documentation	Field notes; educational materials and organisational documents
Institutional process	Faculty members	46 questionnaires
	Steering committee	Documents from four meetings; minutes, presentations and institutional correspondence
	Institutional documentation	Budget and planning documents
	Patient partner involved in developing the institutional programme	One reflective note concerning her prospective role and the recognition of experiential knowledge

Analytical framework and analysis

The initial analytical framework drew on recontextualisation theory (Bernstein, 1996; Singh, 2002; Hordern, 2014) and research on patient partnership (Towle et al., 2010; Pomey et al., 2015; Gross & Ruelle, 2025). It distinguished three analytical functions: pedagogical interactions and appropriation (R1), knowledge qualification and legitimation (R2), and conditions for curricular and institutional integration (R3). Four analytical temporal dimensions were used to situate these processes: the prior institutional context (T0), the educational event (T1), recontextualisation (T2) and subsequent consolidation (T3). These categories guided the analysis without representing successive stages or mutually exclusive categories. Academic acceptability was inferred from evidence of the qualification, use and legitimation of experiential knowledge. Curricular stabilisation required converging evidence of institutional formalisation and continued implementation.

All data sources contributed to the qualitative interpretation of the case. Closed-ended responses were examined as expressions of respondents' perceptions and positions regarding experiential knowledge, with counts and frequencies used to describe their distribution. Open-ended responses and other textual data were analysed to explore how experiential knowledge was appropriated, qualified and legitimised.

The analysis followed an abductive approach, involving iterative movement between the theoretical framework and empirical data (Timmermans & Tavory, 2012). It was conducted by the lead researcher in three stages. First, textual data were coded in NVivo® using the previously defined analytical categories (R1–R3 and T0–T3). A single excerpt could receive multiple codes. Second, matrices were developed for each case component, cross-referencing analytical functions, time points and actor categories. Findings from closed-ended questions were used to complement this analysis. Third, the matrices were compared to identify convergences, divergences and processes that were not carried forward across the case components. The significance of observations was assessed according to their relative recurrence, level of detail and relevance to the process under study, rather than frequency alone. Divergent observations informed revisions to the initial framework and the reconstruction of the interpretive model presented in the Results. The interpretation was discussed with a medical education and social researcher and an education researcher. The theoretical model and manuscript were also critically reviewed by a patient partner, the Dean of the Faculty and a general practice researcher.

Ethics and reflexivity

The “A Storm of Life” activity and its associated data collection received a favourable opinion from the Ethics Committee of Saint-Étienne University Hospital (IRBN1212025/CHUSTE), issued following its meeting on 4 June 2025. Data collection for the educational day and institutional component followed the university's procedures for participant information, consent and confidentiality, as described below. Student and faculty questionnaires were distributed institutionally through LimeSurvey® (LimeSurvey GmbH, Hamburg, Germany), following written information on the research objectives, confidentiality and voluntary participation. Student questionnaires were

anonymous from the point of collection, and voluntary submission after receiving this information was taken as consent. Identifying information from faculty respondents was separated from their responses before analysis. Consent was obtained from theatre company members before the group discussion. The use of the institutional corpus was authorised by the relevant institutional representatives. Research participation had no consequences for students' academic assessment or for the roles of other participants.

The lead researcher also organised both educational activities and was involved in the institutional process under study. Several co-authors held responsibilities within these activities and processes. This involvement facilitated access to the research setting but may have influenced data selection and interpretation. To address this risk, the analysis distinguished observations, participants' accounts and the researcher's inferences. Critical responses and divergent configurations were retained in the analysis. Institutional documents produced or co-produced by the lead researcher were treated as records of the process under study, rather than as independent evidence of its success. Comparison across sources and collective discussion of interpretations helped examine alternative explanations and mitigate the influence of researcher involvement.

RESULTS

The abductive analysis of the three embedded case components identified four empirical configurations, each highlighting a distinct dissociation between recontextualisation operations. These configurations illustrate how analytical functions, temporal dimensions and recontextualisation settings were articulated. A subsequent cross-case synthesis enabled the reconstruction of a distributed space of recontextualisation.

Strong mediatisation without explicit pedagogical recontextualisation

"A Storm of Life" transformed the patient's experience before it entered the university setting. The illness narrative had been selected and staged by a patient partner and her theatre company. The performance constituted a form of artistic mediatisation, making the experience accessible to a large audience without determining how it would subsequently be used in education.

Field notes described increasing student attention during the performance, marked by declining mobile phone use, bodily responses synchronised with the performers, a silence before the applause and a prolonged standing ovation. Immediate comments described the performance as "moving" or "emotionally powerful". Some students already made connections with professional practice: one referred to the opportunity to "see things from the other side of the desk", while another described it as "a real lesson in empathy". However, this collective response was not accompanied by explicit pedagogical recontextualisation. No structured discussion with the theatre company or collective pedagogical debriefing was planned. Students were therefore left to make their own connections between the experiences presented, medical knowledge and clinical reasoning.

Seven months after the performance, student responses indicated lasting memories and different forms of appropriation relevant to the patient–clinician relationship. One student noted that the performance made it possible to "convey the real meaning of patients' testimonies beyond words". Another wrote that "this story allows us to see the patient as more than someone who is ill and to understand all the consequences of cancer in a person's life", adding that "it's incredibly valuable and really teaches us to be human beings who know how to talk to other human beings". These responses suggested that some students engaged with the experience beyond its emotional dimension. However, they documented self-reported individual appropriation rather than observed changes in clinical practice or collective pedagogical elaboration.

The account of the patient partner, who drew on her experience of breast cancer in developing the performance, highlighted another dimension of this configuration. She described her position between healthcare and educational settings: "today I speak to healthcare professionals (…) tomorrow I return to my place as a patient". She also presented experience as a source of embodied knowledge: "things you can only know when you've felt them in your own body". These statements indicated that the experience had already undergone a process of qualification before entering the educational setting. However, the epistemic status of these contributions and their relationships with other forms of knowledge were not explicitly addressed during the educational activity.

Discussions prompted by the activity contributed to its continuation and its gradual inclusion in the work of the steering committee. Following the initial performance in Saint-Etienne, the activity was taken up at the Faculty of

Medicine in Lyon, where it was staged on 26 March 2026 with a collective debriefing. This experience subsequently informed the introduction of a debriefing session in Saint-Etienne. These developments documented a gradual transformation of pedagogical framing, without providing evidence of curricular stabilisation.

This configuration shows that artistic mediatisation can make an experience collectively accessible and generate lasting forms of individual appropriation. Its subsequent adaptation across educational and institutional settings also opens up further opportunities for recontextualisation, without guaranteeing curricular stabilisation.

Curricular framing without sustained engagement

In contrast, the thematic educational day, organised in collaboration with the French Cancer League, had an explicit curricular framework, with compulsory attendance and stated learning objectives. It combined a morning plenary session, afternoon small-group discussions with patient partners, forum theatre and a collective debriefing. However, this framework did not ensure sustained student engagement during the morning plenary session. Field notes described a progressive decline in attention, conversations among students and an intervention by a teacher to refocus the group towards the end of the morning. They also recorded informal exchanges in which several association members and patient partners reported difficulties finding their place within this lecture-based format. Students' open-ended responses were consistent with these observations, describing the session as “too long”, “too theoretical” or noting that it was “difficult to stay focused”. One student explained that “the theoretical part of the morning is […] a bit long and does not offer as much as the forum theatre or the patient testimonies”.

The presence of patients did not, in itself, lead to explicit pedagogical engagement with their knowledge. The lecture format largely determined who could speak and ask questions, leaving students with few opportunities to relate experiential contributions to other forms of knowledge. The teacher's final intervention, inviting students to reflect on their attitudes towards patient partners, represented an initial attempt at pedagogical reflection. However, the data did not establish whether this intervention led to the appropriation of experiential knowledge.

This configuration highlights a dissociation between curricular framing and pedagogical engagement. Patient involvement and formally stated learning objectives do not, in themselves, ensure that experiential knowledge is actively engaged with during educational interactions.

Documented pedagogical recontextualisation without observed use in clinical practice

The afternoon activities of the thematic educational day produced a different configuration. In small groups, students' questions prompted patient partners to clarify and formulate their accounts. One patient partner described the students as “fully engaged and active participants, rather than mere bystanders”. Others noted that “the questions helped us provide more detail” and described “rich and constructive exchanges”. One student explained that “the patients' testimonies helped me understand their perspectives”. The accounts thus evolved through these interactions. One patient partner explained: “I systematically adapt my testimony according to the group's reactions and questions (...). I have a clear structure to guide me, but I make sure not to reveal everything at once, so that students have the opportunity to come back to me with questions.”

Forum theatre extended this work by transforming patients' accounts into situations that students could replay and modify. One student commented that this format allowed them to “think about what we would do in that situation”. The performers described a space for practice that offered “the right to make mistakes”. The subsequent debriefing brought together patient partners, performers, teachers and students to reflect on the enacted situations. The proposed responses were examined in relation to lived experience, medical reasoning and the challenges of the patient–clinician relationship. These recontextualisation processes were undertaken by several actors within the same educational activity. One patient partner noted that “forum theatre (...) prompted some initial questioning (...) which I was then able to draw on in my testimony”. Experience was therefore no longer simply presented to students; it was revisited and transformed through educational interactions.

Students' comments also highlighted the importance of these pedagogical mediations. One respondent called for “a debriefing session on the experiences students had heard about”, noting that some might have been “deeply affected by the patient partners' experiences” and then felt “somewhat left to deal with it on their own afterwards”. This comment expressed a need for pedagogical support to help students reflect on the experiences presented.

Among the 24 students who completed the follow-up questionnaire two months after the educational day (10.0% of attendees), responses described self-reported changes in clinical perspectives, particularly regarding patients' personal histories, the communication of diagnoses and the patient–clinician relationship. One student wrote that “in medicine, we tend to forget that patients are human beings, not objects we are trying to repair”. Another noted that “taking into account the patient's history and life outside healthcare has become more important”. A third observed that, for physicians, communicating a diagnosis may become routine, whereas for patients it is the moment “when their life changes forever”. These responses drew on patients' contributions to reflect on clinical practice beyond their emotional impact. They provided evidence of self-reported cognitive appropriation of experiential contributions. However, one student stated: “I haven't had the opportunity to undertake any hospital placements since the intervention (…) But I know that the care I provide to my future patients will be different and improved.”

This configuration highlights collective pedagogical recontextualisation associated with self-reported cognitive appropriation of experiential knowledge, without evidence of its actual use in clinical practice.

Institutional formalisation without established stabilisation

Institutional documents described operations to move from individual educational initiatives towards a coordinated patient partnership programme within the faculty. The transition from a Faculty of Medicine to a Faculty of Health provided a favourable context for this development. A faculty leader responsible for education expressed the ambition that patients could become a cornerstone of the new Faculty of Health. This ambition was accompanied by the development of an educational and scientific structure. One institutional presentation identified a “misalignment” between evolving practices, societal expectations and university frameworks. It proposed examining the conditions under which experiential knowledge could be recognised as “a form of knowledge in its own right”. These discussions concerned not only the organisation of patient involvement, but also the legitimacy of experiential knowledge, its place in the curriculum and its governance.

Faculty members' responses showed that this recognition remained contested. One respondent stated: “For a long time, we have relied on the knowledge we teach, but today we need to open our doors to patients' experiential knowledge.” In contrast, another described experiential contributions as “decorative” within a curriculum in which students were primarily expected to “absorb knowledge in order to become competent”. These contrasting positions reflected different understandings of the epistemic status of experiential knowledge within the institution.

This development was accompanied by concrete steps towards formalisation: establishing a steering committee, coordinating educational activities across several years of study, adopting a cross-curricular programme through a faculty governing body, appointing a programme lead, appointing a patient partner to the faculty governing committee, establishing an academic department with a dedicated financial cost centre, and developing a proposal for an academic chair. Institutional documents explicitly described the intended transition “from local initiatives to a coordinated programme”. These developments indicated progressive institutional integration beyond symbolic recognition alone. The approval of a pedagogical project grant for the sixth-year Health, Society and Humanities programme enabled the integration of “A Storm of Life” into a broader, structured curriculum combining different educational approaches and incorporating patient partnership across several activities. Research funding was also secured through the Regional Health Agency to support participatory research within the emerging patient partnership structure. These two funding sources provided dedicated resources for educational and research activities. However, their time-limited nature did not establish long-term institutional sustainability.

Formalisation did not establish a lasting redistribution of responsibilities and academic authority. Meetings continued to address patient partners' status, remuneration, contractual arrangements, the allocation of responsibilities, student representation, resources and funding. Agreements with patient associations were also being considered as a means of formalising and financing their contributions to educational activities. Several decisions remained at the planning stage. Faculty questionnaire responses also highlighted the relationship between academic and material recognition.

A reflective note written by a patient partner outlined initial proposals for formalising this role within the future structure, including its responsibilities, status and forms of recognition. It emphasised that these arrangements would need to be adjusted as the programme developed. The note also highlighted a tension inherent in this process: for knowledge to circulate within the institution, it was “shaped, selected and adapted”. The patient partner therefore called for “working through tensions rather than reducing them”. This contribution showed that formalisation concerned not only the organisation of educational activities, but also the conditions under which experiential knowledge was recognised and transformed.

This configuration shows that institutional formalisation contributes to the recontextualisation of experiential knowledge without guaranteeing curricular stabilisation. The data documented an ongoing process of institutional development, in which statutory, organisational and material conditions remained only partially established.

Cross-case synthesis: reconstructing a distributed space of recontextualisation

The cross-case analysis did not support a cumulative trajectory. The four empirical configurations revealed dissociations between the mediatisation of experience, pedagogical engagement with experiential knowledge, knowledge legitimation and institutional consolidation. However, these configurations were not independent: some operations were taken up and transformed in other educational or institutional settings. Comparing these configurations led to the reconstruction of a distributed space of recontextualisation comprising four operations:

- Mediatising experience: selecting and shaping lived experience to make it shareable.
- Engaging with experience pedagogically: organising interactions that enable questioning and formulation.
- Qualifying and legitimising: recognising experiential contributions as knowledge relevant to education and establishing their relationships with other forms of knowledge.
- Consolidating institutionally: formalising objectives, responsibilities, resources and conditions for continuity.

These operations were distributed across three interconnected settings: pedagogical interactions (micro), educational activities and organisational structures (meso), and curricular and institutional governance (macro). They involved patient partners, students, performers, teachers and institutional leaders, whose positions shaped their capacity to transform, qualify and legitimise experiential knowledge. Authority was unevenly distributed, particularly regarding decisions about what could be recognised as legitimate knowledge and incorporated into the curriculum. Operations could be taken up, transformed or left without further development across settings, without following a predetermined sequence.

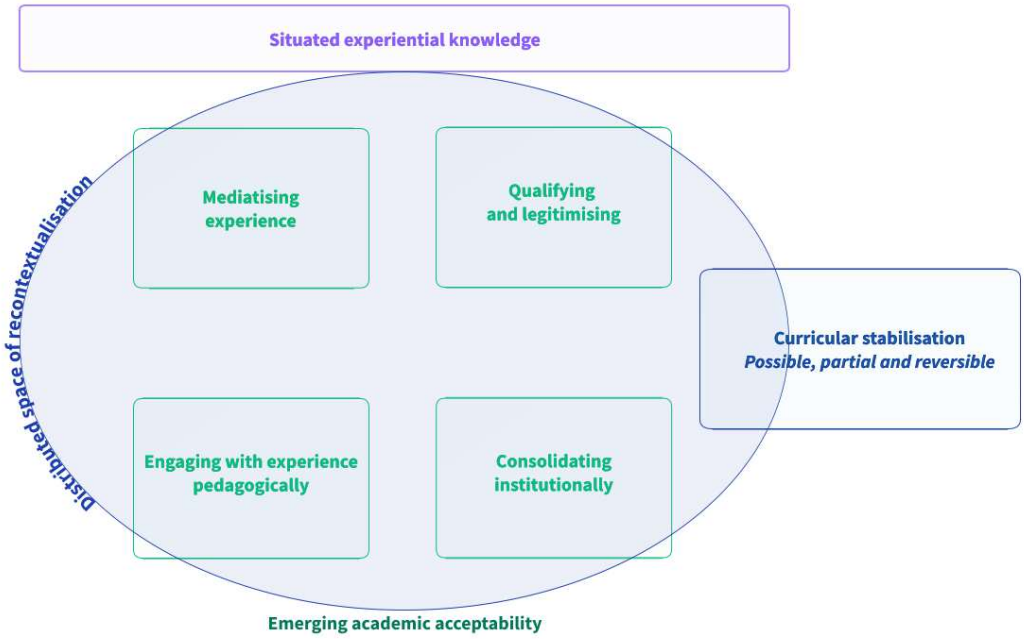
The configurations showed that experience could be made shareable without explicit pedagogical engagement, or be addressed through educational interactions without evidence of its subsequent use in clinical practice. Similarly, the inclusion of an activity in the curriculum did not guarantee student engagement, while institutional formalisation did not establish long-term stabilisation.

Table 2 summarises the four empirical configurations, distinguishing the phenomena documented in each from the limits of inference. Figure 1 illustrates the four operations within the distributed space of recontextualisation and their relationship to academic acceptability and curricular stabilisation. In this model, academic acceptability depends on the situated configuration of these operations, while curricular stabilisation represents a distinct, possible and reversible outcome.

Table 2 Empirical configurations, documented phenomena and limits of inference

Empirical configuration	What the data support	Limits of inference
Strong mediatisation without explicit pedagogical recontextualisation	Intense collective response; heterogeneous self-reported appropriation	No evidence of uniform changes among students or demonstrated causal effects
Curricular framing without sustained engagement	Explicit learning objectives; limited engagement during the lecture-based session	No conclusion regarding the ineffectiveness of lecture-based teaching
Documented pedagogical recontextualisation without observed use in clinical practice	Questioning, formulation and qualification of knowledge through educational interactions	No observed use in clinical practice or demonstrated causal superiority of any educational format
Institutional formalisation without established stabilisation	Institutional coordination, legitimation and formalisation	No evidence of long-term stabilisation or sustained redistribution of epistemic authority

Fig 1 Reconstruction of a distributed space of recontextualisation



Note. The four operations are analytically distinct but may interact across educational and institutional settings. They are neither sequential nor cumulative. Academic acceptability may emerge from their articulation, whereas curricular stabilisation remains a distinct, contingent and reversible outcome.

DISCUSSION

This study shows that knowledge derived from patients' experiences changes in form and status within a distributed space of recontextualisation. The operations of mediatisation, pedagogical engagement with experiential knowledge, knowledge qualification and legitimation, and institutional consolidation follow no predetermined sequence or cumulative progression. They may be articulated or remain without further development. Academic acceptability can therefore be understood as a situated property of recontextualisation configurations, distinct from curricular stabilisation.

This interpretation extends research on patient involvement in education, which has documented its perceived benefits and the challenges of institutional integration (Barradell et al., 2025; Gross & Ruelle, 2025). While patient partnership models primarily describe patients' roles and levels of engagement (Towle et al., 2010; Pomey et al., 2015; Bennett-Weston et al., 2025b), this study examines what happens to the knowledge they contribute to education. The four configurations suggest that the transformations of experiential contributions cannot be reduced to changes in the roles or positions of the actors involved, although these processes remain closely connected.

Making experience shareable does not guarantee its recognition as knowledge for education

The mediatisation of experience and pedagogical engagement with it are two distinct operations of recontextualisation. A narrative, testimony or artistic work selects and shapes aspects of lived experience to make them shareable (Castro et al., 2018; Pols, 2013). This transformation may elicit a strong emotional response without determining how the knowledge conveyed will be used in education. Verbatim theatre illustrates this distinction: in the absence of a structured collective debriefing, the pedagogical interpretation of the experience remained largely individual. This situation revealed heterogeneous forms of individual appropriation, but did not establish that experiential contributions had been collectively qualified as knowledge for education.

In contrast, the thematic educational day documented explicit operations of pedagogical recontextualisation. Exchanges with patient partners, forum theatre scenarios and debriefing sessions enabled experiential contributions to be questioned and reformulated in relation to clinical practice. However, these operations did not demonstrate the actual use of this knowledge in clinical practice. Mediatisation, pedagogical engagement with experiential knowledge and its use in clinical practice are therefore distinct phenomena requiring different forms of evidence. These findings suggest that pedagogical dialogue may create conditions for the recognition of experiential knowledge when participants can question, compare and reformulate contributions rather than merely receive them. From a critical pedagogical perspective, dialogue is not simply an exchange of experiences but a process through which participants can critically examine knowledge and the relations of authority that shape its legitimacy (Freire, 1970). Such dialogue requires attention to who can speak, whose interpretations are taken seriously and who can influence what counts as legitimate knowledge. However, dialogue alone does not guarantee recognition; its possibilities depend on pedagogical framing and the distribution of authority among participants.

This distinction also calls for a more nuanced understanding of the role of emotion in learning. A memorable experience may encourage subsequent reflection without, in itself, providing evidence of learning. In the corpus

studied, follow-up responses primarily documented self-reported cognitive and professional appropriation rather than the persistence of the initial emotional response.

Recontextualisation is a distributed accomplishment

In Bernstein's (1996) theory, recontextualisation involves the selection and transformation of knowledge as it moves into the pedagogic field. Hordern (2014) extends this perspective by describing a socio-epistemic process distributed across educational and professional settings. Building on these approaches, our study reconstructs four operations whose articulation varies across configurations: mediatisation of experience, pedagogical engagement with experiential knowledge, knowledge qualification and legitimation, and institutional consolidation. Their articulation shapes the academic acceptability of experiential knowledge.

These operations unfold across interconnected pedagogical, organisational and institutional settings. Patient partners, students, performers, teachers and institutional leaders may contribute to several operations, but their positions shape their capacity to influence them. Teachers exercise authority over pedagogical framing, while university governing bodies have greater control over curricular formalisation and institutional decisions. The distribution of recontextualisation operations therefore does not imply an equal distribution of authority.

This interpretation also resonates with Elias's (1970) configurational approach, which emphasises interdependencies between individuals. The configurations examined suggest that opportunities for recontextualisation depend on how interactions between actors are organised, rather than on pedagogical formats considered in isolation. Artistic mediations, educational exchanges and collective reflection may thus contribute to the pedagogical engagement with experiential knowledge.

This perspective complements existing patient partnership models. The Montreal Model describes a continuum of patient engagement (Pomey et al., 2015), while Towle et al. (2010) distinguish patients' roles in educational activities. Gross and Ruelle (2025) highlight patients' liminal position between social and educational settings. These approaches help explain how patients participate in education. Our study shifts attention towards the trajectories of the knowledge they contribute, while recognising that these trajectories remain linked to actors' positions. The liminality described by Gross and Ruelle (2025) can thus be considered alongside a distributed space in which experiential knowledge circulates between different regimes of legitimacy.

This distribution highlights tensions between the recognition of experiential knowledge and the recognition of its contributors. An experiential contribution may be considered relevant to education without its contributor receiving corresponding statutory or material recognition. Recognition may therefore remain partial or unevenly distributed across configurations. This perspective calls for connecting the recognition of experiential knowledge, the recognition of its contributors and their participation in decisions determining its place in education (Fraser & Honneth, 2004).

Academic acceptability is situated and non-cumulative

Academic acceptability does not correspond to a single threshold of recognition. The configurations examined show that the reception of experiential contributions, their appropriation by students, their qualification as knowledge and their curricular integration may develop independently. An educational activity may be positively received without

the knowledge it conveys gaining academic legitimacy. Conversely, an activity may be formalised while the legitimacy of the knowledge involved remains contested.

Academic acceptability depends on how experiential contributions are qualified and related to other forms of knowledge. It is therefore situated and relational. Fricker (2007) shows that credibility judgements are shaped by social experiences and may be revised through critical reflection. Patients' accounts may thus be positively received without being recognised as legitimate knowledge, particularly where academic relations of authority influence judgements of credibility (Carel & Kidd, 2014).

This perspective invites examination of the criteria through which academic institutions recognise experiential knowledge, without assuming that these criteria are neutral or fixed. It also distinguishes the transformation of knowledge through its incorporation into education from its potential reduction to an illustrative role.

Curricular stabilisation requires specific institutional work

Curricular stabilisation does not automatically follow from the academic acceptability of experiential knowledge. It depends on institutional arrangements concerning responsibilities, remuneration, training, learning objectives, resources and governance (Bland et al., 2000; Barradell et al., 2025; Paxino et al., 2025). These arrangements support the long-term continuation of educational activities but are rarely documented through immediate educational evaluations. Institutional consolidation thus constitutes a further operation of recontextualisation. Incorporating experiential knowledge into curricula and institutional structures involves negotiating its place within existing university rules and practices. This process may support its recognition and transmission, but may also favour forms of participation most compatible with academic norms. The corpus highlighted this tension without establishing its long-term consequences.

Curricular stabilisation is therefore not necessarily a measure of greater educational value. Some contributions may remain relevant without becoming permanently embedded in the curriculum. The challenge may be less to stabilise experiential knowledge as fixed curricular content than to establish durable conditions for its recognition, critical discussion and pedagogical use. However, the absence of permanent curricular integration should not be confused with institutional precarity, characterised by a lack of remuneration, formal status or participation in decision-making. Symbolic recognition of patients and their knowledge may thus coexist with inadequate material conditions.

An integrative theoretical framework

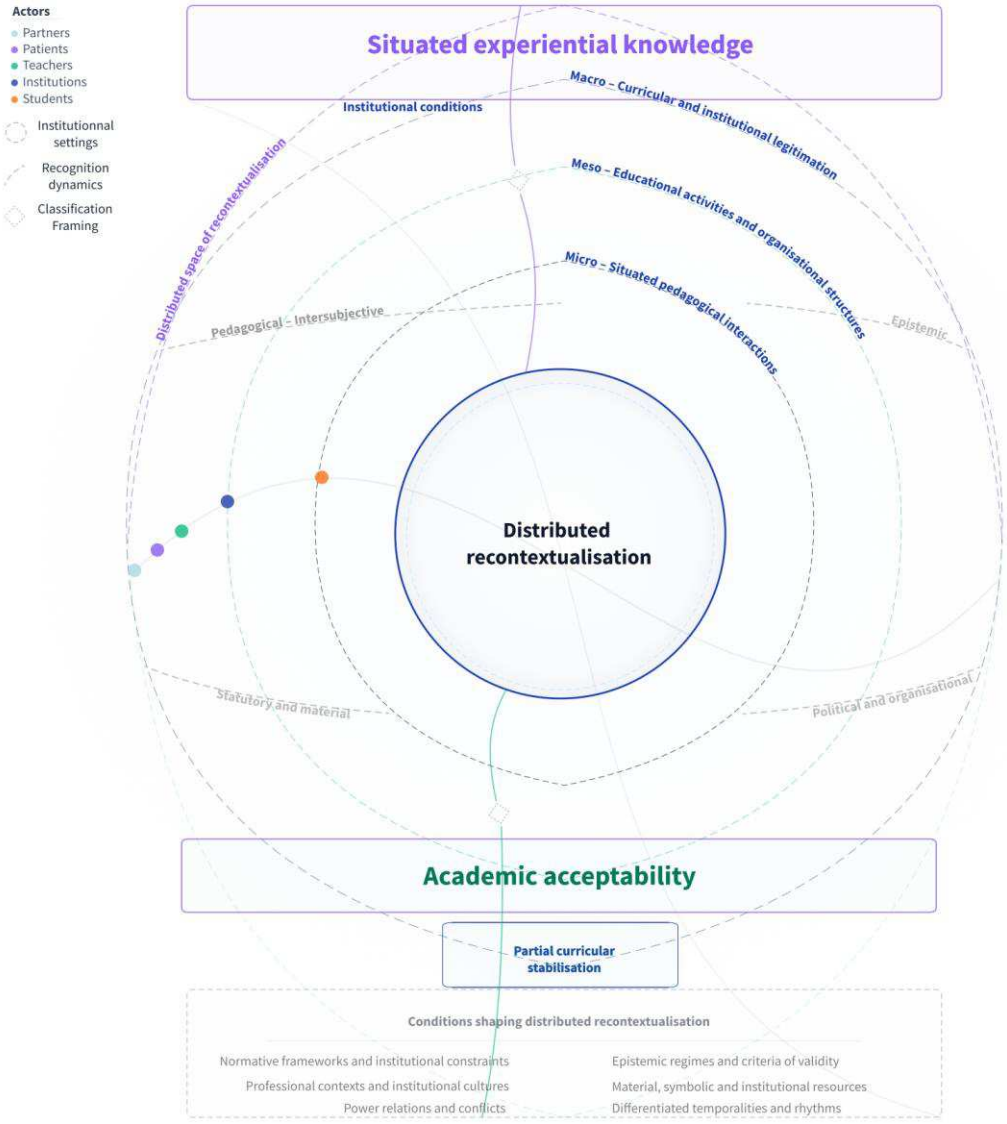
While Figure 1 summarises the four operations reconstructed from the empirical configurations, Figure 2 situates them within a broader theoretical architecture incorporating social, epistemic and institutional conditions. Although developed from an empirical study of patients' contributions to medical education, the framework examines how experiential knowledge is recontextualised, rather than proposing a fixed classification of patients' knowledge. Its relevance to other forms of experiential knowledge remains to be examined in further research.

This framework brings together three interconnected settings: pedagogical interactions (micro), educational activities and organisational structures (meso), and curricular and institutional legitimation (macro). It distinguishes four interrelated dimensions of recognition: pedagogical and intersubjective, epistemic, statutory and material, and political and organisational. These dimensions constitute an analytical synthesis informed by theories of recognition (Fraser & Honneth, 2004), epistemic injustice (Fricker, 2007) and critical pedagogy (Freire, 1970), rather than a pre-existing typology. Bernstein's concepts of classification and framing further illuminate how boundaries between forms of knowledge and relations of control shape their recontextualisation.

Actors occupy different positions across these settings and have unequal authority to influence the transformation and recognition of experiential knowledge. Their possibilities for action depend on the configurations of recognition, institutional conditions and power relations in which they participate. Academic acceptability can therefore be understood as a situated outcome of these configurations, while curricular stabilisation remains a possible and reversible institutional outcome.

This framework provides a basis for further research on the intermediary processes connecting actors and settings of recontextualisation. Participatory approaches could help examine how these processes shape the recognition of experiential knowledge and the distribution of authority across educational and institutional contexts.

Fig 2 Integrative theoretical architecture of distributed recontextualisation



Note. This conceptual framework integrates four analytically distinguished but interconnected dimensions of recognition, informed by recognition theory, epistemic injustice and critical pedagogy. Recontextualisation unfolds across micro, meso and macro settings through interactions among actors whose positions and authority may vary across configurations. These processes are neither sequential nor cumulative. Academic acceptability may emerge from their articulation, while curricular stabilisation remains a possible, partial and reversible outcome.

IMPLICATIONS

Implications for curriculum design

The proposed model invites us to approach patient involvement by examining what happens to patients' knowledge within education. Planning patient participation is not sufficient; it is also important to establish the conditions under which their knowledge can be transformed, recognised and potentially integrated into the curriculum. Four questions can guide this process.

- Which experiential contributions are selected for educational purposes, by whom, and in what forms? Preparing a testimony, a theatrical scene or a case involves mediatisation. The choices made during this transformation should be made explicit.
- How can experiential knowledge be engaged with pedagogically? Interactions between patients, students and teachers can enable experiential contributions to be questioned, reformulated and related to other forms of knowledge. These operations depend on pedagogical framing and opportunities for participation.
- How can experiential contributions be recognised as knowledge for education? Learning objectives can specify what experiential contributions help students understand and how they relate to professional reasoning. This clarification helps avoid restricting patients to an illustrative or relational role.
- What institutional conditions can sustain their recognition and pedagogical use over time? Remuneration, training, responsibilities, resources and participation in decision-making can support the recognition of experiential knowledge and its contributors.

These questions provide an analytical framework for examining curricular decisions rather than a sequence of steps to follow. They may also be used to study how other forms of experiential or professional knowledge are introduced into education.

Implications for evaluation

The findings lead us to propose a principle of evaluative coherence for educational programmes involving experiential knowledge. This principle requires defining the object of evaluation (*evaluand*), selecting appropriate data sources and limiting inferences to what those sources can support.

The reception of an educational activity, pedagogical recontextualisation, the use of knowledge in clinical practice and curricular stabilisation are distinct phenomena requiring different forms of evidence. Models focused on educational outcomes, such as the four-level model described by Kirkpatrick and Kirkpatrick (2006), remain relevant for evaluating learning and its application in practice. However, they do not, on their own, explain how experiential knowledge becomes academically acceptable.

The principle of evaluative coherence therefore distinguishes the evaluation of learning outcomes from the evaluation of knowledge trajectories within the curriculum. These objects can be examined together, provided that the evidence collected and the conclusions drawn remain aligned with each evaluand.

STRENGTHS AND LIMITATIONS

The main strength of this study lies in the analysis of several educational and institutional components within a single case. This approach enabled us to examine the trajectories of experiential knowledge beyond an individual educational activity. The diversity of the corpus and the abductive approach allowed us to compare different sources and reconstruct configurations of recontextualisation, while considering what each source could support.

This study has several limitations. Its single-centre design and evolving institutional context require caution when considering the transferability of the findings. The two educational activities differed in format, content, student populations and data collection procedures, and were not designed to support causal comparisons. Participation in the questionnaires was voluntary, and response rates were low, particularly at follow-up, introducing a risk of selection bias. The anonymous and unpaired questionnaires did not allow individual trajectories to be followed, and self-reported use of knowledge could not be considered evidence of changes in professional practice. The corpus did not allow us to characterise the diversity of experiences represented among patient partners, or the diversity of students and faculty members. Small-group interactions were documented mainly through participants' accounts. Although institutional formalisation was documented, the observation period did not allow us to assess its long-term sustainability or whether it would lead to a lasting redistribution of epistemic authority. The lead researcher's involvement in the educational activities and their institutional development facilitated access to the research setting but may have influenced data selection and interpretation. Reflexivity, comparison across sources and collective discussion of interpretations helped examine this risk without eliminating it.

The proposed model therefore offers analytical rather than statistical generalisability. Developed from a single case, it represents a theoretical proposition to be examined in other institutional contexts, health professions and configurations of patient participation.

CONCLUSION

Patient involvement in medical education does not necessarily imply recognition of patients' experiential knowledge. This study highlights the distinction between the place given to patients in educational activities and the place given to their knowledge within the curriculum.

By reconstructing a distributed space of recontextualisation, this study illustrates how experiential contributions may be transformed, questioned and legitimised through pedagogical and institutional processes involving different actors. Academic acceptability emerges from these configurations rather than from patient involvement alone, while curricular stabilisation remains a distinct, contingent and potentially reversible outcome.

These findings invite a shift in perspective: beyond asking how patients participate in medical education, we need to examine what happens to the knowledge they contribute, who has the authority to recognise it and under what conditions it can become part of the curriculum.

DECLARATIONS

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Competing interests

Loïc Tranchant, Xavier Gocko, Angélique Savall, Émilie Fontaine and Philippe Berthelot were involved, in different capacities, in the design, organisation, coordination or institutional development of the educational activities and patient partnership processes examined in this study. Marie-Christine Piperini supervised the master's dissertation from which this research originated. These non-financial interests and their implications for reflexivity are addressed in the Reflexivity section.

Ethics approval

The study was conducted in accordance with applicable institutional requirements. The “Storm of Life” educational activity and its associated data collection had also received a favourable opinion from the Ethics Committee of Saint-Étienne University Hospital (reference IRBN1212025/CHUSTE) before the activity took place. The use of institutional documents included in this study (meeting minutes, presentations, correspondence and planning documents) was authorised by the relevant institutional representatives.

Consent to participate

For all data collection activities, participants received written information at the beginning of the questionnaires distributed through the institutional LimeSurvey® platform (LimeSurvey GmbH, Hamburg, Germany). This information explained the research objectives, data processing procedures, confidentiality safeguards and the voluntary nature of participation. Completing and voluntarily submitting the questionnaires after reading this information was considered to constitute free and informed consent to participate in the study. Student questionnaires were anonymous from the point of collection. Identifying information collected through the faculty questionnaire was separated from responses before analysis. Free and informed consent was also obtained from theatre company members before the group discussion. Participation in all components of the study was voluntary and had no consequences for students' academic assessment or for the professional roles of other participants.

Consent for publication

All quotations included in this manuscript have been anonymised. Participants whose quotations could potentially allow indirect identification provided consent for their publication.

Data availability

The data used in this study include written responses, field notes, institutional documents and qualitative data that could potentially allow indirect identification of participants or educational activities. They are therefore not publicly available. Requests for access to anonymised data will be considered on a case-by-case basis, in accordance with applicable ethical, regulatory and institutional requirements.

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Final approval of the manuscript: All authors.

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