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 4

Involving Patients in Curriculum Development and Assessment

PART 1
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PART 2
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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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Involving Patients in Curriculum Development and Assessment

GUIDE 4

PART 1: CURRICULUM DEVELOPMENT

Guide coordinator: Angela Towle
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1. Definitions

Curriculum development:	involves problem identification and general needs assessment; targeted needs assessment; goals and objectives; educational strategies; implementation; evaluation and feedback.
Co-design:	a participatory process in which patients are treated as equal collaborators in the design process.

2. Why Involve Patients in Curriculum Development?

Involving patients in curriculum development enhances the authenticity, relevance and social accountability of health professional education (Towle et al. 2026). Patients bring lived experience that grounds the curriculum in real-world priorities, helping educators and students / learners address complex needs like stigma, cultural care or patient safety with more nuance and humanity. Their participation also helps keep curricula, which are notoriously slow to change, up-to-date in response to emerging opportunities and challenges, such as virtual care or climate change. In addition, partnering with specific groups of patients can amplify underrepresented perspectives and help address systemic health inequities, ensuring curricula reflect what truly matters to diverse communities. As recent research shows, patients and health professionals often value different aspects of care, so including patients helps rebalance curricular focus toward empathy, collaboration and shared decision-making (Towle et al. 2026).

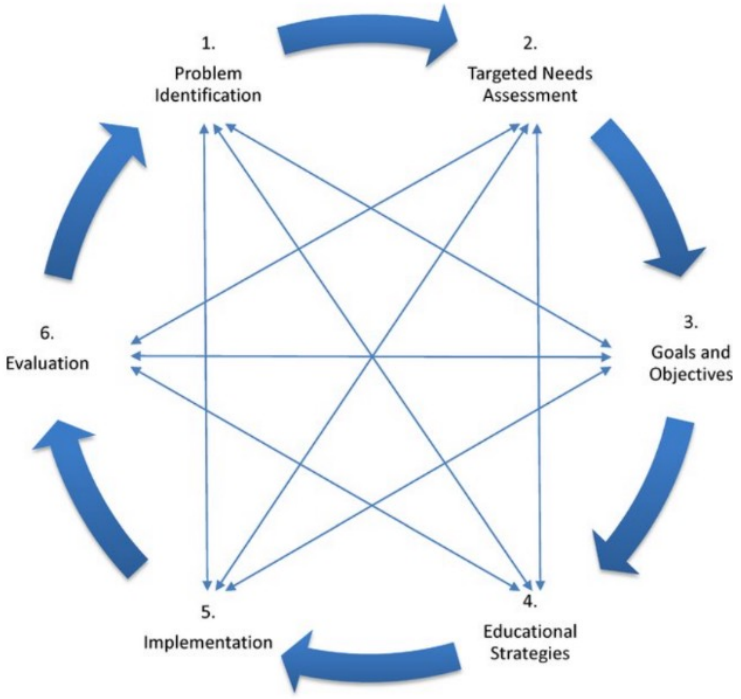
3. Framework for Curriculum Development

We have structured this guide around the six-step curriculum development model of Kern et al. (2022), a widely used framework in HPE (see Figure 1). We provide patient involvement strategies, practical tips and examples relevant to each step.

1. **Problem Identification:** identifying what healthcare or educational gap needs to be addressed.
2. **Targeted Needs Assessment:** understanding the needs of specific learners and context.
3. **Goals and Objectives:** defining what learners should know, feel and be able to do.
4. **Educational Strategies:** selecting teaching methods and materials.
5. **Implementation:** delivering the curriculum and managing logistics.
6. **Evaluation and Feedback:** assessing learners and refining the curriculum based on outcomes.

TIP: Build relationships with the people you want to involve in curriculum development before you begin the process.

Figure 1: Kern's Six Steps in Curriculum Development



"For true transformational curriculum development, where there is significant reciprocity, where everyone benefits from the process, you need really strong, stable relationships. And that takes starting off small and prioritizing the relationship, rather than the educational outcome to begin with."
James Bonnamy

4. Ways in Which Patients Can be Involved in Curriculum Development

The main ways in which patients are usually involved in curriculum development are by providing input through an initial consultation process (steps 1 to 3 in Kern's six-step approach). Some innovators have explored participatory co-creation processes that begins with needs assessment and continues through curriculum design, implementation and evaluation (steps 1 to 6). For example, Brand et al. 2024, Bonnamy et al. 2025 and co-creation examples described in Section 5. Patients involved in teaching or co-teaching, and community members experiencing problems with care, may also identify needs and opportunities to develop or revise curriculum. These initiatives can lead to collaborations not only with health professional educators who design curriculum, but with students (see Section 6).

Consultation processes get patient input into the curriculum either at the level of general or targeted needs assessment, or into competency frameworks. Consultation implies that the opinions of patients are sought, but decisions about whether, or how, the input is subsequently incorporated into curriculum design, teaching and evaluation are made by health professional educators. Consultation methods include surveys, focus groups, interviews, Delphi or other consensus building processes, or community forums, workshops or symposia. Input from patients may complement input from students and health professionals.

Co-design is a more intensive and participatory process in which patients work with faculty, and sometimes other stakeholders such as students, from an initial needs assessment step through to implementation and program evaluation. Co-design requires attention to the process of engagement to ensure a safe and productive environment where all participants feel respected, heard and supported. Regular meetings of the design group are needed to build relationships and a sense of ownership of the curriculum. Successful co-creation initiatives often use facilitators with strong skills in levelling traditional hierarchies, and/or conceptual frameworks that set the rules of engagement.

TIP:
Consultation is the easiest way to get started.

EXAMPLE 1: The Collaborative Learning College Research Subcommittee at the Centre for Addiction and Mental Health, Toronto (clc.camh.ca/mod/page/view.php?id=1643) use comfort agreements (sets of co-created expectations) that serve as the foundation of collaborative practices. Comfort agreements translate shared values into clear, concrete actions so expectations are practical, participatory and relational. To create a comfort agreement, group members share mutual expectations needed to ensure everyone can engage in ways that feel right for them. Comfort agreements differ from traditional group rules and agreements in that they are co-created, fostering shared ownership and mutual accountability for how the group works together. Unlike guidelines that govern how people interact within a space, they articulate the fundamental values and motivations that underpin the group and its work. Comfort agreements are living documents that are revisited regularly, often at the beginning of meetings, during check-ins and in debriefs, with members invited to reflect on what they would like to keep, change or add. In this way, comfort agreements act as accountability mechanisms, helping groups examine whether they are living up to their shared values as the work unfolds. Comfort agreements are also intended to be actively leveraged in practice to navigate difficult or uncomfortable situations, such as reaching consensus and managing interpersonal tensions. Team members are encouraged to signal a potential breach of the agreement, such as by raising a peace sign to prompt group conversation, a pause or a one-to-one check-in. This creates space for reflection and allows teams to adjust as needed. Although comfort agreements are valuable in all group work for challenging power imbalances, they are especially important in collaborative efforts that involve voices historically excluded from decision-making processes.



5. The 'How To' of Curriculum Co-Design

EXAMPLE 2: Brand and colleagues (2025) describe how to establish and sustain collaborative and successful partnerships with patients to co-design health professions education. Based on five co-design principles (inclusive, respectful, participative, iterative, outcomes focused) they provide applied examples and lessons learned from four co-designed projects across four health care disciplines and learning contexts. They stress the importance of actively managing power imbalances, which may be caused by traditional and often complex social, cultural and institutional interactions, from the outset. This requires critical reflection, reflexivity and a commitment to mutual recognition of expertise.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.

TIP:
Co-design is a process, a way of thinking and working, rather than a single event.

EXAMPLE 3: Based on lessons learned from patient and healthcare professional subject matter experts working together to co-create curriculum, Graves and colleagues (2025) identify six recommendations represented by three themes:

1. Select the right partners: Select subject matter expert patient partners; Recruit subject matter expert healthcare professional partners.
2. Provide the right supports: Provide partnership training; Follow partner-centred timelines.
3. Create the right environment: Provide equitable benefits; Adopt flexible approaches.

EXAMPLE 4: Bennett-Weston and colleagues (2025) adopted the National Institute for Health Research co-production principles (Sharing of power; Including all perspectives and skills; Respecting and valuing knowledge of all involved; Reciprocity; Building and maintaining relationships) to develop three curriculum streams: i) delivering evidence-based empathy lectures; ii) involving patients in biomedical science teaching; iii) implementing longitudinal empathic communication and clinical skills teaching. Based on their experience they identified five key learning points to assist curriculum developers to co-produce medical curricula: i) appoint an individual point-of-contact to support participants; ii) create a feedback loop; iii) encourage various modes of engagement; iv) explore and be open to all contributions; v) be transparent about the process.

EXAMPLE 5: Ferguson and colleagues (2025) describe a 'backwards course design activity' that they have used during the first meeting of planning committees which demonstrates the value of patients and their lived experience in course co-creation and sets the tone for their subsequent involvement. Backwards course design involves specifying the desired outcomes of course completion and then outlining the content required to achieve these outcomes. They have recently completed this activity for a new course on Fetal Alcohol Spectrum Disorder with a committee including patients, clinicians and researchers.

EXAMPLE 6: Molloy and colleagues (2024) adopted a Design Thinking approach to co-design a postgraduate mental health nursing degree. Design Thinking is human-centered and focuses on collaboration to support meaningful representation of key stakeholders. This approach was adopted in response to calls for higher education to partner with patients in preparing health professionals for specialist practice and to support curriculum development in line with emerging standards and frameworks for health professional education. In order to create fairer access to participation, the patients were employed on contract and paid for the work completed.

EXAMPLE 7: Johnston and colleagues (2025) co-designed a fully online 6-week unit for postgraduate mental health students and a hybrid 12-week unit for undergraduate psychology students on suicide prevention education. By working collaboratively with diverse voices, these units bridge the gap between academic knowledge and real-world suicide prevention practices. People with lived experience of suicide ideation, attempt, and/or bereavement were recruited through a partner organization. A critical pedagogical approach was taken to challenge traditional academic knowledge hierarchies, centering the two units on lived experience and public expertise.

6. Patient or Community-Initiated Curriculum Development

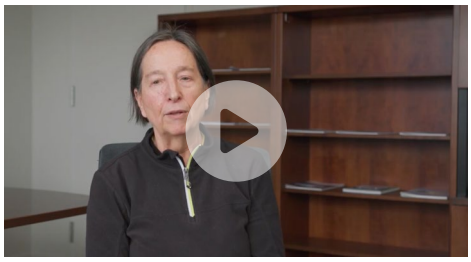
Patients who are involved regularly in teaching may also recognize the need for supplementing curriculum content. Patients who are given the freedom and support to draw creatively on their lived experiences can learn from the reactions of students to identify which parts of their experience are of most value to fill gaps in the formal curriculum. In this way patients and students can be partners in co-creation of curriculum components that directly meet the needs of learners. Both patients and students have a vested interest in improving the relevance and impact on training and there are mutual benefits and synergies when patients and students collaborate on curriculum redesign.

TIP:

When patients / community members identify gaps in curriculum based on their experiences and drive the change, those responsible for HPE have the satisfaction that they are addressing a real need in the community.

> **EXAMPLE 8:** In this video clip, Carolyn Canfield describes how she took the initiative to redesign a patient safety curriculum which she had co-taught for several years at the University of British Columbia.

VIDEO: learning.media.ubc.ca/media/Guide+4%2C+Clip+1+-+Carolyn+Canfield/0_q57rs98e



> **EXAMPLE 9:** In this video clip, James Bonnamy describes two examples of curriculum development at Monash University which originated from needs identified by community members who had experienced problems with the care that they and others were receiving. Both were grassroots projects driven by their concerns and desire to make health care better for themselves and others. One was related to eating disorders and the second to cognitive bias in healthcare decision-making.

VIDEO learning.media.ubc.ca/media/Guide+4%2C+Clip+2+-+James+Bonnamy/0_s2h0kifn



Summary of Patient Involvement Across the Steps of Curriculum Development (see Section 7 for examples and more tips)

STEP	FOCUS	PATIENT INVOLVEMENT	TIPS
1. Problem Identification	Define priority health, community and system needs.	Public consultations, forums, lived experience narratives, inquiries, identifying care gaps.	Elicit priorities at systems, community and at individual patient-provider levels.
2. Targeted Needs Assessment	Specific learner needs & environment.	Listening sessions, focus groups, co-designed needs assessments, patient-prioritized issues.	Involve students and faculty in listening to patient perspectives.
3. Goals / Learning Objectives	Learning outcomes (knowledge, skills, attitudes).	Translate lived experiences into learning goals and objectives, or competencies.	Leverage faculty expertise to ensure learning objectives are clear and measurable.
4. Educational Strategies	Content, methods, learning and teaching strategies, teaching activities, assessment and evaluation methods.	Storytelling, patient-led workshops, simulations (e.g., patient-led debriefing), multimedia co-creation, co-teaching.	Stay open to non-traditional teaching methods like arts based methods, patient-created videos, poetry, storytelling circles, etc.
5. Implementation	Delivery, rollout, logistics.	Pilot testing with patient feedback, trauma-informed facilitation, flexible scheduling, co-presenting.	Test new approaches through small pilots before scaling up to full implementation.
6. Evaluation	Review effectiveness, learner growth, and patient experience.	Co-design evaluation tools, patient feedback on learners and programs, reflective debriefs, feedback to contributors. Revise curriculum based on feedback.	Share outcomes with patients involved in the curriculum development and implementation.

7. Examples of Patient Involvement Across the Steps of Curriculum Development

Step 1: Problem identification

> **EXAMPLE 10:** Public and patient input into shaping the mission of a medical school
>
> meetingofexperts.org/wp-content/uploads/2020/02/Consultation-on-Priority-Health-Concerns-in-BC.pdf

Patients and the public were consulted about priority health concerns of the population as part of a process to revise the mission and exit competencies of the University of British Columbia (UBC) medical school. A facilitated public consultation involved individual patients, family members and representatives from over 30 community organizations. Through forums and surveys, participants identified priorities at the healthcare systems level and individual doctor-patient level, particularly for those who experience poor healthcare due to marginalization and stigma. Their input directly shaped a new mission statement and exit competencies that contained more patient-centred and inclusive language, and emphasized active listening, shared decision-making with patients, and holistic care in clinical education.

TIP:

In recruiting for consultations we have found it useful to use the three categories for patient and public consultations identified by Williamson (2007) namely, individual patients (who can describe and judge their own experience of healthcare), patient groups (who know about the experiences and views of other patients like them), and patient representatives or advocates (who know about the knowledge and interests that all patients have in common and can explain the patient perspective on major issues).

Step 2: Targeted needs assessment

> **EXAMPLE 11:** Patient involvement in the needs assessment phase to redesign a continuing professional development module on end-of-life care for family physicians at UBC (Tajani, et al., 2021).

The process began with a consultation through UBC's Patient & Community Advisory Committee, followed by a 90-minute focus group that included 15 diverse participants. Project leads (administrative staff and family physicians) attended as note takers and observers. Patients discussed key topics / competencies that family physicians should know about end-of-life care and identified useful resources. Responses were grouped into five domains of end-of-life care, and participants voted on the most urgent learning needs. These priorities directly influenced the module's learning objectives and resources.

TIP:

Involving the entire curriculum development team, including health professionals, in the consultations (for example, as observers or note takers) enables more meaningful connection and understanding of the patient perspective, and may lead to health professionals reflecting on, and changing, their own clinical practice.

Step 3: Goals / learning objectives

> **EXAMPLE 12:** Co-creating learning objectives from lived experience (Towle & Godolphin, 2013).

In the Patient & Community Voices Workshops at UBC, patients with lived experience co-develop workshops for health professional students in partnership with faculty and students that are subsequently led by patients. The development process begins with patients' personal experiences of the workshop topic and identification of what patients want students to learn. The role of faculty is to translate these identified learning needs into a form of instructional objectives familiar to students and faculty. The role of students is to provide information about their learning needs and feedback on proposed activities.

TIP:

Faculty can help translate patient-identified learning needs into educational objectives to meet course and accreditation requirements.

Step 4: Educational strategies

> **EXAMPLE 13:** Deaf and Hard of Hearing people designing learning activities (Ham et al., 2021).

Deaf and Hard of Hearing (DHH) people co-developed and led interactive workshops for health professional students as part of a participatory education initiative at UBC. Supported by a local DHH community organization, people with lived experience designed an experiential learning activity to address real-world communication barriers and shared practical strategies for accessible care. The organization provided a location for meetings and educational activities that accommodated the needs of DHH people.

TIP:

Partnering with a community organization that provides programs and services for groups with specific healthcare needs makes it feasible for them to design and facilitate workshops for health professional learners.

Step 5: Implementation

> **EXAMPLE 14:** Deaf and Hard of Hearing (DHH) workshop implementation (Ham et al., 2021).

After two meetings to co-design the workshop (Example 13), the third meeting was a dry run of the workshop for three students to get feedback from all members of the co-design team. Modifications included ensuring wide representation on the panel of DHH speakers, for panelists to keep focused on health-care related experiences, provision of a take-away handout for students to remember key communication strategies, and opportunities for students to practice working with a sign-language interpreter and assistive listening equipment. Three DHH people delivered the revised workshop and further modifications were made based on student feedback before advertising the workshop to all students.

TIP:

Implementing new patient-led educational activities with small numbers of volunteer students permits refinement based on feedback from students and patients.

Step 6: Evaluation

> **EXAMPLE 15:** Iterative refinement of a virtual care curriculum based on patient feedback (Parsa et al. 2026; UBC Medicine Educational Media, 2024).

UBC developed *The Listen*, a podcast-based virtual care curriculum co-created with 28 patient and caregiver partners. Designed in response to urgent training gaps exposed during the COVID-19 pandemic, the five-part series reflected patient-identified priorities such as trust-building, digital empathy and accessibility. Feedback was built into every phase: early podcast drafts were reviewed by patient partners and student learners, who provided input on tone, clarity and representation. Their suggestions directly informed revisions, ensuring the final product was inclusive, trauma-informed and grounded in real-world patient experiences. After co-creating podcasts, the teaching team hosted a celebration with patient partners. Students shared thank-you messages and curriculum updates were reviewed together.

TIP:

Plan an event at the end of the curriculum development project to bring everyone together to share evaluations, celebrate success and close the loop. This validates patient input and encourages long-term engagement.

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Involving Patients in Curriculum Development and Assessment

PART 2: ASSESSMENT OF LEARNERS

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1. Definitions

Formative assessment:
also known as assessment **for** learning or feedback. Multiple data points of formative assessments may be used to make a summative assessment decision.

Summative assessment:
also known as assessment **of** learning, often known as high-stakes assessment.

Programmatic assessment:
an approach in which routine information about a learner's competence and progress is continually collected and analyzed, with the intent to both maximally inform the learner and allow for high-stakes decisions at the end of a training phase.

Multi-source assessment / feedback:
also known as 360-degree feedback, is a performance assessment method collecting anonymous feedback on an individual's work behaviours from various sources (peers, supervisors, various health care providers, students and sometimes patients / clients).

Workplace Based Assessment (WBA):
assessment of trainee performance in a practice-based setting using different methods (e.g., direct observation, mini-clinical evaluation exercises) combined with feedback provided by a supervisor, preceptor, advisor or patient.

Competency-based assessment:
a method used to assess an individual's skills, knowledge and abilities in relation to specific job roles or learning objectives (competencies) with an emphasis on real-life situations.

Objective Structured Clinical Examination (OSCE):
an assessment tool based on the principles of objectivity and standardization in which patient roles are traditionally played by standardized or simulated patients (SPs).

Entrustable Professional Activities (EPA):
A fundamental unit of professional practice that can be fully entrusted to a trainee once he or she has demonstrated the necessary competence to execute the specific activity unsupervised.

2. Introduction

In this Guide we emphasize that patient involvement in assessment should be an active process by 'real' patients, drawing on their own, authentic experiences. We are not concerned with assessment by standardized or simulated patients playing a role scripted by professionals, which has been the focus of most work to date. Research and practice focused on patient involvement in the assessment of health professional learners, whether in the context of undergraduate education, postgraduate training or continuing professional development, are increasing, but remain at an early stage. Most published studies on the assessment of learners by patients, are focused on postgraduate trainees, in the clinical setting, come from the USA, and are mainly in nursing and medicine; very little work has been done in other health disciplines (Nemir et al. 2024). This is an area of patient involvement in education with great potential for study and experimentation.

> *"Authentic patient voice is still a whisper in contemporary competency-based assessment in medical education despite the global movement towards greater patient partnership in defining a holistic medical learners' competence".* **Malau-Aduli, 2022**

3. Why Involve Patients as Assessors?

Published work (Ashdown & Jones 2026, Finch et al. 2018, Kearney et al. 2022, Khalife et al. 2022) has identified the following benefits.

- Assessment of learners generally relies solely on professionals' judgement and has been criticized for not providing holistic views of competence. Professional assessment tends to focus more on clinical skills and knowledge / medical expertise, whereas patients focus their assessments on professionalism, communication and authentic patient-centred, interpersonal criteria.
- Incorporating patient assessments, either as a stand-alone group of assessments or as part of multi-source assessments, is a way to produce more rounded feedback.
- Communication skills, attitudes and non-technical skills are rated differently by patients and health professionals, highlighting the need to collect data from both sources.
- Learners would benefit from patient assessments to help in developing patient-centred care and to understand the ways their interactions with patients can influence patient outcomes.
- Including patients as assessors helps assessments to be more authentic and based on real-world experience (i.e., how trainees would perform in the workplace).
- Including patients as assessors will help institutions demonstrate their commitment to be socially accountable to the communities they serve, and ensure that they are equipping future health professionals with skills that align with the dynamic demands and expectations of patients and society.

4. Getting Started: Patients and Formative Assessment

In recent years assessment in HPE has focused more on the powerful role of formative assessment where feedback is a major mechanism for supporting and enhancing learner development. Patients as providers of feedback is the main way that they are currently contributing to assessment. Enhancing and increasing such involvement is an important place to start for HPE institutions when reviewing and improving their current assessment practices.

TIP:

As most work focusing on patients as assessors has been done in the context of formative assessment, this is a good place to start.

Tips and Techniques

- Assessment from patients needs to be valued as much as assessment from other sources.
- Appropriate preparation is needed for faculty, examiners and learners to optimize comfort with, and confidence in, new assessment approaches that involve patients.
- A good place to start is in an existing teaching clinic where preceptors could be encouraged to include patients in giving feedback to learners.
- Start with using an existing validated tool such as the Communication Assessment Tool (CAT) created for patient assessment of the communication skills of physicians, but which could be adapted for other health disciplines (see Example 3).
- Preparation and ongoing support for patients is essential: providing feedback is a skill that needs to be taught (to professionals as well as patients)—patients can't just be thrown into the role.
- Offer various means for patients to give feedback, e.g., verbal or written, anonymous or face-to-face.
- Recognize that not all patients want to be involved as assessors when they are in a clinical setting for health care.
- Acknowledge the risk of coercion in a clinical setting where patients are dependent on care by the professionals who are inviting them to participate. Assure patients that their involvement is voluntary and will not affect the level or quality of care they receive.
- Acknowledge the power dynamics while stating the impact and value of patient feedback to enhance learner training and professional development.
- Maintaining patient confidentiality and/or anonymity is an important consideration, depending on the purpose for which feedback is sought, in order to preserve the patient-trainee relationship.
- Administrative infrastructure and investment by the institution is required: involving patients is not without risk or additional efforts or costs (e.g., for the recruitment and training of patients, and the collection and distribution of assessment data).
- Including a diversity of patients is important to ensure that many perspectives are included in the feedback (see Guide 3).
- In addition to the specific considerations when involving patients in assessment, follow the general principles of patient partnership, such as transparency of requirements and remuneration / recognition.

EXAMPLE 1: In the video clip, Arwa Nemir from the University of British Columbia provides ideas to get started with existing resources.

VIDEO: learning.media.ubc.ca/media/Guide+4%2C+Clip+3+-++Arwa+Nemir/0_068lhrzw



EXAMPLE 2: A barrier to patients giving feedback is the power difference between patients and health professionals in the clinical setting. To address this, Bosveld and colleagues co-designed with patients and healthcare professionals an interprofessional, evidence-informed patient feedback training activity for healthcare professionals (Bosveld et al. 2025). The training consists of an initial 2-hour session which covers theoretical aspects of feedback, and two patients' lived experiences with giving their feedback. Following the session, health care professionals are asked to gather patient feedback in daily practice. In the second 2-hour session, 6 weeks later, participants discuss experiences and engage in peer-to-peer coaching facilitated by a trained patient. The activity was piloted with seven participants: nurses, medical residents and medical specialists. The training fostered a safe space for open dialogue between patients and healthcare professionals.

For more information about the study and next steps see Sehlbach et al. 2024 and listen to the video by Matthijs Bosveld from Maastricht University.

VIDEO: learning.media.ubc.ca/media/Guide+4%2C+Clip+4+-+Matthijs+Boseveld/0_80sklwi6



TIP:

Include training to involve patients in providing feedback to learners as part of continuing professional development for health professionals.

5. Benefits and Tensions of Patients as Assessors in Summative Settings

High stakes summative assessment currently prioritizes objectivity, standardization and reliability so that all those being assessed are treated in the same way. Therefore, patient involvement has largely been confined to the use of standardized patients (SPs) who are trained to play roles in Objective Structured Clinical Examinations (OSCEs). Inclusion of real patients in summative assessment, drawing on their own experiences, will require agreement that standardization is not the only important principle and that authenticity, validity and utility are also important principles underpinning assessment. Also, that involvement of patients will move assessment closer to the realities that health professionals will meet in the real world. A major barrier to including patients in summative assessment is the willingness of physicians and other health professional supervisors / assessors to share the power of assessor roles with patients. However, there is increasing acceptance of the role of multi-source data for assessment—the inclusion of different data sources in high stakes examinations.

> **EXAMPLE 3:** Kearney and colleagues (2022) studied the involvement of real patients in summative OSCEs at an undergraduate medical school. They found that real patients bring authenticity in that their stories develop in a non-standardized way; students feel that real patient assessment is more 'natural' and feel more relaxed; examiners find that students consult in a natural way rather than acting in the exams, allowing them to observe more closely how trainees would be in the workplace. Shifts in marking schemes were needed to reflect the more fluid type of a real patient encounter rather than typical checklists that are used when SPs are involved. It also required an investment of resources since the planning of OSCE stations, and participation of patients in the exam, required extra work, time and effort.

TIP:

As an alternative to direct participation, patients can be involved in the co-creation of simulation scenarios or the training of SPs to make OSCEs more authentic.

6. Patients and the Development of Assessment Tools

There is a lack of assessment tools with evidence of validity and reliability appropriate for use by patient assessors. Assessment is often obtained through feedback forms or patient surveys, and usually related to the care they received. There is a need to create new assessment tools that are co-designed with patients. Two examples are given below.

> **EXAMPLE 4:** A validated and widely used instrument, created with input from patients, is the Communication Assessment Tool (CAT) available at: www.mededportal.org/doi/10.15766/mep_2374-8265.9806.
>
> The CAT is probably the most consistently used tool to get patient feedback on medical student and resident physician performance. CAT was developed and tested by Makoul and colleagues (2007) and can be used by patients to assess the interpersonal and communication skills of physicians in training and physicians in practice. Development of the tool included reviewing existing models and instruments, focus groups with approximately 30 patients, and a national survey (telephone interviews) with 1011 randomly selected members of the public. The 15-item CAT is written at the fourth grade reading level and uses a 5-point response scale with 5=excellent. Field testing with 38 physicians and 950 patients (25 patients / physician) demonstrated the reliability and validity of the instrument for measuring patient perceptions of physician performance and can be successfully completed by both physicians and patients across clinical specialties.

> **EXAMPLE 5:** Moreau and colleagues (2017) describe the development of the **P**arents' **A**ssessment of **R**esidents **E**nacting **N**on-**T**echnical **S**kills (PARENTS) educational assessment tool to assess resident performance in paediatric emergency departments.
>
> The tool was developed through interviews with physician-educators and residents, focus groups with parents, a literature review and a modified nominal group technique with experts. Parents were subsequently interviewed to explore the ways in which they understood, mentally processed and responded to the items on the tool, and how the tool might be used. These interviews led to the removal of one of the 20 items on the tool, the addition of residents' photographs and wording / formatting changes. 37 residents and 434 patients participated in administration of the tool to establish its validity evidence.

Patient involvement in the development of Entrustable Professional Activities (EPAs)

One way in which patients can be involved in assessment is through input into EPAs which focus on clinical tasks performed by postgraduate trainees. This provides an opportunity to integrate the principles of patient-centred care into medical assessment.

> **EXAMPLE 6:** El-Haddad and colleagues (2017) conducted interviews with 11 patients with experience of lower back pain two weeks after discharge from hospital. Interview topics included an account of the hospital admission and the patient's interactions with, and expectations of, health care professionals, particularly trainees. Data from the interviews and focus groups with clinicians informed descriptors for a management of acute lower back pain EPA. Patients and clinicians had several overlapping expectations of trainees but multiple components of the EPA were primarily informed by findings from the patient interviews, especially in the 'required attitudes' section of the EPA, which resulted in practical and measurable descriptors.

7. Future Research

From their systematic review, Finch et al. (2018) concluded that authentic patient assessment is a useful component of student learning but there is insufficient evidence to confirm whether, and in what ways, this feedback yields long-term changes in learners' professional practice. Khalife et al. (2022) suggest exploring:

1. how patient feedback tied to patient reported outcome measures informs and adds to performance assessment;
2. cost-effectiveness studies that address the economic implications of patient involvement, assessment data collection and delivery to learners;
3. the socio-cultural and institutional roadblocks that impede the patient voice which can contribute to a holistic view of the competent health professional.

It is clear that patient involvement in the assessment of learners, and in assessment for learning, is an area for scholarly innovation that has great potential.

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Summary of Tips to Involve Patients in Assessment

Patients as Assessors of Learners

Support patients in giving meaningful feeback on student communication, empathy, and professionalism.

1. Use Simple Feedback Tools

- Start with structured forms like the *Communication Assessment Tool (CAT)* or a basic checklist. Example prompts:
  - Did the student make eye contact?
  - Did you feel heard and respected?
  - Was the student open to your input?

2. Provide a Brief Orientation

- A 30-minute prep session can go a long way.
- Focus on: what to observe, how to give feedback, and why it matters.
- Include practice using the feedback form.

3. Integrate into Real or Simulated Encounters

- Invite patient partners into:
  - Clinical role plays (e.g., breaking bad news)
  - OSCEs or ward rounds
  - Community or telehealth settings
- Use feedback alongside faculty evaluations for a full picture.

4. Encourage Student Reflection

- Ask students to reflect on patient comments:
  - "What surprised you?"
  - "How might this shape your future approach?"
- Include reflections in portfolios or assessments.

5. Compare Patient & Faculty Feedback

- Compare feedback highlights different strengths and gaps.
- Patients emphasize emotional impact and human connection; faculty may focus on technical skills.

6. Close the Loop

- Share how patient input shaped assessment or curriculum changes.
- Offer recognition through certificates, thank-you events, or co-authorship.

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