Patient & Community Partnership for Education
informed and shared decision making

THE UNIVERSITY OF BRITISH COLUMBIA
Office of the Vice-President, Health
UBC Health

PRACTICAL GUIDES TO THE INVOLVEMENT OF PATIENTS IN HEALTH PROFESSIONAL EDUCATION

GUIDE 3

Equity, Diversity, Inclusion and Accessibility

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Before you begin

We recommend starting with the Introduction Guide, which provides essential context for getting the most out of this series.

All five guides are available at https://meetingofexperts.org/programs-activities/practical-guides/

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Equity, Diversity, Inclusion and Accessibility

GUIDE 3

1. Definitions

We have found no universally agreed standard definitions. Preferred definitions and usage of these terms may vary from country to country and over time. The definitions below are our best effort to provide clarity and explanations in the context of this guide.

Equity:	the removal of systemic and interpersonal barriers (e.g., unconscious bias, discrimination, racism, sexism, ableism, anti-2SLGBTQIA+, etc.) enabling all individuals to have fair and just (equitable) opportunity to access and benefit. Equity is also about providing more support for those who need it more, in contrast to equality where every person receives the same level of support regardless of their diverse needs. See ywcaspokane.org/wp-content/uploads/2024/04/equity-vs-equality-1-1.jpg
Diversity:	the variety of unique dimensions, identities, qualities and characteristics individuals possess along with the intersection of these characteristics.
Inclusion:	the intention to foster a psychologically and culturally safe environment in which all individuals are welcomed, valued, respected and empowered to participate fully.
Accessibility:	features and actions that enable disabled, neurodivergent and other equity-denied people to enter and navigate through an environment, and participate with ease, autonomy and dignity.
Allyship:	an ongoing practice of listening, learning, relearning, supporting, advocating, and acting to reduce harm and redistribute power for the benefit of groups(s) of people by someone who is not a member of that group(s). Allyship is demonstrated through action, not intention.

Bias: assumptions or preferences, both overt and unconscious, that influence how we perceive, interact with, and make decisions about others. Bias is shaped by systems and culture, not just individual attitudes.

Intersectionality: a way of understanding how overlapping identities (e.g., disability, race, gender, caregiving) and structural factors (e.g., geography, norms, policies) interact to shape people's experiences. Barriers are often compounded, not singular. The term was coined by Kimberlé Crenshew, a law professor and civil rights activist, to highlight that individuals experience multiple simultaneous forms of oppression which interact to create distinct experiences of marginalization. Historically, intersectionality is about compounded disadvantages and thus tends to be framed using a deficit lens. A strengths-based approach can counter this negative framing.

2. EDIA is Evolving and Context Matters

In this guide we use the concepts of Equity, Diversity, Inclusion and Accessibility (EDIA) as a way of understanding who is present, who is missing and what conditions shape meaningful participation. EDIA and other related acronyms (see below) are simply abbreviations of different frameworks or systemic approaches to seek inclusion and participation from all people. However, we recognize that these concepts are understood and practiced differently across countries, communities, institutions and disciplines, and adapt over time. How people interpret EDIA is also shaped by their life experiences, roles, identities and exposure to different people and perspectives. There is no single, universal understanding—and that diversity of approaches matters.

EDIA language and frameworks continue to evolve. Different communities and organizations may emphasize different values or terms based on their histories, priorities and contexts. Other frameworks you may encounter include:

ACB: Accessibility, Community, Belonging

DJR: Dignity, Justice, Respect

DEIA: Diversity, Equity, Inclusion, Accessibility

JEDI: Justice, Equity, Diversity, Inclusion

DEIB: Diversity, Equity, Inclusion, Belonging

REDI: Reconciliation, Equity, Diversity, Inclusion or Respectful Environments, Equity, Diversity, Inclusion

DEIAD: Diversity, Equity, Inclusion, Accessibility, Decolonization

Rather than trying to choose the 'right' framework, this guide focuses on how the underlying ideas and values show up in practice, especially in patient and community involvement in health professions education (HPE).

3. How to Use this Guide

This guide is a companion to Guide 2: Recruitment, Preparation, Support and Building a Patient Partner Community. If we are serious about preparing health professionals to meet the needs of diverse communities, then diversity in patient involvement is essential. Every missing voice represents a missed opportunity for learning, growth and system change.

IN THIS GUIDE WE USE EDIA AS A PRACTICAL LENS TO ASK THREE CORE QUESTIONS:

1. Who isn't at the table? (Whose voices are missing?)
2. Why aren't they at the table? (What makes it hard for certain people to get there, and what systemic or social barriers contribute to this difficulty?)
3. How do we get them to the table? (What would make participation possible, safe and meaningful?)

Engagement should move beyond tokenism and toward intentional, relational, safe and transformative collaboration, where equity becomes everyday practice, not an afterthought. This work is not something that can be completed, mastered, or checked off. It is ongoing, relational, and requires continual learning, humility and adjustment (or adaptation) over time. Throughout this guide, we emphasize small, intentional actions that can improve equity and inclusion in practice, without requiring new programs or extensive resources.

We have embedded reflection throughout this guide as it is central to how we understand EDIA in practice. Each of us carries conscious and unconscious biases shaped by our life experiences, socialization and the systems we move through. These biases can influence who we invite, who feels welcome, whose knowledge is valued, and whose voices are amplified—often without our intention or awareness.

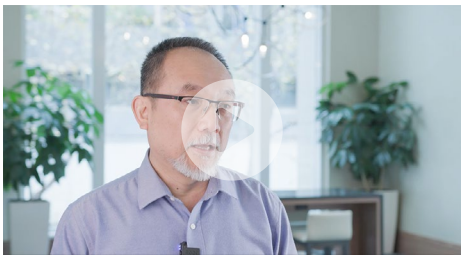
Even well-intentioned efforts can unintentionally create harm or reinforce exclusion when assumptions go unexamined or feedback is overlooked. Ongoing reflection creates space to notice knowledge gaps, uncover bias, challenge privilege, shift power where needed, and strengthen trust and relationships over time.

4. Practical Approaches to EDIA

EDIA can sometimes seem abstract, overwhelming or emotive. In these video clips, three educators share how they approach EDIA in a pragmatic, step-wise way.

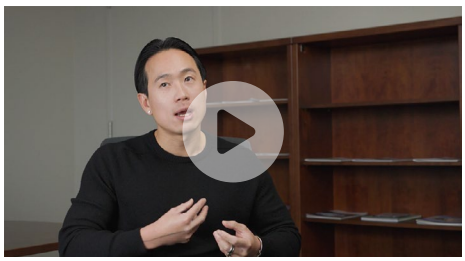
Brahmaputra Marjadi, Western Sydney University

VIDEO: learning.media.ubc.ca/media/Guide+3%2C+Clip+1+-+Brahm+Marjadi/0_74pjkl4z



Tristan Lai, University of British Columbia

VIDEO: learning.media.ubc.ca/media/Guide+3%2C+Clip+2+-+Tristan+Lai/0_rq4rni36



Laura Yvonne Bulk, University of British Columbia

VIDEO: learning.media.ubc.ca/media/Guide+3%2C+Clip+3+-+Laura+Bulk/0_b8n2mnch



5. Who Isn't at the Table?

"I think it's really important for us to be hearing from people who maybe have either chosen not to, or have not been able to access higher education, because that is a knowledge base that isn't in our classroom, just inherently. Because if we're in the classroom, we have the privilege. So, I think it's important for us to be inviting those diverse knowledge sources into our classroom." **Laura Yvonne Bulk**

When patient and community voices are absent, education risks reinforcing inequities and preparing learners for health and social care systems that do not reflect the lived realities of the communities they will serve.

In many HPE settings, patient involvement tends to draw from the same networks and voices. This can unintentionally exclude people based on:

- Culture, language, race, appearance, body size, sex or gender;
- Age or life stage (youth, older adults);
- Geography (rural or remote communities; international or immigrant voices);
- Socioeconomic status;
- Disability, neurodiversity or mental health experiences;
- Experiences of stigma, marginalization or mistrust of institutions;
- And many more.

These barriers often intersect and compound making participation especially difficult for those with multiple equity deserving (marginalized or minoritized) identities.

"The first step towards inclusion is always scan the room. Whenever you're in a meeting, you're in the process of building, co designing something, scan the room and ask yourself who's not here yet? And put it on your agenda to include more of those people next time around." **Brahmaputra Marjadi**

REFLECTIVE ACTIVITY: PERSONAL LEVEL

Take a few minutes to reflect on the assumptions or (un)conscious biases that might shape how you, your profession, or your institution, approach patient and community involvement in the context of HPE.

Ask yourself:

- How do I experience the world, and how does my background shape those experiences?
- What identities do I hold (race, gender, class, disability, education, etc.) and how do these confer privilege or marginalization?
- What assumptions do I bring to this work based on my own socialization, training or culture?

Now ask yourself:

- When I think of patients involved in HPE, who comes to mind?
- Whose voices have historically been most present in our programs? Whose voices have been missing or excluded?
- Do I (or does my institution) gravitate toward individuals or organizations that are easier to engage with, or already familiar with academic environments?
- What assumptions might I hold about:
  - Who is 'ready' or 'able' to contribute?
  - What 'professionalism' looks like?
  - How lived experience should be shared?

To support reflection on power dynamics you may find it useful to refer to the Wheel of Privilege and Power: www.canada.ca/content/dam/ircc/documents/pdf/english/corporate/anti-racism/wheel-privilege-power.pdf

- What is my positionality relative to the communities and people involved?
- What skills, knowledge and resources do I have access to?
- How will these skills, knowledge and resources benefit them?
- How might I engage my power in helpful or harmful ways?
- Am I reinforcing extractive, colonial or paternalistic relationships?

OPTIONAL NEXT STEP:
Write down 1–2 changes you could make, individually or within your team, in response to one or more of the reflection questions.

PRACTICAL ACTION

- **Map equity gaps:** Identify communities, lived experiences or perspectives currently absent from your engagement.
- **Prioritize historically excluded voices:** Focus on including people affected by systemic barriers such as racism, ableism, classicism.

6. Why Are People Missing from the Table?

Even when there is genuine interest in advancing equity and inclusion in patient and community engagement, underrepresented voices are often left out, not because of the lack of willingness, but because systems and processes unintentionally create barriers to participation. Although some of these barriers are non-structural, for example environments which do not feel culturally or psychologically safe, many are structural, embedded in how recruitment, communication, compensation and decision-making typically operate.

PRACTICE-LEVEL BARRIERS (WHAT WE CONTROL DAY-TO-DAY)

- Limited personal networks or informal networks.
- Application and interview processes that assume comfort with academic processes or environment.
- Limited flexibility, accessibility or compensation.
- Power dynamics that make participation feel unsafe.
- One-off engagement with no follow-up.

SYSTEM-LEVEL BARRIERS (WHAT WE OFTEN INHERIT)

- No designated role or designated time for relationship-building.
- Unclear guidance for inclusive engagement.
- Competing institutional priorities; limited or inconsistent funding.
- Historical harm and trauma.
- Administrative systems not designed for community participation.
- Lack of commitment to institutional EDIA policies.

Addressing these institutional-level barriers is important (see Section 8), but systemic change requires intentionality, time, persistence and leadership. Meanwhile many meaningful actions can begin at the individual, course or small-team level. See Section 7 for ideas about small actions you can take right now that would make patient and community participation safer, easier and more welcoming.

TIP:

You don't have to fix the system to make a start. Small actions, taken with care and consistency, can create meaningful shifts in making others feel welcome, safe and valued.

Questions to ask yourself:

Are underrepresented voices missing because they are hard to reach (assuming that we have thought of and tried reaching them), or because we are relying on goodwill, workarounds and personal resilience rather than making inclusion possible by design?

Start by asking:

- Who has been invited and through which avenues?
- Who is currently involved—and whose voices are missing? What are the histories of these communities in relation to health and social care?
- Why are people dropping off or declining to participate?
- What small changes could make participation easier, safer or more welcoming?
- How prepared are faculty, staff and students to engage with diverse lived experiences?
- How will we know if our engagement is equitable, meaningful and improving over time?

REFLECTIVE ACTIVITY: INSTITUTIONAL LEVEL

Take a few minutes to reflect on how your institution approaches patient involvement in HPE.

Consider:

- Are recruitment practices unintentionally favouring certain individuals (e.g., those with higher health and language literacy, confidence, time availability or cultural familiarity)?
- How accessible and inclusive are orientation and onboarding processes?
- What kind of supports are (or aren't) in place to initiate and sustain long-term engagement with underrepresented groups?

When considering who should be included, we need first to examine how knowledge is produced and what paradigms are upheld:

- Whose knowledges, experiences and powers have shaped existing understandings of this topic?
- Whose perspectives are absent, erased or devalued?
- Who might recruitment or engagement strategies exclude?
- What new questions might emerge if I centre those typically unheard from?

PRACTICAL ACTION

Find out if there are specific EDIA courses offered by your institution for students that can be referenced when they prepare to engage with patients.

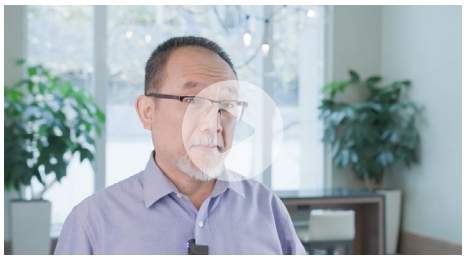
OPTIONAL NEXT STEP:
Write down 1–2 changes you could make, individually or within your team, in response to one or more of the reflection questions.

7. How Do We Get Everyone to the Table?

By 'Get Everyone to the Table' we do not mean that the aim is to physically seat everyone at tables within our academic institutions. Rather than expecting people to come into academic systems, we need to shift toward meeting people in their own environments, networks and rhythms. Going to where people are in their communities is especially important in the beginning when efforts should focus on relationship building, by listening and showing up in community spaces. Relationship building takes time. Additionally, it is important not only to have diversity of voices around the table, but authentic belonging means those voices are heard and valued.

In this video clip Brahmaputra Marjadi from Western Sydney University suggests practical ways to engage with diverse communities.

VIDEO: learning.media.ubc.ca/media/Guide+3%2C+Clip+4+-+Brahm+Marjadi/0_w9426o0o



Here is another example from Milena Lisboa

> *"For me, the most thoughtful and ethical way to build a genuine partnership is by going into their communities and getting close to them. They tend to be very distrustful and have suffered a lot. Often, the university or public policies come in a way that feels violent or intrusive. We need to approach their communities with great care, so we can understand the complexities of living under those conditions. By being close and really on the inside, by trying to understand from within what it's like to live in that situation, we can begin to build a relationship of trust. For me, trust is a key word when we talk about inclusion, because we can only include people once they place their trust in us. Inclusion needs to go both ways, because we also need to be included in their community. And we need to do this with great care. It calls for openness, respect and ethical behaviour."*

What can you do to bring unheard voices into HPE?

GET RESOURCES IN PLACE:

There are time, cost and capacity implications for increasing diversity, even on a small scale. Plan for these early to avoid overburdening patients or relying on short-term fixes. Having a plan helps sustain long-term relationships.

GET HELP FROM EDIA EXPERTS:

Most institutions have equity, diversity, inclusion or accessibility offices. Although their primary focus may be students or employees, they often have valuable expertise, resources, and sometimes funding, that can support patient engagement.

> **EXAMPLE:** *At the University of British Columbia the Centre for Workplace Accessibility covers the costs of Communication Access Real-time Translation (CART) services for a patient partner who is Deaf.*

DO YOUR HOMEWORK:

Before reaching out, take time to learn about the communities you hope to engage. This shows respect, builds trust and mitigates harm. Seek guidance from colleagues or community members with lived or professional experience. Explore community organization websites, reports and public resources. Identify the appropriate community representative to invite you into their spaces, especially when you seek to engage with Indigenous or harder to reach groups.

BUILD RELATIONSHIPS:

Show up and show you care. Attend community events. Find out about local organizations and leaders, which ones have most credibility and are most effective in the community. Join conversations and listen before making requests. Trust grows through presence and time, not proposals.

PARTNER WITH COMMUNITY ORGANIZATIONS:

Community groups already hold trusted relationships. Ask how involvement in HPE could benefit their community so that you develop relationships that are mutually beneficial. Co-create opportunities rather than offering pre-designed roles. Respect organizational timelines, priorities and capacities.

USE PLAIN LANGUAGE AND RELATIONAL INVITATIONS:

Replace formal recruitment language with relational invitations. For example: “We’re learning and would really value your opinions” not “We are seeking participants to fulfill educational objectives”.

What can you do to bring unheard voices into HPE? *(cont'd)*

DEVELOP AND CONSISTENTLY USE ACCESSIBILITY PROTOCOLS:

These might include:

- Awareness of cultural events and practices, dietary and other restrictions;
- Participants bringing a support person;
- Childcare arrangements;
- Accessible spaces (e.g., close to parking, washrooms, pee patches for service dogs);
- Interpreters for spoken or signed language;
- Special dietary needs;
- Small group settings;
- Use of microphones;
- Sensory considerations (lighting, distracting or noisy backgrounds, smells, etc.);
- Low barrier transportation;
- Use of technology.

> **EXAMPLE:** Here is a checklist for making your event accessible that may have some useful ideas. UBC Equity & Inclusion Office Checklist for Accessible Events: equity.ubc.ca/resources/accessible-events/

MAKE SUPPORT VISIBLE, NOT EXCEPTIONAL:

Instead of waiting for people to ask for accommodations, say: "We're happy to adapt timing, format or supports—just let us know what would help."

START SMALL AND LEARN OUT LOUD:

Take one step at a time. Begin with a small engagement activity. Reflect on what worked, what didn't and adapt. Share learning openly, both the process and the outcomes, not just successes. Document, share and act upon the feedback. Be mindful that there is no one-size-fits-all approach. What supports one group may need to be modified for another.

BE FLEXIBLE:

Offer options instead of prescribed structures, for example:

- Identify more informal spaces for learning (classrooms can be intimidating);
- Offer shorter educational sessions;
- Offer participation virtually rather than in-person;
- Consider asynchronous engagement;
- Provide flexible scheduling: can some sessions occur in the evenings or weekends?

What can you do to bring unheard voices into HPE? *(cont'd)*

BE CREATIVE:

Recognize that some people will never want to come into the academic institution. What are other ways that their voices could be heard by students? For example:

- Written or audio recorded contributions;
- Digital storytelling (video);
- Co-creation of cases or scenarios;
- Arts-based methods: theatre, poetry, photovoice;
- Take students out into the community.

USE TRAUMA-INFORMED APPROACHES:

Many people have experienced some forms of trauma, including medical trauma, systemic harm, discrimination, colonization, disability-related trauma and personal loss. Trauma-informed approaches create conditions where people feel safer, respected and in control of their participation.

- Assume trauma may be present, even if it is not visible or disclosed.
- Prioritize emotional safety alongside physical, psychological and logistical safety for both patients and students.
- Offer choice and control: allow people to decide how, when and how much they participate. Consent should be explicitly explained as well as the ability to withdraw without jeopardy.
- Normalize opting out, taking breaks or changing levels of involvement.
- Provide clear information about what participation will involve so there are no surprises.
- Avoid pressure to disclose personal stories, especially those involving distress.
- Offer multiple ways to contribute (discussion, written input, reflection, co-facilitation).
- Be attentive to signs of distress and check in gently when needed.
- Follow up after emotionally heavy sessions.

RECOGNIZE AND COMPENSATE TIME, LABOUR AND EMOTIONAL CONTRIBUTIONS:

Equitable engagement means valuing people's time, expertise and emotional labour in meaningful and respectful ways. Recognition and compensation should reduce financial burden, not barriers to participation.

- Offer fair, transparent compensation aligned with local benchmarks and community norms (e.g., living wage hourly rates; policies regarding peer payment standards).
- Provide flexible options (honoraria, gift cards, professional development, transportation, childcare or charitable donation).
- Be attentive to how payments may affect benefits, tax status or financial stability, and offer alternatives when needed.

Note: Plan for sustainability by embedding compensation into budgets and funding proposals, rather than relying on short-term or ad hoc funding.

8. Addressing Institutional Barriers (When You're Ready)

Meaningful EDIA cannot rest on individual effort alone. Long-term sustainability requires system-level support, including:

- Designated roles or teams responsible for patient and community engagement, with training in EDIA.
- Appropriate workload allocation and professional recognitions, such as tenure, academic promotion and excellence awards.
- Leadership buy-in and allocation of resources.
- Clear and simple processes for recruitment, orientation, support and compensation.
- Alignment with institutional goals and values, including any related to EDIA.
- Advocacy and/or reporting channels if anything goes awry that are confidential.

These shifts are often built gradually through relationships, evidence and small successes. To get you started, here are a few ideas that are most relevant to reducing barriers to participation. For more general approaches to institutional buy-in, refer to Guide 1.

DEDICATED ROLES AND SUPPORT

- Advocate for a designated person who is responsible for recruitment, orientation and ongoing relationship-building, and who has EDIA training.
- Create clear accountability for supporting patients throughout their involvement.

FAIR COMPENSATION AND RESOURCES

- Minimize rigid institutional barriers regarding honoraria payments (e.g., people having to provide personal information to get paid, long wait times for compensation and onerous paperwork).
- If possible, have ways to compensate participants that maintain their anonymity.
- Provide options for upfront payments to cover unexpected expenses that may prevent participation.
- Offer practical supports such as transportation, parking, childcare or technology access.

ACCESSIBILITY AND FLEXIBILITY

- Provide multiple participation options (virtual, in-person, hybrid).
- Develop schedules that respect and acknowledge health, caregiving and life circumstances.

REDUCE ADMINISTRATIVE BARRIERS

- Use simple application processes.
- Offer support for completing forms.
- Provide clear timelines and consistent points of contact.

REFLECTIVE ACTIVITY: ACCOUNTABILITY AND ACTION

Take a few minutes to reflect on how your institution can move into accountability and action to support patient and community involvement in HPE through an EDIA lens. Critically reflect on the following questions:

- What have I learned from this process?
- How might I shift how I act in the world based on what I've learned?
- What systems, structures or assumptions need to change?
- How do I critically engage in this work without burdening people from equity-deserving groups?
- Who am I accountable to, and how will I show that accountability?

OPTIONAL NEXT STEP: *Write down 1–2 changes you could make, individually or within your team, in response to one or more of the reflection questions.*

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9. Recommended Resources

Association of American Medical Colleges Center for Health Justice. The Principles of Trustworthiness Toolkit. https://www.aamchealthjustice.org/key-topics/trustworthiness/trustworthiness-toolkit

Healthcare Excellence Canada. Health Equity Framework. https://www.healthcareexcellence.ca/resources/health-equity-framework/

Khan S, Moore JE. Embedding equity into implementation: the equity iceberg. The Center for Implementation; 2023. https://thecenterforimplementation.com/toolbox/embedding-equity

Nixon SA. The coin model of privilege and critical allyship: implications for health. BMC Public Health 2019; 19(1):1637. https://pubmed.ncbi.nlm.nih.gov/31805907/

Peltier C. An application of Two-Eyed Seeing: Indigenous research methods with participatory action research. International Journal of Qualitative Methods 2018; 17(1). https://journals.sagepub.com/doi/full/10.1177/1609406918812346

Sayani A, Maybee A, Manthorne J, Nicholson E, Bloch G, Parsons JA et al. Building equitable patient partnerships during the COVID-19 pandemic: challenges and key considerations for research and policy. Healthcare Policy 2021; 17(1):17-24. https://pubmed.ncbi.nlm.nih.gov/34543172/

The Wheel of Privilege and Power. https://www.canada.ca/content/dam/ircc/documents/pdf/english/corporate/anti-racism/wheel-privilege-power.pdf

Two-Eyed Seeing (Etuaptmumk – Mi'kmaq Elder Albert Marshall). Seeing the strengths of Indigenous ways of knowing and Western ways of knowing together, for the benefit of all.
Two-Eyed Seeing Video

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