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COMMUNITY AND PATIENT VOICES IN HEALTH PROFESSIONAL EDUCATION (CVHEd)

Improving care for vulnerable populations through their participation in the education of health professionals

Research Report No. 3: Report of University Key Informant Interviews

March 2014

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a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

Funded by: vancouver foundation

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Overall CVHEd Project summary

Our health care system has many barriers for people who are vulnerable or marginalized including access to services, communication with health professionals, and receipt of true patient-centred care.

Changes in health professional education can help to reduce these barriers.

We believe that an important change is to draw upon the lived experience of citizens and include their authentic and autonomous voices in an enhanced education for students at the University of British Columbia.

This 3-year community-based participatory action research project will inform i) development of a mechanism for communities to engage with the university and ii) development and evaluation of an educational model leading to participation by communities in health professional education.

The research should lead to diverse end-users of the health care system having the power and a mechanism to have sustained influence and participation in the education of health professionals.

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Summary of Key Findings

The following summary is drawn from interviews with 22 key informants (e.g. Deans, academic leaders) at the university. Interviews were designed to explore their ideas about how the involvement of community organizations, patients and citizens in the education of health professionals could be made a core part of health professional education at UBC.

1. Health professional programs at UBC provide a good education in the basic science of health care.

Scientific knowledge is paramount in most programs. Anatomy, physiology, pathology, risk factors and population health norms were thought to be well covered. Informants were satisfied with the training students receive on practical health care skills.

2. Health professional programs at UBC need to produce graduates who are better at working in partnership with patients, communities and other professionals.

Discussions about how healthcare professionals should be educated differently were focused on the need for them to be able to work in partnership and be more "patient-centred." For many informants, this meant providing students with more opportunities to develop better "patient-based skills", particularly communication skills (especially listening) and cultural competence. For some it also meant learning to work with communities on community-defined problems and addressing a lack of interprofessional education so that students are better equipped to work collaboratively with other professionals.

3. Health professional programs at UBC could do a better job of teaching about the broader contexts of health and illness, including helping students acquire a good understanding of the social determinants of health and patients' lived experiences.

Most teaching about the social determinants of health and patients' lived experiences was described as patchy and occurring predominantly "in the early years" of training. Informants thought that these and related topics such as advocacy and social justice need to be embedded throughout training so that they are not seen by students as "add-ons" and easily forgotten by the time they are in practice, but rather become "an integral part of their everyday thinking".

4. Patient / community involvement varies across programs.

The amount and range of patient involvement varies by program, but the two main approaches are to bring patients into the classroom and send students into community settings. Guest speakers, standardized patients and community service-learning occur in most programs. Many of the patients brought into classrooms to tell their story are from marginalized / vulnerable groups. Community involvement was broadly defined and included people from a range of non-profit, corporate and government sectors such school boards, patient organizations, professional bodies, health authorities and other government agencies (e.g. Work Safe BC, ICBC). Nursing, Medicine and Occupational Therapy reported a wide range of community involvement, including in advisory roles and student selection. Audiology and Speech Sciences reported several mentorship type initiatives. Dentistry reported a lot of community service-learning. Pharmacy and Physical Therapy wanted to expand patient / community involvement in their programs.

5. Most patient involvement at UBC is small scale and episodic.

With the exception of the volunteer and standardized patient programs, patient involvement in health professions education at UBC could be characterized as small-scale, episodic and largely dependent upon the efforts of committed individual faculty members to make it happen.

6. Patients and lay community members could play important roles in training health professionals.

Real patients add "authenticity" and make learning interesting and meaningful. Informants saw patients and other people from the community as having important expertise to contribute to health professional education particularly in helping students understand patients' lived experiences, advocacy, cultural differences, community needs and resources. Patient / community involvement was also seen to be an important way to help students connect their classroom learning to practice and develop patient-centred values.

7. Patient involvement in creating learning materials, standardized / volunteer patient involvement in clinical settings, and opportunities for patients to share his/her experience with students should be enhanced.

Informants identified different ways in which patients / community are involved in education at UBC along a spectrum of involvement (see Appendix C). They gave many examples of categories 1 to 3. Informants were unanimous that patient involvement is an important part of student learning and there was a lot of interest in working with patients to create learning materials (especially to increase authentic case development since most cases are developed only from clinicians' experiences), inviting more feedback to students from standardized / volunteer patients, and developing patient involvement activities to address gaps in curricula (e.g. interprofessional education, social determinants of health and patients' lived experiences).

8. Assessment of students, curriculum development and institutional decision making require patients /community to have special expertise if they are to be involved.

There were few examples of involvement in these areas, e.g. an example of a community-based course in which community members determine the students' final grades and some programs that have invited community input into curriculum reviews. However, partnering with patients / community on student assessment, curriculum development and strategic planning were new ideas for most informants. Many informants had reservations about these types of community engagement and there was disagreement about the extent to which patients / community should be involved in decision making. There were concerns that people from the community would not have the necessary knowledge and expertise for educational and institutional decision making and some queried how involvement of lay people in these areas might affect the confidence, autonomy and professional identity of students. Some informants were concerned about the potential for patients to give students feedback that undermines evidence-based practice. Others thought these could be opportunities for students to consider what to do when faced with patients who make decisions that are contrary to best practice.

9. Some types of patient / community involvement require involvement of university leadership.

Some informants were enthusiastic to "push the envelope" of patient involvement in the areas of assessment, evaluation, curriculum development and strategic planning, but thought that this would require widespread agreement, endorsement and leadership within their faculty and/or the university. These types of involvement were also thought to require more careful attention to the selection, preparation and support of people from the community for these roles in order to avoid tokenism or raising expectations of special interest groups that could not be met. Since current patient involvement is done largely at the discretion of individual faculty members, course directors or departments, involvement in assessment and decision making activities were seen to be complicated by the need to have more people involved and be more purposeful about recruitment, preparation and support for community members to take on more sophisticated roles.

10. Select people who are committed to student learning and ensure that different perspectives are represented.

Selecting the "right people" was top of mind for most university informants. They were committed to providing good educational experiences that expose students to different perspectives / world views and help them be more empathic to patient experiences. Although they were enthusiastic about involving individual patients, some were wary about working with community organizations based on previous experiences with special interest / lobby groups and/or concerns about the agenda these groups might bring that may conflict with the university's educational agenda. There were also concerns about "essentializing" experiences that could reify stereotypes and desires to safeguard students from people with an "axe to grind". The key, they thought, is to select people who share their educational agenda and want to "reach out to students as learners".

11. Establish true partnerships with community based on trust, mutual respect and reciprocity.

A lack of mutually beneficial relationships was identified as a major barrier to involvement and many thought there is a need to develop community-university partnerships that are based on trust, mutual respect for the expertise each side brings to the table, and reciprocity. Informants recognized the potential for relationships with the university to be seen as one-sided and exploitive, especially when the community is engaged "too late in the process", university faculty / students see themselves as the primary experts or problem solvers in the relationship, and when student engagement in the community is short term and structured around the needs of the academic calendar. Some thought that these problems could be overcome if the university were to invite community partners as "equals at the table", invest in building "win-win" relationships, and develop systems of reciprocity and ways of "giving back" to community.

12. Develop systems to compensate patients / community members for their service to the university.

Informants were clear that patients / community educators need to be compensated for their service to the university. Compensation was viewed as an important way to recognize the value of their contributions and also pay for their time and inconvenience. However, some informants spoke about the difficulties they have in properly compensating community participants for their contributions as a result of various rules and regulations, fears of affecting disability allowances, etc. When it comes to rewards, recognition and compensation for patients / community members some thought there is a need to find ways to "do business differently". A range of rewards and recognition were recommended such as monetary payments, tuition credits, honorary appointments, recognition at graduation ceremonies, access to university resources, bus tickets, thank-you cards, certificates of appreciation, etc.

13. Provide preparation and support for patient / community educators.

Most informants thought it is important to prepare and support patient / community educators. This should include an orientation about the university learning environment and culture, curricular learning objectives and assessment criteria. Depending on the individual's role and prior experience, specific training on how to speak to large groups, facilitation skills, and opportunities to debrief, and/or similar training (e.g. instructional skills workshops) and support (e.g. problem-based learning tutor support meetings) currently offered to faculty should be offered to patient and community educators.

14. Accommodate special needs and vulnerabilities.

University informants acknowledged that vulnerable / marginalized people and people living with chronic conditions / disabilities have burdens and life circumstances that might interfere with their ability to reliably participate in education and they recognized the need to create safe spaces to facilitate participation and plan for times when they are unable to take part.

15. Address the power differential and share power.

UBC is a place of privilege. The difference in power between the university and community was seen as perhaps the most significant barrier to authentic participation of patients and community members in health professional education. To begin to address power differences and achieve authentic community engagement will require a cultural shift within the university to sharing power and valuing the unique knowledge and expertise of patients and community. Informants suggested that a shift toward sharing power would be complicated by issues associated with risk management, liability, what knowledge is considered valid and fears of losing jurisdiction over what students learn.

16. Systemic involvement requires institutional commitment and leadership.

Many thought that large-scale, institutional level involvement of patients / community requires leadership and support from executive levels within the university. Introducing faculty rewards and incentives and building it into performance reviews and program evaluations were seen as important university structures that would embed patient / community involvement into the fabric of the university.

17. Establish an office / unit to facilitate involvement.

The majority of university informants talked about the need for an office or unit to facilitate a more integrated approach to patient involvement. An office, they thought, would be a "clearing house" for a wide range of community-university partnerships and a place where faculty could go to find people with the right expertise. Likewise, it would serve as a single entry point for people in the community who wanted to become involved. Most envisioned a university-based office. Some envisioned an office in the community like the UBC Learning Exchange. Regardless of location, there was consensus that embedding patient involvement across health professions education at UBC requires, at minimum, "a facilitator" or "leadership group" to be responsible for its management and coordination – especially activities related to building and maintaining relationships, recruitment, preparation, support, program development and evaluation.

18. Prepare students for a different way of learning.

Informants recognized that opportunities to learn from patients / community can be powerful and transformative experiences that have the potential to influence students' professional values and identities – especially when students are put into unfamiliar contexts. Given that these learning environments can be "messy" and unpredictable, many thought that students need to be in some way prepared for a different learning experience. The fact that many health professional students come from relatively privileged backgrounds, and that the university learning environment privileges scientific knowledge over experiential knowledge, were also reasons to prepare students. By preparing students, informants hoped it would help students "be receptive" to patients / community as teachers and avoid it being treated like "another experience for them to check-off their list."

19. Offer faculty development.

If patient / community involvement were to become mainstream, some suggested that faculty would need some training. Training, they thought, was needed on how to include patients, manage vulnerability, prepare students for learning from patients, and what to do when things go wrong. A suggestion was to identify interested faculty and support them by reducing their work load in order to develop the necessary partnerships in the community and create curricula.

20. Partnership with the university is beneficial to community.

Campus-community partnerships are beneficial to the community. The opportunity to influence health care education, research and practice were identified as main benefits to community. A partnership with a large post-secondary institution also validates the work and expertise of community.

University key informant selection and recruitment

University key informants were initially identified by the core project team using the following criteria: 1) Faculty who already **involve** community members; 2) People who are **interested** in the idea of community engagement broadly; and 3) People who are **influential** at UBC but not necessarily involved in health professional education or community engagement. Snowball sampling identified additional informants.

Invitations were sent to 25 potential informants at the university. Twenty-two were interviewed (Appendix A). Participants included deans, associate deans, directors, department heads, curriculum coordinators, course directors and professors from the following faculties, schools and units: Audiology and Speech Sciences, College of Health Disciplines, Dentistry, Education, Nursing, Medicine, Occupational Therapy, Pharmaceutical Sciences, Population and Public Health, and Physical Therapy. Interviewees also included decision makers in the Vice President and Provost's office who are responsible for the academic mission of the university, implementation of the Aboriginal strategic plan, and oversight of key academic centres such as the Centre for Teaching Learning and Technology and the First Nations House of Learning.

Interview design

The interview schedule (Appendix B) was adapted from the interview questions used with community key informants in the preceding consultation. Questions were re-phrased where appropriate. For example, "How should health professionals behave differently?" became "How should health professional students be educated differently to make them more responsive to societal needs?" As in the community interviews, an information sheet with examples of patient /community roles in health professional education along a spectrum of involvement was e-mailed in advance of, and referred to during, the interview to help participants identify aspects of patient involvement in education that were of most interest / relevance to them (Appendix C). All interviews were conducted by the lead UBC researcher. Interviews ranged from 42 to 68 minutes (average 55 minutes).

Analysis

Interviews were audio-recorded and transcribed verbatim. An interpretive thematic analysis was done to identify recurring ideas within each topic area covered in the interviews. Selections of narrative were organized by themes in each of the following topic areas: How should health professionals be educated differently to better meet the needs of society? (interview Question 2); What ways are patients / community involved in the education of students at UBC? (interview Question 3); What roles could patients / community play in educating health and human service students at UBC? (interview question 4); What levels of involvement are of most interest / relevance? (interview question 5); What needs to happen to enable and support community members to participate in health professional education at UBC? (interview question 6); What are the barriers to authentic participation of patients and community members in health professional education? (interview question 7); What structures would facilitate involvement? (interview question 8); What are the benefits? (interview question 9).

Key Findings

The key findings are organized by interview topic areas. Each topic area includes a high level summary of the data and an inventory of relevant narrative organized by themes. Themes with an asterisk also appear in the community interviews. Fillers "um", "like", and "you know" have been removed from quotations.

1. How should health professionals be educated differently? (Interview Question 2)

University informants expressed confidence in teaching practical health care skills. Communication skills, cultural competence, interprofessional collaboration, advocacy and patient-centred care however, were identified areas that are "a lot harder to teach." Informants thought their programs need to do a better of job of teaching students how to work in partnership with patients, communities and other health professionals. There were concerns about the lack of interprofessional education and recognition that health professional students are largely educated in the "silos" of their disciplines. Moving beyond "mix and stir" approaches to interprofessional education and bringing students together in "meaningful ways" were seen as priorities. Informants also thought their programs could do a better job of integrating throughout the curriculum a greater emphasis on the social determinants of health, patients' lived experiences and reflective practice that otherwise can be seen by students as "add ons" and less important than practical clinical skills. Some identified the need for more community-based learning opportunities outside of clinical / acute care settings.

Table 1. Main themes for how health professionals should be educated differently

Theme	Quotations
How to work in partnership with patients / communities*	1. …it's been presumptuous for those of us at the ivory tower to assume that we know what society's needs are and we do that in a horribly simple proxied manners where we say we've got a health outcome, some mortality rate of this group or this population or the morbidity rate needs to improve and so we start a program to address those, whether or not it's what the community themselves, community members themselves want. …But then where's all the other stuff, where's the stuff about the interpersonal, the **communication**, the **collaboration, working in a team, understanding and respecting somebody's cultural background,** what they may have gone through. Those things are a lot **harder to teach**. …the skill set is a lot harder to achieve than the actual content. …the best people for that are the community members. CVHEdU02,p.2
community defined needs Communication	
Culture, history, context	2. …**the whole concept of whose knowledge it is…** CVHEdU02,p.3
Cultural competence	3. …**culture in a broad sense**, not just ethnicity but culture in general, is that I don't think we understand, I don't think our patient population has ever been homogeneous but I think we assumed it to be … Now they're quite comfortable saying this is not my problem, it's our problem. CVHEdU02,p.3-4
Patient-centered care	4. …**we do have patient centered moments in our curriculum they're pieces of time, but** how well are they integrated and how intentional are they, how consistent are they over time and **how are we passing on the message of the role of the health professional within that relationship.** CVHEdU04,p.8
	5. …despite all the stuff we talk about cultural diversity, I don't think we do very much of that. CVHEdU09,p.7
Not patient-centred enough	6. …I'm not sure that we're as engaged with the communities as we should be and I've been mulling over what that could look like. So we don't have a community advisory board. We do have community members working with our students all the time but in a completely unstructured way because every time a student meets a patient they're working with someone from the community. …**I don't think we're patient centered enough** and I don't think we've begun to influence the values of our students around their need to begin to react to the needs of society rather than the needs of medicine or the health care system. CVHEdU09,p.1-2

…connect students in a different way with people from the community *…put them [students] in someone else's context…* Don't pathologize / essentialize *…what defines evidence base doesn't usually include the community voice…* Learn to work outside the norm Learn to work with uncertainty / variability Social accountability Patient-centred care community defined needs Listening	7. …bring that real kind of patient center value into the graduates we're producing. …connect the students in a different way with people from the community. CVHEdU10,p.2 8. …learning sites in communities are hugely important where organizations in those communities can have a say, if you will, in the delivery, in the development, in the interaction. …it **puts them in someone else's context** and I've always found that critically important for my own learning and what I've noticed in other people's learning. If you can actually go in there where you don't think that you're going to be the deliverer or the teller or so on but that you're actually going to be involved in some level of mutuality and some level of receiving knowledge as well as doing knowledge, then I also think that if we can have students understand the notion that one of the most important things probably is curiosity so they go with this openness rather than knowing the notion of delivery. I also think it has students feel vulnerable which is not a bad thing. CVHEdU12,p.3-4 9. …**community members of course…they don't wanna be pathologized**. So … **they see themselves, their health, and wellbeing in much more holistic terms** and so **they don't wanna be pathologized or essentialized**, and that's what we wanna do in medicine…. flavor around medicine is building the evidence base and **what defines evidence base doesn't usually include the community voice**... It could be patient voice. But really unless that patient voice fits into all of this other evidence, then **there is no room for anything that is outside of the norm that doesn't fit into that algorithm or paradigm.** CVHEdU13, p.1 10. …**it's so nice to have a recipe**. …**I don't know what the biggest fears are for health professionals but I imagine not knowing would be an enormous fear.** …**But voicing that and talking that through and working that through, and helping people come into terms with that**…"**This is a messy case. This isn't clear** this is the example of the patient with diabetes who… the doctor did everything right and its still didn't work. Then what are you gonna do?" kinds of conversations. And I think **having those kinds of conversations around patients might be something that's really helpful to folks who are becoming health professionals.** CVHEdU15, p.4 11. …We have to be accountable to the folks we serve, who are the patients, and again I think giving them a voice would be a powerful way to make sure that we are meeting their needs. CVHEdU17, p.1 12. …we talk a lot about **individualized care**, **patient centered care**. I don't think we do that right now. I think we've largely processed the folks that we work with. We fit them into a program rather than trying to find the best interventions to meet their needs....we do need to **share health** as a profession and a provider team. CVHEdU17, p.1 13. They really would rather us do a project on Y instead of X. And now, we've gone to them because we really like the idea of X. …maybe we haven't as an institution, learned how to be a real partner yet. CVHEdU16, p.7 14. …it was astonishing as a patient to be treated like he didn't know anything, he had nothing to offer. CVHEdU19, p.1 15. We usually walk in and start talking. …but Chief [Name] was giving a talk last week about ... He said "Listen to us! Please, listen to us!" …**that listening piece**, I don't know how to teach to be honest. CVHEdU21, p.3

It's about more patient-based skills… (communication, listening, partnership skills) *…cultural sensitivity and cultural competence…we do a rather mediocre job at really getting to the meat of that…* *…you need to know more than just about the human body, physiology and anatomy. You need to understand how this body functions within cultural contexts.*	16. …the **lobby groups**. And so, there are times I struggle that with palliative care group, we've got the pain people coming in, we got whatever, we need more time in the curriculum, we need this, we need that. Part of me sort of says, why are we getting hammered on this? I mean, do we really not teach enough around palliative care, for example? …**But of all the skills our graduates have, they're not connecting to the patient problems. And if they listened and connected to patients more, then** they… I say sort of softer issues such as …, and palliative care is just just one example where **it's not that people don't have skills to prescribe morphine or do this or do that, but it's a surrogate for "Listen to us!".** …**Maybe we haven't stopped to listen. So is there any value in talking to some of those people that are banging the door around "curriculum got to have more of this, more of that" because I can't help thinking if we really dug into that, it isn't about [disease] or [treatment]. It's actually about some of the more qualitative skills, more patient-based skills that we need.** CVHEdU21, p.12 17. …things like **cultural sensitivity and cultural competence**, we know how important it is. Students know how important it is and actually I would say **we do a rather mediocre job at really getting to the meat of that**… **the patient's voice not only from sort of the condition point of view, but if also it could be from their cultural context, it could really assist the students to really grapple some of those issues that we struggle with**… CVHEdU16, p.5 18. …you **need to know more than just about the human body, physiology and anatomy. You need to understand how this body functions within cultural context.** …The **understanding of the family structures and the ways in which authority versus decision making, including decisions about one's health in some cultures are complicated by this social norms.** I think it's tremendously important again for the patients. I think it also **dealing with the diverse population of patients early on, I think helps develop students' both respect, and understanding of the need to cater their communication skills in ways that can be effective for people for whom English is an additional language or no language at all.** So, I think dealing with the diversity of the patient from early on is critical in developing some of these professional skills that are very important. And I think also, and I know **we hear this a lot from students once they enroll in professional school, they want to be as close to practice the real thing as they can. That's a hugely motivating factor. It's the factor that reinforces all the learning that happens in classrooms in the labs.** So, I believe that there is a strong value in terms of the quality of learning experience and effectiveness of learning experience **if students can have access to authentic context**. CVHEdU20, p. 3 19. we do a pretty good job at taking first year medical students who are sensitive human beings and turn them into chief surgical residents who sometimes forget to actually ask the patient their name. CVHEdU21, p.10
IPE – How to work in partnership with other health professionals* *…there's very little interprofessional education…*	1. …the ability **to get our students to work together in a meaningful way** CVHEdUPilot,p.4 2. …**a lack of really interprofessional education** and I think it's something that the College of Health Disciplines has pushed for a long time. They've had a committee on it but I think **the practical reality is there's very little interprofessional education.** …**most of the patients get a very two-dimensional look at their problems. Whoever they see gives their sort of impression rather than another person with a complimentary skill set looking at the same problem and say, "Well, I see it this way."** CVHEdU09,p.1 3. …**we rush into the treatment phase quite quickly** and so if you're evaluated by a dentist you're probably gonna get a dental procedure even if your problem is a neurologic facial pain thing which isn't dental related at all. I mean as a pathologist I see this all the time. Patients that get multiple root canals before someone says 'gosh maybe it's not a root canal.' {Chuckle} I mean that's kind of you go to an endodontist, you get a root canal. It's you go to an oral surgeon and get a tooth pulled. I think if there are other people in the initial assessment, the patient could get a better comprehensive view… CVHEdU09,p.8

…we rush into treatment	4. we're now starting a collaboration with pharmacy to get the pharmacy students to come and work with the dental students to evaluate the medications that patients are taking. Dentists don't have access to Pharmanet so it's actually not possible to verify exactly what your patients have been prescribed. CVHEdU09,p.12
…we educate students in silos… Avoid "mix and stir" approach	5. …**we educate students in silos.** …**I still think there's a way that we can share some competencies, some codes of ethics across the disciplinary boundaries so it would be a way of providing more time where students are brought together to understand, to complement and to intersect their roles as health care professionals in the delivery of good health care in a patient centered environment.** …a caution and we need to be well aware of historically and perhaps you've heard me say that can be what I call the **mix and stir theory**, so we bring students from different disciplines together and we tell them that they need to respect each other and get on with it when in fact we might create the very spaces that re-entrenches the hierarchies by doing it that way. …**it's often the social activities which is a learning environment just as much as a PBL group or a classroom environment where students actually begin to understand and appreciate each other.** …**the breaking down of the professional barriers often happens mostly in social environments.** CVHEdU12,p.1
Silos	6. we have become quite **siloed in our approaches in education** around all the differing areas of the health profession, and that … it's… the outside community is asking for health care teams, is asking us to work together, is asking the deliverers of health care to work together, and it absolutely, in my experience, is the right way to go. CVHEdU18, p.1
Social determinants of health / Population health / health advocacy / social justice/ psychosocial factors in health	1. …**there isn't really a deep understanding and the role of the health professional as an advocate for the community**, which is a very important role but I don't think we provide enough experience, preparation, understanding CVHEdUPilot,p.4
	2. …being aware of social determinants of health or broader perspectives of health and the range of services and professions and workers cause they're not always professionals that are contributing to meeting the needs of society, so kind of how all of those things fit together. … understanding how to get going or how to get started, the actions to take to meet those needs. CVHEdU03,p.1
Role of the health professional as an advocate for the community *…that service actually feels like a place where yes, I want to be, I feel good here, I feel accepted here…* *…that stigma exists, that you don't want to contribute to it…we do not want to re-traumatize people…*	3. …**a social justice lens** to our curriculum and to embed that across the curriculum throughout the curriculum **so that it doesn't feel to the student that it's some kind of add-on**, it's just some kind of little thing that maybe they need to know over here and maybe one day they'll use and maybe one day they won't, and rather than it become **an integral part of their everyday thinking** when they think about people. …**it would be important for the student to understand number one that not everybody can get to health care and that when they do get to health care those interactions aren't always respectful, nonjudgmental, etc. particularly for people who really are terribly marginalized by social and structural inequities** …so **it's not just about getting to the service, it's about, cause services are there, there are lots of services, it's about that that service actually feels like a place where yes, I want to be, I feel good here, I feel accepted here**…So in my area of mental health and addictions there's huge stigma so students have to understand that you're looking through a social justice lens then you'd understand that, **that stigma exists, that you don't want to contribute to it,** that many people who are marginalized by social and structural inequity, not all people, but many have trauma histories, violent histories, … **trust issues and we do not want to re-traumatize people within the system.** …So the student really has to be well prepared so it's not just the social justice lens, but also within our programs we have to be able to provide the student with the skills, the skill development around negotiation skills, navigating skills, in terms of communication, getting to resources, understanding resources, understanding what that's like for people in the everyday world, people who have these issues. CVHEdU05,p.1-2

We need to be much more holistic…The psychosocial factors haven't really been emphasized all that much.	4. **We need to be much more holistic** about what we do in our program I believe, and others are beginning to see this too. **The psychosocial factors that we haven't really emphasized all that much.** CVHEdU06,p.1 5. **one area where we're lacking right now is around working with marginalized populations and around the physio role and Aboriginal populations.** CVHEdU11,p.2
Marginalized / vulnerable populations *Social determinants of health quickly disappears…a body is more than a body…*	6. …disciplines understand a body very differently so having learners in an environment or from a discipline where they're actually taking notions of marginality and health into serious consideration when it's not often taught, raised, bridged with learners in other environments is that those learners may in fact impact other learners in a way that really has other disciplines understand a body in more ways than a biomedical body. …I think that **generally speaking people understand no doubt that disadvantage or social class is a major indicator, social determinant if you will of health, yet at the same time that so quickly disappears out of both the context and the formal curriculum and the way of seeing a body when it enters the clinical or professional environment.** So in some ways it's like having reminders constantly in your presence that **a body is more than a body** is more than body. CVHEdU12,p.2
Victim blaming	7. I mean **everything is framed like that's life choices, or anyone has the ability to pull up their bootstraps and lablablah, but really actually understanding all of that determinants and the structures that create all of those barriers.** So I think that's deeper, way deeper understanding than that you can get in a lecture or a case study. You can get some light bulbs on that but you have to … experiential leaning is at least from my background and understanding, I see it change lives all the time. CVHEdU13, p. 3.
…those are one-offs as opposed to a cohesive plan.	8. As a profession in physiotherapy are we doing a good job at meeting the human health resource need of rural BC much less so than urban? So, I think there are probably areas of growth there. There is a large emphasis on, interprofessional education, and there is probably room for continued growth, for continued improvement in that area as well, although we just got accredited and we can give you [unclear] examples of… where we are effectively engaged in interprofessional education. But to the extent to which **those are one-off stands as opposed to a cohesive plan.** CVHEdU16,p.1
…putting one toe in the water…one-offs.	9. one of the things does concern me is that… which is **putting our toe in the water so we engage with patient experiences in the early years of medical education almost as one offs**. I mean I'm trying to, how many exposures to a situation like that a medical student might have in first year or even in second year, but **they are single digit encounters**. CVHEdU21, p.3-4
advocacy	10. …but you do tend to become a little more jaded about what you might be able to accomplish over time and so, faculty members who may have been out for thirty years, and have kind of the system beat you up for that period of time**, you become less willing to take those risks in terms of advocacy** …and kind of been there and done that. I've tried that ten years ago, I tried it again eight years ago, I tried it again five years ago", and "enough". Whereas students and the early career practitioners, they are the ones I think that will push the system and they are the ones who have the energy, the altruism still, the drive to make it work, so I guess …**it's to find the balance between showing them what they need to advocate for.** I think they will discover that for themselves in a very short order **without becoming too much of a downer.** CVHEdU16, p.4
Our system is upside down…we start with a pretty intensive attempt in first year to listen to the patient…by the time you are ready to into practice, it's been 4 to 8 years that you ever actually last took time to think through the contextual issues and determinants of health…	11. …**our system is almost upside down**. So, **we start with a pretty intensive attempt in first year to listen to the patient in DPAS** and everything else. And **the further you go through medical school**, particularly, but I have sense to some extent in Nursing and Dentistry, anyways, **the more you get away from that. So, by the time you are ready to go into practice, it's been four to eight years that you ever actually last took time to think through the contextual issues and the determinants of health**… CVHEdU21, p.10 12. the need for a patient advocate and the lack of really coordination, as people become very ill in the health system…These are very expensive and complex things, and individual practitioners have to function with nor rules of their area. So they have to checks and balances but I am saying that the system does not integrate well… CVHEdU18, p.1-2

Understand patients' lived experience*	1. …**when our self-directed project students and our community service learning students as well go out into the community to do their work, and maybe to a certain extent when the other students in the discussion group students do their assessments of community needs, they are confronted with certain realities that they could probably be protected from certainly in the first two years of the undergraduate curriculum.** In DPAS you will know we have, and I think they still do this to a certain extent, we used to do it a great deal, **we'd have people come in representing various community interests or various health conditions and they would speak to the whole class or we'd have, and still a lot come in and go in to the small group tutorials and talk and that's good, that's nice exposure but it's, it gives the students a kind of home court advantage** and I'm not sure that while those are extremely valuable, I always liked them very very much, they're often very moving emotionally, **they don't take the place of getting out into the places where people live.** …**So the health professional who works primarily out of an office, or perhaps even out of a hospital, sees certain things day and day out and that's how they think the world works. …But they learn things in a particularly unusual environment and the world that they think exists because of their clinical experience is really not the world that exists once that patient walks out the door**… CVHEdU01,p.1-2
"home court advantage"	
	2. But really **making students much more aware of what a patient who has a particular disease state and has to live with** or a particular condition, sensitizing them to that, **developing those attributes and empathy, understanding, appreciating what that individual goes through**… CVEHdU06,p.1
	3. …**helping students understand what it's like to be sick and what it's like to interact with the health care system** and for a fair proportion of our students I think that happens already through their personal lives or a family member themselves and that's why they became interested in medicine. …just a quick story about one time we were running a seminar about a patient who was trying to make some lifestyle changes and **one of the medical students in the group said, 'at what time do you fire the patient for not listening** to what you're telling them to do?' And another student said, 'excuse me, have you ever tried to make any change in your life?' This is not a, and so clearly there was a, I wouldn't call it a skism, but there are different points of view in the class and clearly some people don't have an appreciation for the real challenges that some folks have. CVHEdU08,p.1-2
…we're still dominated by the scientific knowledge agenda and the concept of the physician as scientist first and foremost…	4. …**we're still dominated by the scientific knowledge agenda and the concept of the physician as a scientist first and foremost** and that's not a belief I've ever actually held because I think the ability to be empathetic and to understand and to adapt one's behaviors in that way is actually fundamental to being a physician. And so is there something we can do and I think **it comes from giving students experiences with patients but not as patients but with as people.** Is there something we can do to help students understand the need to be able to connect with people in all sorts of different ways to understand their life stories and to develop that empathy. CVHEdU10,p.2
Empathy	
…it comes from giving students experiences with patients, but not as patients, but as people.	5. …**students learn about the disorders from the perspective of practitioners** but also **they don't learn the perspectives from the people who are living with them and yet, somehow, when we are involved with people who are, just because we work with people who are fine but suddenly they have a disorder, professionals are expected to have some understanding what the future is gonna be like for those people**, learn how they possibly can, if they haven't really learned from perspective of those… CVHEdU14, p.1

Pre-admission volunteer work *a surrogate for understanding social determinants of health*	6. …**realizing that everybody is gonna be different and they or any experience of someone before them does not necessarily help them understand of this person** but at least, it gives them …. It reminds them that there is a different perspective, and that would help people see just beyond that little piece of involvement … to have a longer view and a **broader perspective**. CVHEdU14, p.1-2 7. It's easy for experts to assume that if the rationale for the decision is obvious and people will agree and yet it's almost never about logic. People are social animals, and intelligent social animals, nevertheless, do things for reasons that kind of have a deep cultural basis, experience basis … and I think that's missing too. I think we're treating too much of medicine as a logical problem with a logical solution. CVHEdU19, p. 2-3. 8. …it think what really changes students and their approach and their relationship with indigenous peoples is to really be **able to contextualize** it, to see where the life is and to experience from people's own mouths what's happening, so I think that's a missing component. They all have to do a rural rotation **but it's in the context of health professional worldview** which has nothing to do with a patient's or community's perspective, or on health. So I think that's the biggest thing that is missing in the medical school, in the curriculum. CVHEdU13, p. 2 9. And **we really don't get the context** in which they are coming forward with their presenting signs, symptoms, and disease. I think educationally, as a surrogate, we've kind of wondered a little bit. **So now, we expect all the medical student applicants to be doing two years of volunteer work in Africa, having built water treatment plans, and so… to me, what we really want, we are using that as a surrogate for understanding the social determinants of health but we think that by doing that, they'll get the context of disease. So then, we bring them in day one. We can't just teach them about the anatomy, the physiology, the surgery, and this and that, and so on, and we don't have to worry about the rest because they've all volunteered in Africa, so they got the piece.** Yet, it isn't, that isn't sufficient. …I'm on a bit of scanner lately that **this whole intersect between patient and ambulatory care has had such a gap today that people fall into a large abyss right there, but most of the issues are actually post-discharges that we need to be understanding and looking at much more directly** …and **we do it anecdotally, we sort of have them follow one family or they follow one week** …**And we think that they're gonna extrapolate that to their entire practice, but it's not embedded.** CVHEdU21, p.1-2 10. …**we don't see the person**, **systematically or culturally**, there is clearly a problem. I mean we've all grown of in the culture of "what do you know about congestive heart failure?", well, ok "what do you know about the person with congestive heart failure?", we never say that. We say "what do you know about congestive heart failure?" so **there is kind of that macro level culture that affects everybody and I don't blame learners** probably for this, worse at the other end of the spectrum. …It's what are the people with these issues and how do we sort of present that? I think **we are starting to see the curriculum framed much more about the person with this issue, as opposed to this issue**. CVHEdU21, p.4
Reflection Examine stereotypes Don't assume	1. …**to get more students to embrace the notion of reflection** and not to view it cynically. …**do we need to find better and more varied ways of having them reflect**… CVHEdU01,p.2 2. …**re-examine their stereotypes**… CVHEdU01,p.3 3. …understanding what the patients want and that you can't just, **you can't just make assumptions** about their level of knowledge or their hunger for knowledge about their health is important. I think that's been a big paradigm shift. CVHEdU02,p.3

	4. We don't talk to them and my experience has been, including medical students that most students, because they're there because they care, are very willing, but if we don't do it near the beginning and they get acculturated into certain ways of doing and thinking that is much more difficult in my experience has been to do. CVHEdU12,p.10
Avoid reifying stereotypes	5. …**the service learning experience didn't actually shake up their perceptions and their stereotypes. It actually reified in what they believed because we weren't there to kind of have the conversations with them and debrief** with them and ask questions like, "why do you think you came in to the afterschool program like that?" , "why do you think that was the concern for him?", "why do you think he might have that behavior, she might have that kind of behavior?". …**it's actually quite easy to make service learning relationships and relationships with community organizations really poorly.** CVHEdU15, p.5
Counter deficit views	6. …**actually spending a lot of time with people who have different experiences, who have different illnesses, who have different ways of being in the world and learning from them** so that …**so that we can kind of challenge those stereotypes and biases and deficit views and I think that would only improve things.** CVHEdU15, p. 7-8
Self-awareness, see themselves as part of the problem and solution	7. **when it comes to the structural inequities that exist in society**, … **health care providers don't necessarily see themselves as part of the solution and they don't necessarily see themselves as part of the problem**. … I believe that awareness building around that will actually create change and that will mean breaking down the silos where most physicians don't know indigenous patients as people and human beings with challenges rather than the pathologized person that they have to try to save. So I think it's **changing a worldview** and I think **once you've that worldview changed, I don't think that you can practice in the same way. Or you will have to figure out how to bring that with you, but I don't think students have enough of that experience to be able to**. They are so indoctrinated that they don't have enough of experience to deal with them. CVHEdU13, p. 2
Non-clinical / Non-acute care work / work in community / community-based learning	1. …**we've got a very strong acute care centered focus** and I know that our nursing students as novices that's what they're insecure about, they want to know how to take blood pressures and start IV's and do all those hands-on skills. …**we aren't doing as good a job with leadership succession and nurses on advanced practice, understanding what their role both in hospital, in primary care centers and in the community looks like.** CVHEdU04,p.1
	2. Most of my experience in my training have been through clinical placements and that's where you see the real live patient or client. …So I certainly in this area in particular think that there is a lot that we can do to strengthen these relationships that **go beyond the clinical placement experiences** where students do get to work in a variety of settings where they see real clients or real patients. CVHEdU11,p.1
community-based learning transformative	3. …**where they learn the most about themselves bet they say it's community based learning sites.** …but my notion is that **those learning experiences are transformative for people.** CVHEdU12,p.14
Awareness of their power	4. I've had a chance to talk to many students who participate in the clinic, and everyone whom I talked to, said that **this was the most important part of their legal education**, that for the rest they say, of course it was great to interact with professors, great to interact with students, interact with adjuncts, but **they said this part of knowledge of what their power as a lawyer might be and their value as a lawyer might be, how they need to be careful as they engage with law in the practical sense.** And **a lot of awareness of things that they had not considered, came through this experience**… CVHEdU20, p. 1
Leadership	1. **True leadership, not just, the traditional kind of leadership**. CVHEdUPilot,p.4
	2. **I know we do give them leadership, I know it's in there and it's melded through but it's very different when you're in a student role and not really able to enact it when you're living on the unit and you're all of a sudden made manager and you've got budgets and you've have resources and you have other people to report to.** CVHEdU04,p.9

Selected differently (Admissions) Students from privilege Increase diversity	1. **So attracting the right people to come in to really be sensitive to providing health care as a specialized individual but also contributing to the overall health care team and what special skills can you bring but in a much more holistic view how can you contribute to the overall being of that individual.** CVHEdU06,p.3 2. The folks that apply to medical school are from a higher, my understanding is they're from a higher socioeconomic status. How they don't reflect society is they aren't from rural settings as much as the general population, or they don't represent rural settings as much in the general population and they're from a higher socioeconomic status. CVHEdU08,p.1
CQI	1. The other big, I think, gap in our curricula are, is around quality improvement. We talk about it and yeah, people do chart audits or what have you but again, **the notion of really making CQI as just a fundamental way of doing business and how do we not only teach our students the principals of it, but how do we actually demonstrate to them in practice the critical nature of quality improvement, and then how do they do that in an interprofessional way….** CVHEdUPilot,p.4
Identity development & knowledge construction *…let's talk about values here.* *…professionals wouldn't be able to see the patients as entities without identities and values.* Humanize the profession	1. When I think about learning, **I don't think learning is just acquiring knowledge or memorizing bits of information. I think about learning as something that absolutely has something to do with the construction of knowledge and with coming to know. But I also think learning has something to do with who we are and being a certain kind of person and becoming a certain kind of person. So I think learning has connection to identity, so that's key.** And then I don't.., I wouldn't stop there. I would add a third component. I would argue that learning has something to do with **what we value and how we value things**. …**I think coming to know and constructing knowledge is more than that but there is also the side of the identity work that needs to take place and also conversations around values** which I think historically, North America, and I mean in other places as well, but certainly **it's a difficult thing to say "let's talk about values here". But I think that's a huge part of it.** …I think it would make a huge difference to health care because **professionals wouldn't be able to see the patients as entities without identities and values. And that would spring from the fact that they know… that they themselves, that their own identities matter and that their own values matter.** So, I think it would be one of the things that could help us… I mean we often talk about **humanizing the profession**. CVHEd-U-15, p. 2-3

2. Examples of patient / community involvement at UBC (Interview Question 3)

The most commonly reported ways in which patients / community members are involved in the education of health professional students at UBC included guest appearances by patients who are invited into the classroom to tell their story, volunteer and standardized patients (lay people who play the role of patients) involved in clinical skills training, and interactions with patients through clinical placements. Nursing, medicine, occupational therapy and the faculty of education reported having patients / community members involved in advisory roles, usually for the purpose of informing curriculum changes. These advisory roles were described as occurring "from time to time" and in an "ad hoc" way with a wide range of participants from the community that have included patients, clinicians, representatives from community organizations, school boards, health authorities, and employees of government agencies (e.g. Work Safe BC, ICBC). Nursing, medicine and OT reported having patients / community involved in the selection of students for admission. The 'Interprofessional Health Mentors' program and 'Allies in Health Fair' were noted exemplars of patient / community involvement at UBC. With the exception of the standardized and volunteer patient programs, most patient involvement at UBC could be characterized as small scale, episodic and largely dependent upon the efforts of committed individuals to make them happen.

Table 2. Examples of patient / community involvement in education at UBC

Type	Program / topic	Teachers	Students	Quotation
Guest Speakers / Lecturers	Patients tell their story	Patients	Health professional students medicine	1. I think **all of the programs at some point will bring a patient or a client into the classroom to tell a story**… CVHEdUPilot,p.1-2 2. …**sometimes physicians will bring patients in but not in an organized way**… CVHEdU08,p.2
	DPAS	Mental health & addictions patients Adolescents Indigenous community members People with serious illness using alternative medicine	Medical students	3. …**people who are living with mental health issues have come into class**… CVHEdU01,p.3 4. we had kids come in and talk about adolescent health, so anywhere between the ages of 12 and 18, a pediatrician by the name of [Name] would bring some of the people he was working with and they would tell stories that would make people laugh and cry and really give the students insights into, not just adolescent worlds but adolescent worlds in terms of the way they think about their health …CVHEdU01,p.3 5. Certainly we have lectures with community people that tell their lived experience and try to share some of that with students. CVHEdU13, p. 3 6. We've also had panels of people who are dealing with serious illness and have turned to complimentary and alternative therapies to help them deal with that illness. And they talked about why they did that. CVHEdU01,p.3
	Sexual Orientation	Community members Gay Day DES transgender	Medical students	7. …when we're teaching sexual orientation, the people in the community call it Gay Day …and I was actually quite pleased and appreciated that curriculum leaders were creating this day or a few days where we talked about sexual existence in it's different forms and **yet people in the community saw it was Gay Day, it was a day you poked and prodded at people that were a little bit different. And so it's interesting that something that was meant to be quite proactive and positive isn't seen that way by everyone.** CVHEdU02,p.4 8. …again in downtown eastside a patient that we bring in … eventually, some student will get bold enough and ask, this is in a lecture format so there's half the class so whatever 128 of them, and they start asking questions about your past medical history and do you have sex with men and do you have sex with women and do you do drugs and he/she is really quite generous in the comments that they give and they're very open… CVHEdU02,p.4
	OT		OT	9. …individuals who are involved as guest lecturers if you'd like to call them that, not teaching a whole course but coming in to an organized course to deliver specific content… CVHEdU03,p.3 10. …pretty much like we have consumers coming to almost each and every of our subjects now. I think the only one that we might not really have, like fully clients involvement would be kind of like our research methodology class. CVEHdU07,p.3
		Arthritis patients from Arthritis Society	OT	11. OT often have individuals come into… who are patient partners come in to provide education, like "this is my experience, this is how you can assess me better. This is how you can help me meet my goals." I know that there is a course that [Name] and [Name] are trying to put together from a methodology largely on a patient-partner model through the Arthritis Society. CVHEdU17, p. 2

		Sex trade, adolescents, gay/lesbian, Aboriginal	Nursing	12. I know that a lot of our faculty bring in guest speakers, and especially with the research that faculty are doing in some delicate areas, the sex trade and teenage issues and the gay and lesbian issues, the Aboriginal population especially related to domestic violence… CVHEdU04,p.2
	Pharmacy	People with Epilepsy	Pharmacy students	13. …they bring in a patient with epilepsy. And they may have a video clip that they show…so that they see first hand what a person experiences when they're going through a seizure. CVHEdU06,p.2
	Speech & Audiology	patients	Audiology students	14. …involving people into the class and talk about some aspect of living with whatever condition that we maybe talking about. CVHEdU14, p.2
SP's standardized patients	Standardized patient program	Lay people playing the role of patients	Faculty of Medicine Medicine, OT, PT, SPL	1. …the **standardized patient program**. Now these are **lay people who play the role of patients**, but they're playing a role. CVHEdUPilot,p.1 2. I don't know if we can count the standardized patient but I participated in in January, February with the medical students, we had Speech and PT and OT there… CVHEdU04,p.2 3. They are involved in some of our assessment procedures. They help out being as the standardized patient. They're involved in some of the role plays as well. They are also involved in giving feedback to students. …and say this is good, this is not good, I mean this is how I feel as a consumer sitting in here, and these are the language that we don't quite appreciate. So kind of like involving them in doing that kind of evaluations. CVEHdU07,p.3 4. I guess there's standardized patients but I don't know if those are frustrated actors or if they're, how representative they are of the broader kind of societal spectrum. CVHEdU08,p.2
			PT	5. my colleague [Name] has tried to access the, I think there's a pool of patient partners that, or community organizations that they're having established partnerships or relationships with and my understanding is that we have not had much success in accessing that pool as a resource for our program. So for the most part we either have like volunteer models who are healthy individuals who maybe are trained to act as a, like a, they have a condition or an injury or whatever… CVHEdU11,p.2
			PT	6. …in another medical school, we had members of the trans community upper right cases, members of the gay and lesbian bi-sexual community write cases. Certainly in that environment we had a large learning resource center where we did the typical, had simulated patients and so on working with students. …and in that environment we had, and people were paid of course, but we had simulated patients that were widely representative of cultural diversity but also always historically marginalized communities working there. CVHEdU12,p.4 7. And, standardized patients I know that it … Physiotherapy group uses folks that ,…, to provide for their OSCEs. But I think they are the only group under my portfolio that uses standardized patients; Midwifery may… but I'm not that familiar with their program. CVHEdU17, p. 5.

				8. ….we've got more standardized patients and that kind of thing which help a little bit to have indigenous actors that are actually playing themselves or their relatives in certain situations. …I know that with the standardized patients we have created and we are working on some OSCEs nationally. There is a whole bunch of indigenous educators that is the Indigenous working group. And we also with each other share resources and evaluate and create OSCEs. CVHEdU13, p. 2-3
	Communication, ethics, professionalism		Dental students	9. We have standardized patients that help them with their communications skills, give examples of ethics and professionalism issues… CVHEdU09,p.3
Volunteer Patient interviews / Home interviews	DPAS	Volunteer patients	Medical students	1. …going out and interviewing [patients] either in their own home or… CVHEdU01,p.4 2. …volunteer patients where they are either interviewed or that they're examined. …**The very motivated facilitator faculty member in the room might ask the patient who's there, how did you feel and were you comfortable in the wording of the questions, did they, were they off putting in any way.** CVHEdU02,p.5 3. …the DPAS Disability Home Interview… CVHEdU08,p.3
Volunteer patient exams	Intimate	Clinical teaching associates	Medical students	4. …we have the clinical associates and I think they're really important as well around the intimate exams… CVHEdU08,p.6
	OT (e.g. patient transfers)	Patients	OT students	5. …they're certainly involved in clinical settings so we do clinic visits where volunteer patients agree to teach a student something or have a student practice them so the people will volunteer at Purdy Pavilion when students are learning how to do patient transfers. CVHEdU03,p.7
	PT	Patients	PT students	6. …we have our own clinicians contacting clients or people they've worked with to come in and be patient models… CVHEdU11,p.2 7. …in year one, the very first term, students practice interviewing in groups because of our class size with patient partners that come in. CVHEdU16,p.1
	Patient Partners	Trained Arthritis Patients	OT	8. …we have had patient partners at various times but the patient partners program we're using is no longer funded so they, and that one comes with a bit more of an expectation from the patients to be a teacher because that, it has a specific training program attached… CVHEdU03,p.7
	Pharmacy	People with chronic conditions (typically seniors)	Pharmacy students (Directed Studies course)	9. We also have a group of students who have looked at patients with arthritis and what it's like to live day to day with arthritis, how difficult it can be to manage things even as simple as dressing yourself or making a meal or just the day to day routine things. …a **directed studies course** where students, a small group of students were assigned to a patient with a particular chronic disease state, so arthritis could be one, diabetes another, asthma another. And they went out to these individuals' homes and actually **interviewed them in their homes and spent time with them over a term really seeing how they managed their life** … CVHEdU06,p.2

Clinical placements	Clinical years – encounters with patients	Preceptors (health professionals)	Medical students	1. …in the clinical years … and they don't probably have much choice in this is that they are used I guess for teaching when students are treating them as inpatients or outpatients so it's where we're going to where the teaching environment is the bed, the hospital bed, or it's an outpatient clinic and so the students are are exposed to patients who from whom they're learning. CVHEdU02,p.5
			Nursing	2. …that last term they are matched one on one with a nurse in a unit in a site where they're doing all the work there. Some of those sites have been community members and then for the graduate students they have preceptors and a practicum type experience at the end, whether it's education, leadership or scholarship research aspect, they have members. And I say community, they're health professionals in the community but that means that they're usually embedded in a population where they're getting that experience. CVHEdU04,p.2
			Medicine	3. In the clinical setting it's gonna be dependent on what the orientation of the clinician that's teaching them. So it may be very much a biomedical model or it may be bio psychosocial model that the clinician takes and I know in family practice we have quite a mixed bag. We have some people that are taking students to single rooming occupancy suites in the downtown eastside and the students don't want to go cause they say we're not getting any physical exam. And we have a lot of docs that are just sort of moving patients through their practice and not that concerned with the broader kind of determinants of health and stuff. CVHEdU08,p.3
	Clinic / hospital placements / long-term care facilities		Dental students	4. we have a clinic that patients come here and they're treated. … in their last years they're in the hospital working with medically complex patients and in the long-term care facilities working with frail elders and looking at the problems of dementia and institutional care delivery. CVHEdU09,p.3
	PT	Patients in clinic	PT students	5. …through clinical placements there is obviously a lot of patient involvement there. CVHEdU16,p.1
Advisory Boards / panels / committees	Advisory panels on curriculum change		Medicine	1. …the one or two advisory panels that we've had, you have the levels, the advisory panels that we've had where **I think they've given advice on parts of curriculum, parts of courses that needed to adjust or change.** Having said that I don't think we've had patient groups ever write a course or write chunks of a course even. I think they've probably given them some feedback at times but not at a sort of high level like that. CVHEdU02,p.5
	competencies			2. …I have communities that are creating the UBC competencies with community input so they are part of the committee that creates that and the curriculum that we ultimately created also was from their recommendations... CVHEdU13, p. 3
	F. of Education	School Board reps		3. …**the Faculty of Education has an advisory board on their education program and the usual characters are there, like the Superintendent of the Vancouver School Board and a few others** will be there arguably and, I don't know if they are, but arguably you want around that table parents, students…. CVHEdU02,p.16

Adhoc	OT	Patients, reps of WorkSafe BC, ICBC, BC Rehab Society, BC Coalition of People with Disabilities	OT	4. …**from time to time we have clients, individual clients, who serve in an advisory capacity**, **either on an Adhoc committee or when we actually maintain an advisory committee which we're not very good at, it kind of waxes and wanes when we need more advice.** …And then we have other kind of **consumer representatives that are more corporate** and so they're emphasizing or more interested in maybe the community needs so that's where somebody from **WorkSafe BC** or **ICBC** or something so they're from usually the rehab department or claims department or something so **they have this societal or community interest in mind that they know occupational therapists could help fulfill but the individual who's coming as an employee of that corporation and it's integrated into their work and we just approach the corporation and say is there someone who would be interested in doing this.** So it's a consumer perspective but it's more, it's actually all the ones I can think of are probably more like a **third party payer perspective** in terms of the community that they're representing. And then on occasion we've had, maybe it's more of a liaison so somebody from like **BC Rehab Society** or so they're not necessarily again the person living with a disability or a health condition but they're engaged with an organization that has a similar goal and we're looking at whether there's a partnership opportunity, but other organizations would be like the **BC Coalition for people with disabilities** so they usually, **sometimes it's their executive director who doesn't necessarily have a disability who's connected with us, but more often than not it's somebody who has an illness or a disability who's also representing the organization so they can give both the kind of a first person account as well as an organizational account.** CVHEdU03,p.3-4 5. **We have consumers sitting in our advisory committees advising the delivery and the development of our curriculum.** …**also advising kind of the development as well as the direction of the department.** CVHEdU07,p.3
	Nursing	health authorities, clinicians, consumers		6. …last year **we set up a community advisory committee for our undergraduate** program and …And **what I like to see and I think we are as we're moving to more curriculum re-design within our own program to involve more and more community people in that.** … we were able through Vancouver Coastal Health get in touch with a consumer group that they use. …we have two people coming from an organization that represent consumers… CVHEdU05,p.3
Mentorship	Health Mentors program	People with chronic conditions	Health professional students OT Nursing	1. The Health Mentors Program that you know so well is in my mind **one of the most robust examples of really having patients who are clearly themselves, but with a more formalized role with some training.** CVHEdUPilot,p.1 2. …with the health mentors program. So there's opportunities for students in smaller groups or one on one to individually meet with people who are living with a chronic illness… CVHEdU03,p.3 3. **The other big component for School of Nursing is the Health Mentor Program and I know that probably about half of our students I believe, 50 or 60, participate in that program**… CVHEdU04,p.2

			PT	4. …our students have an opportunity to take part in the Health Mentors Program. It's unfortunate that you have restrictions on numbers because **it is something that we would probably consider being a mandatory requirement like occupational therapy** if you had the capacity. CVHEdU11,p.2
	Peer mentoring	Spinal Cord BC	Speech Language pathology students	5. I reflect on Spinal Cord Injury which is familiar to me. I mean largely they are peer program. Peer mentoring program is used to facilitate learning for our students. CVHEdU17, p.3
	Aphasia Mentoring project	People with Aphasia	Audiology and speech sciences	6. most recently I have started this program with people with aphasia …they meet once a week and students are involved in their activities with them and some of those activities include very explicitly giving presentations to students about living with a disorder. Just chatting with the students, having students work alongside them, doing sort of everyday kind of activities… CVHEdU14,p.2
Admissions	MMI	Lay community members Firefighter, flight attendant	Medicine	1. And patients involved in institutional decision making, student selection reviewing and funding applications, I sat on the MMI question writing committee this year for the first time. …half of the people who sit on that group are community members, …we had a firefighter, we had a flight attendant… CVHEdU01,p.5-6
	OT		OT	2. …we've had people engaged in as an interviewer for admissions from time to time. CVHEdU03,p.4
	Nursing	consumers	Nursing	3. …we involve our community in our admissions processes… CVHEdU05,p.3-4
Video Recordings	OT			1. …sometimes people don't like repeating their stories so we've often recorded a story so we'll use recordings as well. CVHEdU03,p.5
	Pharmacy	Epilepsy	Pharmacy students	2. And they may have a video clip that they show or two or three of those to the students beforehand [guest lecture] just so that they see first hand what a person experiences when they're going through a seizure. CVHEdU06,p.2
Community placements / fieldwork	Strong Start	Families	Nursing students	1. One is a program with young families and there we are saying to the families 'how is this working for you having students here?' …I'm very excited about the **Strong Start** program. …we're using it both pediatric placement and our community placement with different objectives, learning objectives with each one, involving public health nursing and others. CVHEdU05,p.14
	CSL Needs assessment		Dental students	2. we have tremendous involvement of patients at all sorts of levels in our curriculum so the students in the first year in the community sort of doing some assessments of needs, assessments trying to look at the social determinants of health to get some expression and then **they're in the community all four years with community service learning** aspects like that. CVHEdU09,p.3
	PT / OT / Midwifery			3. Midwifery does really a great job …with getting out there and being with people that they serve. I think that is largely integrated within what they call their field work. …In PT and OT, have exposure to fieldwork placements. CVHEdU17, p. 2
	One-credit required course (10 hours)	First Nations people, Clinical educators	Audiology and speech sciences	4. That's a course which is just a one-credit course and the student is required to have…I think 10 hours of community involvement with First Nations people at some point in their … over the course of the year. CVHEdU14, p.10

	Elective course	Aboriginal communities Community assesses students	Mixed students	5. …the [IHHS] 408 course that we have has huge impact, because it's taught by community, it's been evaluated and assessed by community members … it changes people's lives. We are trying to bring students to reserves now as part of the curriculum. … We have in elective courses that actually the community has not only created the curriculum which I don't have any control of it. **We created the objectives together but the curriculum varies by community. And we also created the assessment and evaluation tool to get around cultural safety and the community is the one that assesses and evaluates the students, so they are the ones that ultimately have control of it at the final grade.** … **So they [community] are the ones that assess the students and their ability to make relationships.** CVHEdU13, p. 2-3
Special events / info fairs	Allies in Health Fair	Community organizations and patients	Health professional students OT	1. there's the fair that you put on every year where you really have the organizations that are brought in on a much more formal basis… CVHEdUPilot,p.2 2. I think that **when our students go around the community health fair booths, they probably learn more than they can manage in an afternoon of doing that. Each booth is so rich**. CVHEdU01,p.4 3. then things that might be a little bit more elective like the patient voices symposium, although we make it required for our students… CVHEdU03,p.3
Written cases	Medicine	Clinicians Indigenous communities & actors	Medical students	1. All the cases are written by clinicians sometimes with a patient in mind that they're using as an archetype for that particular problem. But I don't, **I'm not aware of any real kind of systematic way that patients, that the patient perspective is brought into a student's medical education. I think it happens if it does haphazardly.** CVHEdU08,p.2 2. …community stories inform any of the cases that are created. And community actors participate in the creation of the cases. CVHEdU13, p. 3 3. …we have an educator position who works under my portfolio, and he is working with the Aboriginal communities right now to pull in more of their experience and their knowledge of health provision within their own communities. So he is really giving them a voice and **they are creating cases and all he is doing is shaping them.** CVHEdU17,p.4.
	PT & OT	Paper cases	PT & OT students	4. **Most programs have an element of case study**… CVHEdU17, p. 2
	Speech Language Pathology	Virtual patients	SLP students	5. Speech Language Pathology also does…I mean they have their patient interaction components as well. There are virtual patient cases. CVHEdU17, p. 2
Community-based research				1. …many Faculty here are involved in community projects, research projects, and they bring those projects …also bringing undergrad students and graduate students into your research so that you have the two way thing happening, one informing the other. …I'm very fortunate to work with a fabulous group of Faculty who are very engaged in community-based research and I think community-based research has a real potential for informing curriculum… CVHEdU05,p.4 2. when I put my research on with all of the Café Scientifiques and there is collaborative health research program initiative with CIHR and NSERC where having end users as a critical, an essential piece to the research that we're actually engaging those organizations more on the research side than we are on the education side. CVHEdU16, p.3

3. **What role could patients / community play at UBC?** (Interview Question 4)

University key informants felt that patients / community could play important roles in helping students learn about patients' lived experiences, advocacy, culture and community needs. Involving patients was seen as a good way to develop patient-centred values and "bridge" theory and practice, while making learning enjoyable and meaningful for students.

Table 3. Main themes for roles patients / community could play at UBC

Understanding lived experience*	1. **Their expertise is more in the realities of their lives** and the lives of the people they serve, their expertise is in what practitioners should know and be aware of and think and feel in order to be better practitioners for that constituency and that's hugely valuable expertise. CVHEdU01,p.5
They're the ultimate examiners …the problem is nobody collects their score cards.	2. …**they have the lived experience** so they have the lived experience of having been unwell, of having had to make a decision to go see a health care provider, and then having to share their story and be examined in some way. …**they're the end users of all that we've taught or not taught. And so to hear it from them I think adds, I think it would add importance, I think it would add gravity.** …**they bring a lot of power actually because it's the real thing, it's what we're all preparing for is to do that and it's kind of like the ultimate test** …**they're the ultimate examiners**. That's probably the best way to look at it. **Now, the problem is nobody collects their score cards**. CVHEdU02,p.8
	3. …parents who **don't fit the norm**, the two dads type scenario and/or the ethnic groups or the family that's living on barely anything on the downtown eastside and what, how do teachers treat their kids. They just assumed they came to school with their tummies full and maybe the child was not successful because their stomach's growling. But I think we, we're too detached to hear those and I think it's only the community members that can bring that. CVHEdU02,p.16
	4. I guess the lived experience, the actual experience of living with a health condition or having been through a particular experience …that **first person account** and so that's unique because we can talk about it as much or assigned readings and or movies so we do a range of different things to help students appreciate different perspectives, but there's nothing quite as powerful as that person coming in…. CVHEdU03,p.4
	5. I think **their experience with their own health and disease processes, how they've tried to maintain wellness in the event of chronic disease**… CVHEdU04,p.3
Health Mentors	6. Well **it's the lived experience perspective for sure**. So I will give a wonderful example because one of our great colleagues in the university introduced us to **the Health Mentors Project. I would say that's a very good example because that project brings the student to the expert in their own health, the consumer.** …The other thing is that the consumer brings forward, brings right to the face of it, the challenges as well as the opportunities and I think it's at that interface that the learner then has an opportunity to actually learn **what navigating a system means for a consumer and what their role might be in supporting, navigation, negotiation, what kind of communication is helpful, isn't helpful, etc.** So I think **the consumer really brings that everyday reality to the learner**, but the learner also brings the reality and the challenges of the bringing practice theory and practice together. CVHEdU05,p.4-5
Navigating the system, communication	7. They actually see the environment in which these individuals live and work and there's this wow factor for lack of a better word that they really opens their eyes in terms of this is not, this would not be easy to handle and putting it right into the real context in which these people live on a day to day basis. …**That real life experience, this is what it's like to live with this type of condition.** This is how I have to try to best manage. CVHEdU06,p.2-3

	8. Real life experience that you're adding. **The lay public adds so much value in terms of reality cause so much of the university still is a classroom based learning approach where you have people just lecturing and you talk about concepts and theories**, but bringing actual individuals in, they could be engineers who are out in practice who now have a chronic disease state, but they have a knowledge base as a professional potentially… CVHEdU15, p. 3-4.
	9. …we teach a lot of skills, we teach a lot of knowledge, but try to help students to really be **able to see things a little bit differently**. I think that that's part of the very important role of education, **having consumers to come and help to bring the context to the class actually would make a big difference** as well. CVHEdU07,p.5
Cases vetted by patients	10. I don't have a lot of experience with patients getting involved in things like case writing or content sort of like curriculum development cause I don't have a lot of experience there and I don't know how that would work, but one could imagine that even **with the small group cases some of them could be vetted by patients** and they could say well why don't you do this or why don't you do that or this happened to me. CVHEdU08,p.3
Barriers to health care access	11. …it's their experiences and life stories. So if you're, if you take for example the work that's been done with the clinical teaching associates where students are taught intimate examinations with volunteers that process. They're learning a very direct skill from a patient but they're also learning from the person in the room what it's like to experience that and I think that's one of the critical pieces. I think what our students are not aware of are some of the health care life stories that patients can bring to them so, for example, the frustrations of patients when you look at a cancer patient for example and **we teach them about the origins of disease and the treatment of disease and all that stuff and we get the students and the residents then get into that kind of mind set of making diagnosis, here's the problem, off you go.** …So how do we bring the human experience of illness into the student's mind? To me that would be important because I think **understanding and empathy comes not from the scientific knowledge, but understanding the experience the patient's going through.** CVHEdU10,p.3
…understanding and empathy comes not from the scientific knowledge, but understanding the experience the patient's going through.	12. … it's their experience of either their disability or their chronic condition, or their situation. If one looks at the complexity of individual lives and the variability within individual lives. Just because I have disease X, doesn't mean that my situation is gonna be exactly like this other individual may have the same disease, but not the same social support. So provide a full picture of what it's like to experience and live with condition. CVHEdU17, p. 2
Health care experiences	13. the kinds of contributions that they could make could be sharing their own experiences, **sharing their own experiences of amazing health care stories**, and the one doctor that was able to solve the problem or the one nurse in the hospital… I remember nurses just like totally transformed an experience for me, or more difficult times... So that they actually give feedback about their own experience with the profession. But they can also give feedback and share experiences with certain differences, illnesses, or diseases. And I think that's crucial information. It brings in **issues like quality of life.** CVHEdU15, p. 3-4.
	14. **the patients provide that real life examples that our students need to experience.** And so, it's one thing to know the theory behind it and they get that in the classroom environment or in their readings, it's another thing, to experience simulation that can allow you to work through scenarios that you may not see in real life because they are rare or they're … it's a quite dangerous situation. But, but **to deal with an individual person in a real life setting then brings all the circumstances that that individual brings to the table and that complexity of dealing with peo**ple, and people who … you have talked about marginalized communities. So, they may have a whole series of issues that are result of their lives. They live much more complex situations because you are looking at a set of symptoms but they are all interconnected with a person. And because health is about building a healthier population, it's about the interplay between everything. And so you can't just isolate your own little piece of it and **you have to, at some point, have that experience in order to be able to do what you do and become a health care professional.** CVHEdU18, p. 3

Insider perspective	15. let me use the interview class as an example. I mean **they could practice interviewing with each other but it's not the same as actually interviewing with somebody with a real chronic disease.** And then we do get feedback from the patient partners in terms of how they felt during that interview. Sometimes, it's extremely positive. And on the odd occasion actually it's not. And the patient didn't actually felt listened to. They felt students are going through a checklist and writing down the response but not actually going off script and actually probing and getting a sense that they are really in a dialogue. And **you would never get that feedback from a simulation practicing with each other** so that kind of feedback is huge. CVHEdU16,p.2 16. … maybe we get a little more deeper at their interaction with the health care system today. So, it would provide insight as to how they truly interact with health professionals in good ways and in bad ways. Whether… I mean we all talk about interprofessionalism and teams and whether that actually happens. So, **it's that insider's perspective**. I think they can give a greater insight of symptomology… CVHEdU17, p. 2-3
Advocacy* Advocacy for	1. …community engagement, understanding and **advocacy**, working, **being able to advocate for communities**, that cannot be done in solo. CVHEdUPilot,p.4 2. Their [community organizations] commitment is beyond belief, it's highly intrinsic, it's highly admirable, and it's driven. And I think our students would benefit considerably by just being around people with that kind of drive. …So that's the organizational piece and there's modeling there and there's all kinds of, it's not just information. CVHEdU01,p.4 3. The other piece is that outside of living with a chronic illness or having recovered from an accident or whatever, people come with their own sets of skills and contributions and so often they've got some other life experience or skill set that adds to or supplements that story that they're telling. So I've worked with one gentleman who was a foreign diplomat, so he's so articulate and people forget that this person who has a chronic illness is not just the illness, they actually had a life and did all these other things and were in high, so you can ask different kinds of questions like okay well you've worked with all these political powerful people, **how would we lobby for this kind of a change**… CVHEdU03,p.5 4. …we have a young man who grew up with juvenile arthritis …he and his mom come and his mom formerly was a nurse and so they are these two really articulate people who just kind of, so he tells his life story and she interjects with things that the family had to consider along the way and they are pretty exceptional and students will never meet clients like that. It's kind of a one in a million kind of group, but they let you know that. …they established a foundation, a Children's Arthritis Foundation, and among the things that their foundation does is they will buy a pair of shoes for any kid with arthritis who doesn't have the means to buy shoes cause that was just one of the things that they found so important. And so they mix together philanthropy {Chuckle} and lived experience and exceptional teaching kind of skills so it's a very unique kind of contribution that they make because of who they are. CVHEdU03,p.6
	5. The ones that I really treasure most from them is kind of they bring in a very unique personal perspective that I can hardly put myself into their shoes. I mean not that I don't know of it, but how they articulate it to the class, how they articulate it in the community, much bigger impact…when the consumer really say it or the community partner says it out, that creates such a bigger ripple than some of the people we want them to hear it, would hear it finally and might be able to **take some action** about it. CVHEdU07,p.4 6. …we ask students to spend time with them to learn their perspective. I mean I think there's value there. …for those groups having students attend them and **learn about what they do and how they advocate for patients**, CVHEdU08,p.4-5 7. …an understanding of difference and the respect for difference. … **somebody who is at UBC who is working in one of our health areas, then by definition, you've probably come from a circumstance that privilege**… **And yes, they will be presented with a people who have had a range of different experiences and in many cases don't come from a privileged background that they come from. And then, these are really tough jobs and you end up in really difficult situations. And you can't teach that in classroom. You have to live it and be a part of it, and so I would argue that that's one of the big reasons why we need to have patients as part of the educational environment.** …**allow them to learn in safe ways and not take advantage of the situations that they are in.** CVHEdU18, p. 3-4

Culture / different world views*	1. We also have one of the people comes is a First Nations elder who's been coming for about six or seven years now, it's a module that we do joint with OT and PT together and the paper cases or clients that they're gonna work on as a two professional team, one of the cases is somebody from an Aboriginal community because we're trying to merge multiple goals into single sessions so the beginning of that module starts with a First Nations elder just explaining different perspectives on healing and …there's always a certain segment of students who are so profoundly touched by that story and another segment, a large proportion who say they just had no idea, he talks about the impact of residential schools for example, they have no idea how recent that history was, how pervasive it was and what it really meant. They've all heard about the issue but they don't know what the issue is. CVHEdU03,p.5 2. Well we just had a really interesting outreach community clinic in [place] where the First Nations band there took it upon themselves to actually educate the students with their culturally and so I was actually sort of interviewed after the fact and I was there for part of it. And I said **I think our students learned more from the First Nations people than the First Nations people got from us.** We treated a lot of patients but, and I think that's happened in several different areas when working the downtown eastside. In the First Nation Health Center there's a dental clinic there and I think what they learn about are people who are on the streets or drug addicts and things like that. CVHEdU09,p.4 3. **anyone that has an experience interacting with the health care system can help students**. And one of the issues in our society, given it's diversity, is how we help students to be non-judgmental and how we also **help them to develop that kind of cultural competence**. So I think it's, I think **it's really important for students to hear from people from different cultures.** Even if it's things around **how different cultures handle death or illness or what the expectations are.** CVHEdU10,p.4
Non-judgmental cultural competence *…the community was actually seen to have a huge level of expertise…*	4. …cross cultural training and it was a scenario put together around handling a death within a family and the scenario, the actual physical scenario of the death was the same in every small group. What was different was either the cultural or the religious background and so what students had to then do was to work with the standardized people in those groups to come up with how they would solve this problem or how they would handle it and then they shared within the group and every scenario had a different solution even though the physical thing was the same. And that was a very powerful thing for the students when they realized that here we have a disease process with an end point that's the same for everyone of these patients and how this was dealt with by the physician or how this should be dealt with by the physician or the nurse within the family was different from everybody. And so creating something like that would be an interesting way of helping cross cultural stuff. CVHEdU10,p.6 5. I hold on to the notion that people within the university, be it education, medicine, other health professions, do have a body of expertise that can be in curriculum development, pedagogy, clinical expertise or what have you, so I'm not one that's willing to kind of see that experience outweighs everything else and will give it all, but I do think that **there's a mutuality that could be developed.** So for example when I worked with the [Region] school when it's new and when we were doing lots of curriculum development and faculty development and so on, bringing people, they actually did it the other way, going to Aboriginal First Nations communities and writing cases with the members of the aboriginal communities so that **the community was actually seen to have a huge level of expertise even in the development of curriculum. Now that sounds so simple these days but it's not easy for many people to give up the ownership of the development of the curriculum.** So I think that community members can contribute directly to the development of curriculum and that **doesn't mean they have curricular expertise in the designing of how it's done and delivered. They have some of that as well or some thoughts on it which we should take into consideration, but I certainly think they have expertise in understanding the context of the issue and how community members as clients, as patients and so on would be worked with when those clients, patients, community members are more in clinical and professional environments**, so that's the contribution to curriculum. I also think **they have a lot to teach us about pedagogy, how we interact with community members so that interactions are culturally based and if you get it wrong people don't come back, that's for sure.** CVHEdU12,p.3

Community identified needs (Organizations)	1. ...the added value from organizations is probably kind of from a planning or goal setting perspective because we become aware of what are the hot issues or topical issues or current priorities of different organizations… CVHEdU03,p.6 2. …this efficiency discourse, this scarcity discourse really for example. It's very much on the minds of people and impacts the organization. They can speak to that from an organizational level and then clinicians can speak to it from that individual patient level as well as consumers and how it impacts. CVHEdU05,p.6 3. And the First Nations bands have been in there. They're in a public school and I think the principal who is in the [name] School **took it sort of upon herself to make sure that our students understood what the setting was in the public schools and what the health of the students meant to their success and education.** I think that's always been useful. The long-term care facilities have taken a lot of responsibility helping students understand people who can make decisions because a lot of institutionalized people don't have their own power of attorney and I think for young dental, probably medical students too, they've really never met a person who can't decide for themselves. CVHEdU09,p.4…the added value from organizations is probably kind of from a planning or goal setting perspective what I would want the community advisory board to do would be to give us advice. I would want to take problems to them. …**we're in the middle of curriculum renewal right now, great opportunity to take some of the ideas coming out to a community advisory board and say would this, do you think this is gonna make our graduates better suited to the needs of society?** Things like that. I would rather take, **I would rather regroup a wise group we could take our dilemmas and things to for some advice rather than a group who says you must put this in the curriculum…** CVHEdU10,p.7
	4. I think that they [community organizations] are in a good position to kind of collect feedback or observations from whatever service they're providing and kind of maybe focus it down for us into identifying what the key things are, what the key gaps are or needs are or messages or feedback is, so I think that they can act as a good maybe liaison between a client or a group of patients and the university. CVHEdU11p,.3 5. …**they can translate between the patient, and the profession, and the educational system** because most advocates at least have a foot in the ground for the group they are advocating for. …because **it's really hard for individuals to get the experience, knowledge-base. They get it over time.** CVHEdU19, p. 4 6. …**they would have a more of a population perspective I suppose to the needs of their group members which could differ from an individual's perspective**… CVHEdU16, p.2-3 7. it could be, as we start to think about what do, what does interprofessional education look like and how do we deal with or how do we equip our students to deal with complex problems that they are going to run into, that these communities can help inform the kinds of experiences that our students have, whether they're problem-based learning. We go through a whole series of ethical reviews and professional requirements as we look at all of these programs and so **to have communities help us think about what are their issues and how do we structure our environment**… CVHEdU18, p. 4
Bridge classroom & practice *...it's a bit of a parlor trick when I'm lecturing that any time I say I had a patient that had, everybody sits forward in the classroom.*	1. So another part of it would be just that re-energizing, re-invigorating our curriculum and our delivery of the curriculum, just keeping it fresh. CVHEdU02,p.17 2. …**a way of bridging from the classroom to the practice environment** and then hopefully they get, cause they develop more in during relationships and the practice environment or more complex relationships in the practice environment but **it serves as a very fundamental bridge between the academic and the practice sides.** CVHEdU03,p.6 3. …**students are riveted** and I know **it's a bit of a parlor trick when I'm lecturing that any time I say I had a patient that had, everybody sits forward in the classroom.** CVHEdU08,p.3

authenticity	4. …it's this **high validity for application of knowledge**. I mean **the student can actually see why did they learn about the heart.** If a person comes with multiple heart medications and a heart murmur or some other pacemaker, some other thing, they can start to say, 'oh now I know why I learned this' and I think it's that important thing in all the health professions which is the relevance of the content. If the students viewed as a esoteric discussion of the Krebs cycle, they don't really learn it. If they look at it as part of the nature of the signs and symptoms that patients present then it actually means something. So it's a really reinforcement of knowledge I think. CVHEdU09,p.3 5. …if we think about our learners or our students, I know, I've observed enough to see that **when it's somebody real or a video of somebody real talking about an experience it's much more powerful for the student.** I think the students, when we have our, we have a series of case based courses and we always invite somebody from the patient partner I guess come in and speak to them and it's a more, it's a less formal session and more of an opportunity for students to ask questions and for the patient to talk about their experiences and I sit in on those as well and the engagement is at a different level than if it was even a clinical expert talking about their experiences. So I think **it just becomes a lot more real for the student and it brings them back to why they're learning what they're learning and I think too another benefit is that we can make up cases or we can make up stories or case studies and from our experience as clinicians or instructors, but I think there's always an element of authenticity that can be lacking and I think the students are pretty perceptive around that.** CVHEdU11,p.3
	6. …we structure our curriculum on the ICF model, on the International Classification Functioning and disability, when there is impairment and disability and participation, … I would say that physiotherapy for better or worse focuses the bits and pieces that don't work in your body, in getting that to a point where you can go back to do the functions that you wanna do, … our patients actually are more satisfied with their lives at the participation level. I don't think as a whole, we do a great job at that, and **that is an element where I think the patient voice could have, in curriculum, the most impact in a way, in terms of encouraging us to think beyond fixing the beds.** CVHEdU16, p.3 7. …one of the most important things is to think about education as an experience rather than as a separate part of your life. CVHEdU15, p.1-2 8. …they go through almost a full 8 months of education before their first clinical placement where they really see physical impairments and so, **bringing patients into the early on really is a bit of a public safety bonus, because they have a chance to really see at first-hand what things look like and how to approach situations in a group before they go out, and are responsible for patient care** …So we certainly would not want a curriculum that did not have that as a core element. CVHEdU16,p.2
Community resources (Organizations)	1. They [organizations] bring the overall need lens to the whole piece, so they bring the reality piece, costs, resources, actual resources, the limitations if you will, but also again the opportunities within a health care environment. So the student really gets to see that piece, gets to experience that piece. The other piece that I think for the student is the student has an opportunity to see the embeddedness of particular societal idea, the whole, that these aren't discrete categories, that in fact the organization is the people and the people, the organization and how the interface between those two things. So I think it brings that. So I think both are really essential for both the individual voice as well as the organizational voice. And of course it allows the student to see what's actually offered ...What services are provided and I'll underline again the limitations of those services as well as the opportunities they afford, so I think it's terrific. CVHEdU05,p.5 2. The other thing I also kind of appreciate them doing is organizations tend to look at things at more at the system level which often times bring like different perspectives both to the student as well as to our different advisory group as well. And that's something quite variable. For example, like we've been involving, supporting and advocating for some housing issues. I would say in fact if we were only like one or two consumers coming and telling about their housing problems, it would not be as profound as having like the Rain City come over and to talk about what they've been doing, how they've been involving consumers in creating different movements. So I think that having that to come in actually help us all to see things more from the system or the systemic level. CVHEdU07,p.5

	3. I mean also that so many health professions do work in those sorts of settings in educating our students about what their organization does, what its mandate is and yeah kind of where the needs are and how our graduates can work better or our profession can work better with those different organizations where there's different populations I think can be extremely helpful. CVEHdU11,p.4 4. So it would be **part of the role of the community organization to be able to give some sense of what's happening in general with people who have these kinds of issues or have these kinds of needs and when there are issues between working across services for example, "this is where the gaps are, or this is where we come and help make sure that these bridges are being built or things like that".** So I think there would be crucial information that they could offer and that they could teach, and that partnership, that relationship should always be set up so that the student really recognizes that they are there to learn from the organization. CVHEdU15, p. 5.
Leadership / CQI	1. I know we do give them leadership, I know it's in there and it's melded through but it's very different when you're in a student role and not really able to enact it when you're living on the unit and you're all of a sudden made manager and you've got budgets and you've have resources and you have other people to report to. And those are the streams too where I think patient input would be incredibly valuable because it's that patient satisfaction with the experience. Most of the time I think if you walk through and ask the patient, what needs to be done or what could be done differently, they'll give you a whole line up. CVHEdU04,p.9 2. What we've actually started to do only in the last year really is to survey our patients in our dental clinic on their experience. And what we're finding is they have some quite interesting comments on what their experiencing which is different than what we think they should be experiencing or what our intent is. CVHEdU09,p.6
Communication / partnership	1. I think more powerfully would be how do you really get students into that ability to really work with individuals and how could you help students develop their relationship and communication skills with individuals in a way that we don't do right now. And I think again you could work with people from the community to help them with that which would require people who've got some time who are willing to undergo training on giving feedback, would be willing to work through scenarios with students and then sit down and be very honest with them in a very non-judgmental non-assessed way. CVHEdU10,p.6-7
Collaborative research (Organizations)	1. with our research projects which means that it would be the MSC Ph.D. students that were maybe connecting with organizations because there's an opportunity to, one they might be approaching organizations for funding towards a particular project or they'll be asking the organization for support for a particular project that's of mutual interest when they approach another organization for funding. So I can think of examples where the organizational pull is valued in moving projects forward and occasionally that would be an educational project or educational based research that was related to the occupational therapy professional or entry level program but more often it's probably solving a problem of or attempting to solve a problem of mutual interest. CVHEdU03,p.7
Role modeling / identity formation	1. I'm constantly thinking about modeling certain kinds of talks and modeling certain kinds of behaviors and modeling certain kinds of actions. And I'm also constantly thinking about ways in which I can involve them with certain experiences that will allow them to do the work that I think they actually need to do **to imagine themselves as future teachers** and I guess that's something I would say that is that I think maybe it makes it more clear. CVHEdU15, p. 2
Knowledge mobilization	1. … a couple of pragmatic ways would be to **identify key informants or the individuals within their cluster** who would provide a really good perspective. So, I guess it would provide a key to the clients group, to the patient groups so that the gatekeepers to a large extent, I think **they can be also partners in terms of knowledge mobilization**. So, **that transition of knowledge back and forth, which largely again would come from the key informants. But, some of the evidence that we get for our research**… CVHEdU17, p. 3
Admissions	1. …perhaps the consideration of what role of community in selection, in advising and admission decisions. CVHEdU20, p. 7

4. Levels of involvement of most interest (Interview Question 5)

Many informants thought that levels 1-3 of the spectrum of involvement were "fairly standard" in their programs and the involvement of patients within these levels should be expanded. There was a lot of interest in having patients more involved in creating learning materials and giving feedback to students. Involving patients in the development of cases was of particular interest since most cases are developed from clinicians' experiences with real patients and in some cases these are used in conjunction with real patients coming into the classroom to speak to students. There were several examples of working with Aboriginal communities to develop cases that reflect Aboriginal patient experiences. These collaborations could serve as a model for co-creating cases with other patient groups. Enhancing patient involvement was thought to be a way to add "authenticity" to classroom learning and make it more interesting for students.

Levels 4-6 however, were received with more caution. Higher levels were generally thought to require more expertise and careful attention to selection and preparation of patients, creating "safe spaces" and ensuring that roles are clearly defined. While there was enthusiasm to "push the envelope" of patient involvement at the higher levels of evaluation, curriculum development and strategic planning, there were concerns about how to do these things well and manage potential problems that might arise. Some concerns associated with patient involvement at the higher levels included: contradictory information being confusing for students, an inability to meet expectations / personal agendas of special interest groups, power, conflation, tokenism, time, etc.

Table 4. Caveats for lower vs. higher levels of involvement

Levels 1-3 Many already doing a lot	1. Levels 1 through 3, especially levels 1 and 2, provide an opportunity for people to, for patients to talk about for want of a better phrase, what it feels like to be treated, to be, and for reasons that I think are perfectly understandable I don't think that would be foremost in our students' minds, especially in their early going, for example when they're history taking or learning procedures like taking blood pressure, starting an IV, that sort of stuff. **They're very concerned about doing it right. They're very concerned, and it's not like they forget the patient's there, they want to do it in as comfortable way as possible. And yet at the same time what it really feels like to be asked the questions they're asking, if that was upper most in a student's mind as opposed to let me just make sure I ask all of these questions, let me make sure I've heard the answers and so that when a preceptor comes in and said, 'right, what did you get out of that,' I can tell them.** Certainly if it was me there's no question that getting those details right would be way ahead of whether or not the person who walked in and walked out felt that that was a reasonable way to spend time. So I think that the **level 1 and 2 in particular where the patient has the opportunity to hold up a mirror to the student in an interaction would be, and is, not would be because I know it's done at times, is very valuable.** And I think, oh that's interesting, I remember when I was a [course] tutor and we had the people with addictions come in to each of the tutorial groups … one of my first students I had in the tutorial who at the end of it all said in essence in his own way to the person who came in, 'And what did you think of this?' …that was a very very important question to ask before we left the room and I was being sort of the perennial tutor, always, okay what are the students getting out of it, what are the students getting out of it, what are the students getting out of it? And I was concerned about whether or not the guest was comfortable but to ask bluntly back, how did you do, how did you feel about this, was brilliant and the person just thanked the student up and down for asking and said 'I was nervous coming in, I have to tell you, you never know how people are gonna take your story, I really thought you people cared about,' it was beautiful, beautiful. And that's, maybe that's pushing more level 3, more going to people who we bring in and say how was that as an experience for you, **you're not just a learning object.** CVHEdU01,p.6-7

...you're not just a learning object. Creating learning materials	2. A lot of the simulation scenarios that have been developed in nursing have been very focused again on **acute care and med surg.** This had home care, this had pediatrics and obstetrics, mental health, and interdisciplinary experiences as well as some quality improvement experiences. Most were based on realistic cases. Do they reflect the patient's perspective? I'm not sure. I can tell you when I do my obstetric ones with the students I always have somebody role playing a family member position and the level of empathy and when they do their reflection and they really do get in the eyes of a patient. …So the standardized patient in a clinical setting I think is very helpful and in nursing we've used those, probably not as much as medicine because of the cost related. I know it's usually with a family nurse practitioner's breast, pelvic, prostate exams. Often we'll use standardized patients. CVHEdU04,p.5 3. I think we use a lot of these. I wish we had more opportunity to use the simulated patient kind of approach cause I think that's really quite valuable to students. … **I would like to see more patients involved in our curriculum. I think we do it minimally.** … **Of course we want to be informed by patient need, by the patient voice, by their understandings, by their experience.** That's why the Health Mentors Project was so terrific because there's no cost really associated with it the way it stands right now. I would like to see more of that. I would like to see more standardized patients number one at all levels. I guess I would, I just think **it would be great to have patients involved in creating learning materials used by Faculty.** But I think we have to pay them for that. CVHEdU05,p.6
Creating materials Problem based cases are developed from real patients Patient involvement in case development is an opportunity to increase involvement (adds authenticity)	4. **Well I thought if we look at, we've at this point have level 3 involvement. We have level 2 involvement for sure and certainly 1. But I, to my knowledge we don't have 4, 5, and 6** and I think that would be really novel for us to look at and involve them as partners in learning. CVHEdU06,p.5 5. I expect **increasingly we're going to be using asynchronous teaching, videos, technology to kind of provide content and one of the things that we can do in those is perhaps use real patients or real patient problems to make those ring a little bit truer.** CVHEdU08,p.5 6. Well I think level one it's clear that **any of the case based stuff or any of the things they learn, a patient, the patients are involved in creating that, either of themselves or in partnership or providing the data that an educator creates so I think level one we do a lot of.** Level two standardized patients, there's a lot and obviously we have lots of patients who volunteer to be treated. We do have patients who come and talk about their own sort of health experiences, again to give, so that's at level 3. CVHEdU09,p.4 7. I think level 1 involvement we do. Level 2 we do already so most clinicians are using examples of real patient problems, students are looking at videos. There's all sorts of stuff there. The whole case history and giving a case history to another is about the use of patient narratives. My concern about that is how narrow or wide that narrative is and what we mean by a patient narrative. Level 2 involvement, we do lots of that. We've got standardized volunteer patients doing things within medicine. There are some examples of level 3 involvement in the medical curriculum where people are brought into the classroom, DPAS brings lots of people into small groups, it brings people to share stories of mental health and addiction, stuff like that. CVHEdU10,p.4 8. **level one**, you've got it listed as involving around learning materials and case studies and things and I think that relates back to my comment about the **authenticity** of a case and I think initially a lot of the case studies we use in the program were based on maybe real interactions with clients or real clients. **And one of the case studies that we still use, the actual client that it was based on comes in and speaks with the students. However, I don't think she had a role in actually developing the case but I think that is still very important to do because of the authenticity piece and I wonder what, I'd be curious into look at what a case might evolve, how a case might evolve if the client was actually involved in developing it versus just through the lens of the clinician's experience with that person. So I, we've not involved any patient partners with developing resources but I think that would be really interesting.** CVHEdU11,p.4

More opportunities to practice with real patients	9. …we have been quite interested in having a few sessions where we do have more standardized patient experiences for our students. I think we have one where we partner with the OT's and it's around professionalism and communication I think. But I've also tutored in sessions in the medical program and I'm not sure if those are all actors or if there are some kind of patient partners involved in that, but **I think it's quite an awesome experience for the students to have an interaction or practice skills with somebody who's trained.** And so I'm, we'd certainly be interested but my experience has been that we have quite limited access. CVHEdU11p.4 10. Well the **first one and the second one are** ones that I've talked about in a **fairly standard**, the third one is the one that what I was raising earlier has a little bit of a trigger for me and I guess so there's that, I'm cautious of that one… CVHEdU12,p.5
Cases largely from clinician's perspective Patients well-positioned to help develop cases	11. I would say **most of our involvement tends to be on that level of providing an opportunity for physios to learn clinical skills**. And I would say probably **less so on the patient voice shaping the education.** I do believe that it's probably more one sided and honestly before agreeing to this interview I hadn't really thought to the role that patients may have on a curriculum on that idea. We have a community engagement committee. And that, …think how we're on that committee… it's not written down but when I looked through our actions, it seems like we are defining community as the community of other physiotherapists who are out working like alumni and etcetera. So, because that's where we are spending most of our time in outreach and we are not a … I suspect from just lack of thinking about it from patient perspective or not actually… for instance, **we certainly don't have a patient voice on our community engagement committee** as an example. So, we haven't really defined it operationally that way and that is interesting. CVHEdU16,p.1-2 teach. Teaching is sharing what they know in a way that it could be understood. So I think it's developed capacity for teaching but also knowledge generation in the community. Cause when you are sharing that knowledge, you are also sharing with community members because at times that's been very small and it's developed more… CVHEd-U-13, p. 6 12. …**everyone has the skills to be able to do it** and they can connect with youth and others that have the skillset to actually teach. They have the ability to 13. I jump down to level one. I would like to think that patients are involved in creating learning materials, certainly memories of those people are largely, if I think of a case-based scenario. I think we bring those experiences based on our own memories of the … I think we give off the patient voice in that I'm thinking of some of the virtual cases that we are developing now. They've been developed in two ways, **largely from a clinician's perspective and memory of the situation or scenario with no voice of the patient.** But, the nice thing is, for instance we are developing a package of, well, it's not me, it's **we have an educator position who works under my portfolio, and he is working with the aboriginal communities right now to pull in more of their experience and their knowledge of health provision within their own communities. So he is really giving them a voice and they are creating cases and all he is doing is shaping them.** CVHEdU17, p. 4-5. 14. the **real patient problems are basis for case learning or virtual patients cases**, or the use of the narrative. I think that's an incredibly important part of involvement and again I look at it from the perspective of other professional faculties where it's really really important to deal with the real cases and I think, in this case, **patients are very well-positioned to help develop quality cases for learning.** CVHEdU20, p. 4
	15. The **number two, struck me as yes, that's a very familiar one**, in lots of ways. And **I like the volunteer people giving, teaching and giving feedback.** That's we do sometimes with our mentors ask them if they have students doing practicum with us, who needs some experience in a particular aspect of clinical practice that they haven't had before. Mentors will kind of position themselves as patients for that student. But they really do position themselves as patients. They understand that the goal of this is not for them to be assessed but for the students to learn how to do an assessment. And then we do encourage them to give critical feedback to the student about what that was like from their experience … CVHEdU14, p.5

	16. And probably the one that is most closely aligned to what we are doing here, currently with the [patient] group, I think is level three involvement. Mainly because it is a faculty directed curriculum, even though we invite input, I think that people in the group see it as faculty-directed and it really is. They don't have a say in the rest of the curriculum at all. CVHEdU14, p.5 17. some of my students have actually worked with medical students before, and one of them was organizing community-service learning class. And from just, it was a couple of years ago, and from her experience, the class was an elective. The students didn't need to take it. So then they were kind of **self-selecting** …**I wouldn't think that a hundred percent of our future, people that we are preparing to be health professionals are actually have level one involvement.** CVHEdU15, p. 7
	18. I think I talked a lot about level three already in terms of sharing experience. And, standardized patients I know that it … Physiotherapy group uses folks that, to provide for their OSCEs, but I think they are the only group under my portfolio that uses standardized patients; Midwifery may, but I'm not that familiar with their program. CVHEdU17, p. 5. 19. I think that drawing from patients is **pretty common**, most specially in the health professions. This is more actually contributing to the shaping and design and **making videos of their experiences or helping to develop cases that kind of thing**. CVHEdU14, p.4
Levels 4-6 Patient feedback to students Power Creating "safe spaces" for patients to give feedback Clearly defined roles Level 6 doable (e.g. MMI) Challenge of tokenism / not being able to deliver	1. Level Four, just for my own personal interest …The role of patients not, beyond the teaching the evaluation is actually a really interesting thought. People are now turning to 360 evaluations and I don't know and I'm sure people have done work on this, but **what kind of information do we seek out from our patients around the, our students' interactions with them? How do we get our patients really comfortable being able to describe this? Cause this is where that power thing really comes in in spades**, right? We have not tapped into this. We would learn so much about really how our patients really feel with the students if we could, if we had the proper tools and the proper preparation, as well as **creating really those safe spaces for our patients to be able to do that.** CVHEdUPilot,p.6 2. …**they [Volunteer Patients] are invited to give feedback but they're not actually evaluating the student** CVHEdU03,p.7 3. **…who would be the right kinds of people when we are developing curriculum.** …So I, if I even think of the college council, should there be a patient sitting there? I don't know. I honestly don't know **what would be the role**. I've sat on boards where there are patients and who are the public representatives and I can see they're absolutely terrific. They bring in a perspective that is outstanding. But in certain ways, how do we know what are, where are the right places? And there probably are some committees where patients really shouldn't be cause it's not really that value added but which are and then how do you prepare, etcetera. And I guess the Patients Voice Network in BC has probably got some good experience as well on that one. CVHEdUPilot,p.6 4. …as I moved up the levels I thought oh good heavens that's asking a lot. And then level 6 seemed interestingly doable so I don't know if these are actually ordinarily presented, but let's presume they are. And patients involved in institutional decision making, student selection reviewing and funding applications, I sat on the MMI question writing committee this year for the first time. …half of the people who sit on that group are community members… So level 6 involvement, we're achieving it there and probably in other places as well and I thought ah how interesting, as I moved up that list of levels I thought gosh this just gets harder and harder. And then we got to level 6 and I thought we're doing, I've got experience that demonstrates to me that we've done that quite well, at least in one context. CVHEdU01,p.5-6 5. And **we've invited feedback when we do curriculum reviews but we, I wouldn't say that we actually engage patients in curriculum development in a formal, in the same way the Faculty are engaged in it.** CVHEdU03,p.8

…at the end of the day we still have the business of running a medical school…	6. **I found really exciting this idea of, I guess it would be level 6 which was, patient, teacher and education evaluation of curriculum development I found quite neat. And I thought there was another one where they were involved in assessment. Here we go, level 4. Because I think we get feedback but we don't really, we don't do much with that scoring. It's done in sort of an informal so how did you feel**, like is it {unclear} or not. There's that piece. And then this piece around development. And level 5 is a little bit of like we've done with some of the courses where they've given some educational decision making. Again, it's been very, in my opinion, **it's been very sort of token and not perhaps not given the clout or the power that it needed to invoke change.** …**at the end of the day we still have the business of running a medical school so, if at on the eleventh hour or something a eureka moment hits a community member or a patient group, that it's hard for us, too much inertia to change that by morning, that you need longer sort of relationships and maybe being involved more in the developmental phase because our ability to change an organization that's this big isn't great.** CVHEdU02,p.6-7 7. …there's a real fine line here with number five because I think we're only beginning to look at how health professionals establish professional identity. And when I think of Surgeons, I was with the American College of Surgeons with a post-grad course last weekend, and we were doing some interprofessional simulation work, the level of confidence that they need to have {Chuckle} to cut into somebody {Laughs} and do something and it's similar with nursing to do some of the invasive procedures to make these quick decisions under really crisis trauma situations, there does have to be a level of professional autonomy and security and confidence in their foundational knowledge and skills. At the same time, most of those crisis situations, if they were listening to the patient {Chuckle} might not erupt to that level. So **it's a fine line between making sure they do establish a professional identity while simultaneously aren't so cocky that they are the patriarchal know everything and tell people how they need to do things. So I, this is one I will struggle with a little bit. I do think patients, if we can view them as equal partners and help students to appreciate what they bring to the table, how do you envision them as collaborating in the educational decision making?** CVHEdU04,p.5-6 8. …the whole concept of academic freedom and how they create their courses. Yes we go through curriculum committees and we have to get Senate approval and the objectives have to stay in place and it's very closely tied to what our accrediting bodies are saying that we need, but how within that can we present that to Faculty as an opportunity then okay that set, you've got your objectives, the way you enact them and teach them and how you go, the methods you use to accomplish that, could include this patient partnership. And that would make it even richer. And then finally the institutional, oh so that's sort of where you're getting at, evaluation and curriculum development. **This little voice in my head, especially as someone, I did my Master's, both the role of educator and the [type] discipline, so I had a lot more education background than most nurses or nursing faculty would have had and I do consider myself a curriculum and evaluation expert, and I think most faculty whether they have that strength or not would consider themselves that** And number five about the patient teacher as equal partners in student education evaluation and curriculum development, so I might be simplifying it but **I'm a bit triggered about the notion of what I would see conflating things to equal.** So I think that **people have different levels of expertise in different areas and I would rather the conversation that I have of people who are participating is to recognize the different level of expertise so that I think that sometimes we give up too much power** in certain, so I think there's a really different notion. For me I always place in what is the difference between the abuse of power and the use of power. So using one's privilege and power appropriately and one's knowledge and experience, seems to me that it's very different than kind of notions of equal. CVHEdU12,p.5

Higher levels Require expertise	9. I think they could be involved very much in **curriculum development bringing organizations in or representatives who can look at your curriculum overall, understand what it is, what is your basic mission in terms of your program. For ours, for us it's to train pharmacists to be medication management experts and to provide pharmaceutical care. But there are a lot of other elements that need to come into this and they can bring those** {s/l clinical} {unclear} aspects in so that they become part of your curriculum from day one so students are introduced to these various components at a lower level and then they increase as they go through the program. So I think there would be a lot of advantage to doing that. **We're going through a major curriculum change right now**…**So this is a great opportunity to involve these types of groups or representatives from these groups because the focus should be on patient, it's not a product that we're dealing with, it's not a drug recommendation, those are secondary.** CVHEdU06,p.4-5 10. **Many of us have been involved one way or the other inviting consumers, clients, whatever you name them to be involved in education, maybe having them as guest speakers, as kind of sharing their story, involving case development, other kind of things. But I think one thing that we should really be thinking of now, and to push the envelope further is to involve them in the curriculum development** or even kind of moving into looking at not just only like one single program but **more at the system level** as to how they should be involved in **advising, directing**, the direction of the whole faculty, of the whole university, some of the **strategic direction that we should be thinking of**. CVHEdU07,p.1 11. …it also **depends on their comfort levels** as well. I mean we know as a matter of fact there are people who are keen and interested more at the sharing level rather than at that much of kind of like a higher level visioning level, and vice versa as well. CVHEdU07,p.3 12. …**I think we did quite well in involving clients in education, in teaching, but not really quite a lot in terms of like visioning, giving us more the direction** of kind of like perspective. And I think that **that's the area that we can further develop** as we go along. CVHEdU07,p.6 13. We have the clinical associates and I think they're really important as well around the intimate exams **there may be some other ways of using those people in less intimate settings but still in settings where their feedback would be valuable.** Again **the challenge there is that we have a particular approach to teaching communication skills and physical exam skills and a patient correcting someone around that may not actually be congruent with what we're teaching**… we could potentially do is just ask students in the clinical years to have, to hand something out to a patient to get some feedback on their interaction with them and that would be a way of them populating an aspect of their portfolio. CVHEdU08,p.5-6 14. …**it would probably not make sense for level 6 involvement to have the medical school doing it. It probably should be at a higher level so that for all the work and time it's gonna take from the university level and for the work and time it's gonna take from these individuals that they actually are answering a question every couple of weeks and being supported to do that and it makes the training pay off** and all that. So if we just did it in the undergrad MD program it might, there probably wouldn't be enough substantive questions that would make it worth everyone's while. So I think on that last bit, at least a panel thought that I have been that I'm fixated on is that I think **it would need to be at a higher institutional level**. CVHEdU08,p.8

	15. I don't think we have many examples where the patients themselves function as the teachers, although there's a lot of feedback that occurs in a patient care experience. I'm never really certain, I mean you **frequently hear a student talking about what they learned from the patient when the patient explained the nature of their problem, but I don't think it's a formal teacher student experience** but there's a lot of teaching that goes on in all those cases. I don't think we have really very much in the level 5 where the patients are equal partners in student education. I think the **faculty members try to facilitate the exchange between the patients and the students to the student's benefit, but I don't think that the patients really are equal partners.** I mean they're largely bringing their situation. I mean **there are examples where the First Nations example where the band actually did a lot of teaching on their own and that was direct teaching, it was cultural diversity sort of aspects. All the students who walked away, 15 students, they all came back just going crazy about what they learned about First Nations.** We had two First Nations experiences this summer. One on the island in [place A] and the one in [place B], very different. The First Nations band in [place B] was very proactive about trying to educate our students on the culture. The [place A] patients were, the population was quite passive and just were dental patients, so I think it differs. I don't know the Level 6, I don't think we have any patients at the highest levels… CVHEdU09,p.4-5
Personal agenda	16. I mean in some respects this [curriculum decision making] does occur at the College of Dental Surgeons level that has community members that sort of look at the profession and the practice and community members in the British Columbia Dental Association and we're involved with that. So I mean we do interact with those people in those settings. But **I'd hesitate to bring a community member in. I'm not certain how you find a person who really thinks about the broader scope of the education and doesn't have their own personal agenda.** Not saying their agenda is wrong but the trouble is we can't change all of our curriculum because one person wants more developmental disability training. It just isn't gonna happen. CVHEdU09,p.5-6
	17. **Level 4 we've got some people doing that but I actually think that we could be doing more there.** So I think where **we're using teaching associates is around specific skills where I think we could really up the level would be around communication skills and feedback to a student.** One of the things I don't think we're very good at is helping students with self-awareness and I think good patient communication skills, training with the patients, giving them feedback and talking to them about the experience of being with them I think would be very powerful. And **I certainly don't think that we have got to the level 5 bit yet where the patients and teachers are equal partners and I think it'd be really interesting to work on that.** I have seen some scenarios, not necessarily in this medical school where a physician has brought a patient to a class and they've done a communication skills training thing and then they've done a feedback with the patient to the student in front of the class which is really very very powerful. And I think we could be doing more there. And we certainly don't have folks working at the institutional level, and I have, actually that's not true because **we've got some community members involved in things like the MMI and selection**, but in chatting to [Name] about what a community advisory board would look like and I think that would be, that's something that we're trying to make progress on. **We have to be very very clear what the role is and the two concerns that are being thrown at me there is (a) how do we select people for it and how do we ensure that people are there not to represent their views or interests, but to give us advice and problems that we bring them. So we would have to formulate the terms of reference very carefully because we would want an interactive board that would help us solve problems rather than one that was seen as a method of being able to influence what we do.** So I think we're kind of thinking those things but I would think if you look at these six levels of involvement, **we are very engaged at one, less engaged at two and then all the way down.** CVHEdU10,p.4-5

	18. I quite like all of them, I think they're all really, I mean the patient sharing their experience with students within a faculty directed curriculum I think is awesome and it's a great idea and we absolutely should do it more cause we're not doing that right now. **Around evaluation and teaching, I think the teaching piece definitely. I don't know about the evaluation piece, I would be interested in that but it depends what that would look like. I mean we have such challenges standardizing exams, that would be my one thought there but if there are models that work that I think that would be interesting. The 5th one kind of made me think around student education, evaluation and curriculum development and I have a fairly large role in that and we just for accreditation report talked about all the sources of feedback we collect from employers and our professional organization and our students and graduates and faculty, like the whole gamut but not anything from the population in which we serve.** And again I would be interested in other models if anyone's doing that, collecting that sort of feedback. I think it would be really very interesting and powerful. CVHEdU11,p.4-5
Caution equal partners "conflating	19. And number five about the patient teacher as equal partners in student education evaluation and curriculum development, so I might be simplifying it but I'm a bit triggered about the notion of what I would see conflating things to equal. So I think that people have different levels of expertise in different areas and I would rather the conversation that I have of people who are participating is to recognize the different level of expertise so that I think that sometimes we give up too much power in certain, so I think there's a really different notion. For me I always place in what is the difference between the abuse of power and the use of power. So using one's privilege and power appropriately and one's knowledge and experience, seems to me that it's very different than kind of notions of equal. CVHEdU12,p.5
	20. I hear from different groups, "if it wasn't for doctor X, you wouldn't know how I exist." And as … to what you were saying, doctor X invited them in and engaged them. But otherwise, **there is no systemic opportunity to impact**. You flagged there, I must admit I twigged to it, as soon as you saw whether it's a consumer, academic council or whatever else, but I think probably **we would need to have some table, whether it's advisory or part of the decision making process, that is a community-based people group that can influence our programming**. We tend to respectfully say that what people want is this. Do we ask people? No, we don't. But it goes back to the paternalistic model that somehow I think we have to create a broader table which will do several things. It will **regularize the input into the programming educationally**. But it will also, marginalize isn't the right term, but it will dilute out outliers in the patient/people voices, so that you actually start to get a pattern, **not just one offs** which scares to death bringing groups of patients like that, because you never know what's gonna happen. So but, I'm being flippant, but we need to do that more…**where we hide now is, "that's fine, but we still need to learn about congestive heart failure".** But what we need to say is "yeah, we need to do that." Because in addition to congestive heart failure, we need to learn about people speak" or whatever, I don't know what you call it, but patient engagement or whatever else. But **we need to give it credence and structure**, so that, they can influence its taking place. It's not enough to say "would love to have more input from them but we can't get through the real system and CHF otherwise" which is probably what we do now. CVHEdU21, p.11-12
Higher levels need others involved	21. I mean the **level-four involvement is kind of the next step up** I think in terms of, if we ask for instance, if we ask our mentors to formally involve themselves. That's an intriguing one, because that makes me think ok, **that would really need to be at a very different level in terms of the whole faculty being involved in that decision, and agreeing with it**, and seeing that it's understanding why we are doing it, seeing it as an appropriate thing to do. … I think the level one, two and three, kinds of things can be done within a faculty-directed curriculum by individual instructors. And beyond that, I think we are moving into a territory that would be sort of higher degree of engagement across the faculty. CVHEdU14, p.5
	22. level four, I think, for years we've used the patient partners from the Arthritis Society to talk about implementing, and to talk about handling, and issues around that. I think that works very effectively. So, I think **there are targeted components of a program where we might be able to get at level four.** CVHEdU17, p.4.
	23. …level five, the one that we are having patient teachers as partners in education, evaluation, and curriculum development. **I think the evaluation and curriculum development piece as really quite a stretch goal in a way.** It really pushes, sort of the participant… CVHEdU16, p.3

	24. So I think, for example, in OSCE station where the students needed to negotiate treatment and goal with a patient who differed with the best practice, I think that would be a very interesting station kind of evaluation to have because on one hand, we emphasize practice, evidence-based practice and on the other hand, we try and emphasize patients as equal partners in the decision making for their care. And what the students would do when faced with the patient's decision that contravened or contradicted what student therapist knows that is best practice. That would be extraordinarily interesting. How they negotiate that so that was the first thing that came into my mind about evaluation… CVHEdU16, p.4-5 25. So level five, it's interesting, cause when I reflect on the OT, when we were developing our new curriculum, we did have consumers involved at that level. They weren't necessarily patient educators but they did talk about, "what were the important key areas that needed refocusing or targeting". It's pretty powerful experience when you get an individual come in and actually teach students. …Certainly from an assessment perspective and from experiential, I think the patients can give really good information. Not confident that at an intervention level that their level of knowledge may have the breadth of understanding. CVHEdU17, p. 4. 26. I think level six would be wonderful, if we could do that. I think to some extent we do microcosms of that. The problem with that is we providing formal positions and how we beat down the bureaucratic doors to get folks who haven't gone the traditional route to a doctoral level, or even a Master's level for instructors. So I see some barriers there, although I would see it as a powerful method for providing student education. I like the idea of, within level six, having patient partners at students' admission committees. Because I think we largely do get bamboozled by students who are either coached very well, or who are great actors and I think sometimes having somebody who is a little bit more removed, who has interacted with folks who are a bit superficial within the health system, might be able to see through those masks. So I think that's a really great idea. I leave level six in a minute, but I have sat on funding boards where they have had folks with set condition. And I say two things about it. I think they have really good insight into what their problems are which I think is what we want for patient focus care. But they don't always represent the larger voice within a diagnostic group for instance. CVHEdU17, p. 3-4. 27. level six is nice, because it seems like that level six is saying, there is a way of actually getting patients and **getting people with different experiences involved that's not kind of a one-off** this class or other class, but it's at some kind of institutional level. And if that's the case, then that's the institution that is showing the values for it. That's the way the institution is saying "this is significant, and it is significant for your education." CVHEdU15, p. 8
	28. Levels one, two, and three seem to me to be absolutely kinds of things that we should be doing. And then as we move to level four, and I hit "patient teachers are involved in teaching or evaluating students", I start to ask myself, at what level are they involved in evaluating students and because **it is my experience that people learn by very high standards, and they learn by assessment. They learn by asking them questions, or asking them to do things. And a huge part of the learning piece is the assessment piece. And I think we are the experts in that area, and it's not that we should be ignoring patients in helping us inform what those assessments look like or helping us decide how we evaluate students. But if as we move into four, five, and then six, it strikes me that we are moving into an area where we are asking people to do things that they are not necessarily trained to do or are experts and I worry about that, both from a fundamental impact on our core mission which is student learning and can they actually start to undermine student learning**, by not fully understanding what they're doing. And then, in the whole series of **legal obligations** we have, and then **are we creating liability** …I think somebody who is a part of our community and we have authority over, needs to make that final decision informed by the information that the patient brings … **I've difficulty turning that authority over to somebody who is not a part of our community because , I can't exercise that other level of oversight over them**, and because I'm not sure they have been forced to think about all the things that you want to think about when you are assessing how the students are doing if that makes sense… Absolutely, their input is part of the process. …And **we are training people who are going to make life and death decisions or gonna interact with individuals and have an influence over their lives and these people have to be really well-educated and that means that we need to be hearing what the patient has to say. Just as we move into the higher and higher levels, I don't think we can turn over the final decision-making to patients…I can see a value for members of the community sitting in the processes and seeing if their concern are actually reflected in the educational environment**… CVHEdU18, p. 4-6

	29. …five and six strike me as further away. And I have to offer a rather inadequate reason for saying so, but… I was a panelist on grant competition run by the [organization] and they always have lay members on the grant panels. Every grant has to explain in a lay language why they are doing what they are doing, and the lay members are given a particular slot to ask questions and their vote counts towards the adjudication of grant which sounds like a fantastic idea, it's kind of a different application of the same thing in practice it didn't work very well because the grant writers were really aiming at an audience of their peers and … Just for my own interest, I always talk to these people at breaks and lunches and sit down beside them and ask them how they got into this and why they are here, and blablablah. They nearly all said "I'm interested in this particular form of cancer as my mother, son, whoever had it and I got interested in it, it was important to me". And so, more or less they said "Yeah, it's really a pity that there was only two grants on this form of cancer" and this is what I find interesting, and all the rest didn't feel I had anything to offer. So I think that's hard, to find there is … concept is great, they are gonna find people who can do it where they are gonna be few and far between…there is a whole lot of theory that goes into the learning as vast practice and I can see the patients being fantastic on the…what does it actually mean to be quadriplegic or whatever is it mean to be actually think about food 24 hours a day, or what does it actually mean not understanding what's happening to you, that's really important, and I think you need some of those **authentic voices to be heard by those designing curriculum, those writing teaching methods, those figuring out what should happen at practice sites.** But when we get to them teaching, I don't know, I can imagine them being powerful in some circumstances but still I'd think **we would have frankly to get the health professions to get comfortable with up to level three which I think is literally possible before we are going to start making progress towards five or six.** CVHEdU19, p.4-5.
	30. …on the sort of two and three, because they share certain similarities, except that I understand the first one is more in a clinical setting, and the second is someone comes to the class, if you will, and contributes. I think both of them are very valuable. I think for students encountering the patients in a clinical setting adds to that kind of motivational real sense of that's what it is, but there are cases, I can think of circumstances where we are having a patient interact with students outside of a clinical context, for example, people who have recovered from illness and are not an active patient at this point in time but have a very valuable comments to share on experiences they have had that can help students, so I would certainly support it. When you talk about the parent, the patient, patients to be involved in teaching or evaluating students, I think there are some aspects of it that I would strongly support, and some where I would side against it. I think a degree of caution needs to be exercised. Each patient, I think has a very particular experience and particular set of preferences on the kinds of things that they do, so I would be cautious of a patient trying to evaluate students ability to perform a particular medical task, because the patient may only be to base this on a very narrow experience …On the five, again it depends on what you mean by equal partners. …They are not professionals. So, while I would always carefully listen to parent's perspective, cause they see students in circumstances and parts of their learning that teachers don't see them, how students respond to certain kinds of homework, how they process certain things that works, parents can be tremendously helpful in educating teachers in those areas, and teachers can be tremendously helpful in reinforcing and even initiating certain forms of learning at home for their children. But in the end, would I hand over as equal partner, decisions about curriculum and pedagogy for the class to parents? I probably would not, but there will be certain areas where I, I very much would engage with them. So, yes, partners, whether I would say equal on all aspects of this process, no! CVHEdU20, p.4-5 31. I puzzled over, because I assumed level one through six meant that there were some sequential stepping. I was trying to package it, I thought that should be number two, that should be number five… I had two explicit thoughts when I looked at this, is that, number one of which is, **is this ironically at risk of becoming too disease focused because it's patients, and so where is the voice of the otherwise healthy active 62 year old woman who has always done all the right things in her life?** And there's something to be learned there conversation today with another colleague "just saw this 93 year old woman, and she is well and she is doing this this and this". **So she wouldn't get heard**. CVHEdU21, p.5

	32. **I can't help to think to an extent that there is a dynamic embedded within these different levels**, at the initial outset, we're asking of them, "would you come in and be a simulation patient" or whatever else. So, yes, I mean it's almost mercenary whereas at the more mature level, level six, very much we're asking, or they're giving of them as opposed to us extracting it. Because they're bringing their input and putting it into part of the decision making and so on, where the tipping point is that, I'm not entirely sure, but I can't help but think that we are not far enough down that pathway and somehow need to move that, because, as **I look at your levels, we are not very far along.** CVHEdU21, p.6-7 33. And the intriguing challenge I think is that it's how one would decide because a patient, I mean how would you design kind of who to represent it at this level? Who will be represented as patients? I mean, for me I can level one, two, three, teaching explicitly about aphasia because it's a nice type of topic. If we decided we want to do it more kind of systematically across the curriculum, what kinds … I think about a range of issues that we are gonna address, … I think … how would we do that? How would we decide which ones? Who is gonna be at the table? CVHEdU14, p.5 34. …**evaluation from patients, scares the crap out of practicing doctors**, because how the patient wanna say about how well I've been there. To the same extent why is it limited to CPD. Why wouldn't we embed that systematically in the medical curriculum? It's not the only evaluation tool. But right now I don't think there's much there. **That would be a pretty quick way of driving it away from the individualistic involvement and more into programmatic, yeah and that's complex, and how do you start to organize all that? But I think that would be quite interesting. You'd have to make sure you have the sample size that was meaningful, so that you don't get, we all run into somebody, where we, don't get on, and that's "oh my goodness, that's my evaluation. So what's the sample size?"** CVHEdU21, p.11

5. What needs to happen to enable and support community members to participate in health professional education (HPE)? (Interview Question 6)

Selecting the "right people" was top of mind for many informants. This meant finding people with "life experience," who "have a broad voice," and are committed to student learning. There were deep concerns about finding good representation of different perspectives and avoiding people who would "push a particular agenda" or who have an "axe to grind." Suggestions for how to select the right people included recruiting through community organizations and creating processes for screening individuals for different roles.

Informants recognized the potential for relationships with the university to be seen as one-sided or exploitive and thought there needs to be careful consideration put into establishing mutually beneficial relationships, including developing a range of rewards and recognition to compensate community members for their service to the university. Some examples of different types of compensation included: remuneration, tuition credits, honorary appointments, recognition at graduation ceremonies, access to university resources, thank you cards and certificates, etc.

Preparation and support for patients to work within the university environment, creating safe environments for them to participate and accommodating special needs and vulnerabilities were also important considerations to enable and support involvement.

Table 5. Key ingredients for patient / community participation in HPE

Select the right people Good representation (e.g. community leaders) *Identify the right players…who can speak on behalf…they have to have a broad voice.* *…somebody who has an axe to grind or somebody who has their own shtick …can undermine and discredit that process.* A system of selecting people with the right experience	1. …**identify the right players in a community**, who are really the **individuals who can speak on behalf**. I think that, I think what probably has happened over the years, because **it's often a matter of who would like to volunteer to sit on this or do whatever and often enough it may not be the right person** who does that, so our, **many people's experience with the community voice or the voice of a patient has been somebody who has an axe to grind or somebody who has their own shtick**, right? And that's not, and **that unfortunately can undermine and probably discredit that process.** And so this, that's why it is a whole process of understanding need, being able to identify those who are really able to speak, those who understand that **they have to have a broad voice**. CVHEdUPilot,p.4-5 2. …we run into this dilemma so often it's the **balance between recruitment and open invitation**, isn't it, to say well to be even handed we better put out a broad invitation here and then we'll try to put a decent filter in place. …extraverts come forward and they may or may not be your best choices. So we end up having to put in place a selection system that starts to look a little bit like our admissions process and we do. …**a system in place that's continually attuned to possible people who could be very good at this. I guess the more we get out into the community, the more we can see people you'd say, and you might be able to approach and say that there's a role in this particular module where someone with your experience could really help, would you like to consider it? And then we are proactive.** I think we'd all be more comfortable with that than just say sending a message to people in a particular community group and saying anyone come forward, we need, cause you get as you well know you sometimes get people who really have, **they see this as the ultimate soap box** that may or may not be helpful. So I guess what I'm saying is **the better we get at engaging the community on a broad basis, the more people we can have our eyes open for**. …**You really need a pretty big pool to draw from.** CVHEdU01,p.9-10
Engage with community broadly and recruit carefully Different perspectives represented Good if patient involvement can address multiple curricular goals (e.g. IPE, social determinants) Clear roles Screening process *non-essentializing* representation remuneration	3. …**on the one hand we're happy with the level of involvement that we have, but if people go away it can be hard work to find replacements** because people, it's not, for whatever reason life changes. So, knowing alternative, **knowing different modes of connecting with people who are genuinely interested in those opportunities would be one good thing.** On the other hand if we have a list of people who are really interested and we can't ever tap into them then that's not very respectful either, so it's kind of we're trying to find a little bit of a balance there. **Curricula are pretty tight and short in a way so there's, it's trying to find the most efficient ways that engage all the different perspectives we'd like to be engaged.** And so **finding opportunities where more than one goal is met at a time**, so if **we're dealing with interprofessional goals at the same time we're dealing with client or consumer goals and some other social determinants of health goals**, so some other learning goal that goes beyond that interaction or appreciation of the different perspectives or experiences. I think that helps to a certain degree as well because it's **more efficient in terms of meeting multiple needs at one time**. CVHEdU03,p.8-9 4. Bringing people in to be in the classroom with you, co-teaching can be very effective in particular courses, particular content with patients, particularly people who have that kind of background and really have a passion for those sorts of things. **Not everybody can do that effectively**. **You have to be careful who you bring into the classroom.** …being really **clear about their role**, and then the fit of that role with the person. **There's some kind of screening process that you interview, you don't just bring people in willy nilly but you actually have a process that fits so it's not off putting but at the same time it's kind of rigorous so you have the right people in the classroom.** …When you're teaching Aboriginal Health, I've had experiences where you have somebody come up, so here I am, I'm really pushing for a **non-essentializing approach** to Aboriginal health, to indigenous health and **trying to get the students to think critically about culture and then if you invite somebody in who's the quintessential indigenous kind of person and they're like essentializing**, it can be so bad. CVHEdU05,p.7-8

Recruit through patient organizations *…good communicators…able to tell their story in a way that the student hears and understands.* agenda *The challenge is picking the right people…* Avoid axe grinders *…getting the right people…a cadre of people that are good at this [teaching]…*	5. …she was like a dog with a bone in her questions and everything but I appreciated it because it was like wow, **this person really wants to have the right person at our meeting** and I appreciated that. But there was **a lot of time went into that**. CVHEdU05,p.8 6. that brings up the issue of representation and **who really is the representative cause sometimes we pick the easy way, the easy representative, the person who looks most like us.** CVHEdU05,p.12 7. … **we can just go out to them and to the Arthritis Society, to the Canadian Diabetes Association and the chapters here and just present to them this is what we're looking for, would you be interested? And I think you'd get a lot of buy-in**... CVHEdU06,p.7 8. **Mental health is a huge huge problem** as you well know and bringing in individuals from those types of organizations, the **Mental Health Association or societies** that we have, the local ones, I think it **would be very beneficial for our students**, **bring patients in who live with major depression or who they live with schizophrenia.** We know how to treat them in terms of drug supports but those aren't always successful and for a good number of reasons. What is it like to live as a manic depressive? What is it like to live with chronic depression or schizophrenia? CVHEdU06,p.8 9. I think one of the challenges often with **patients that have a burning desire to get involved in medical education, they've often had a dissatisfying interaction with the health care** system and they may have a particular issue that they're, or agenda that they're pushing. …So **the challenge is picking the right people** but I think getting students and patients together where they can interact, when I've seen it work, when I've seen it it tends to have worked well and tends to have been quite **riveting**. CVHEdU08,p.3-4 10. …we might get people who are quote unquote "**axe grinders**" who come in and **have a particular agenda that they want to drive** and this is an excellent opportunity for them to shape young minds because it took two years for them to be diagnosed… CVHEdU08,p.8 11. **getting the right people** …**a cadre of people that are good at this** but I think it takes a particular type of person. …**it's a lot to ask somebody to walk into a room of 300 people and to disclose, to even just to talk in front of 300 people let alone be able to do it in a way that is genuine and educational**... CVHEdU08,p.10
Passionate about teaching health professionals *…we didn't plan it, they planned is for us…* Partnership *…a clearing house…*	12. I was startled by how well they did and these were people in the community. They weren't educators, they were, well one of them I think was a teacher in the school, principal of the school there but I mean **for the most part they weren't educators but they were quite passionate about having health providers appreciate the difference in a First Nations rural community. It was quite extraordinary really and I think we just have to find more of those opportunities.** …So I think, I think you have to **get the right people in those settings** …**find out who else can do that and are there other people who feel that much passion because we didn't plan it, they planned it for us and we kind of stumbled into it. They took us to places that no one goes to. I mean they were sacred sites for their population and took the students and Faculty there.** CVHEdU09,p.7 13. …do the inventory and get someone to think about what are the advantages and disadvantages of these different sites, **how willing is the site to help with all of this**. Because I mean we used to do our professionalism and community service program at a lot of different sites and some were just bad and we stopped going there. But it took two or three years before we learned **which sites could predictably give the students a good experience**, the patients, the whoever was the population of the site, the administrators of the site, and many have to think of the three populations as the person receiving the care, the person who's sort of primarily responsible for them at the site and then **how do our students fit into that whole milieu.** But we've got some really good sites now and I think we feel pretty good but it's taken a few years to do that. But **a clearing house**… CVHEdU09,p.14

Avoid lobbying by special interest groups… *the agenda by which they're working is an educational agenda set by us…* Clear goals, objectives, parameters People with wisdom and life experience Recruit through an established body or community groups Recruit known contacts Identify key informants / gatekeepers to be the "key" to the patient group *…a cohesive and well-balanced educational experience.*	14. one of the concerns I have is that we are continually **lobbied by special interest groups and most organizations represent special interest groups**. So I think there are working with other organizations I think is important but provided that **the agenda by which they're working is an educational agenda set by us** because we have had students directly lobbied by special interest groups …I mean organizations provide resources, they provide access to people with the experiences, but they also have their own agenda and so I would be, **I would want to be very clear about what the lines of engagement were and what the objectives of what we were trying to achieve were.** CVHEdU10,p.4 15. **up until now that recruitment has been done pretty informally**. …the worry there is you get people who have a **personal agenda or a narrow agenda, and so how do you find the people that have that wisdom and that breadth who are actually, and that life experience who will be able to bring to us something which is not tainted by personal bias.** And so I don't really know how we would do that and I think what we would probably have to do is find, my inclination would be to **go to an established body or established community groups** and say we're looking for some folks, can you, these are the parameters, these are the kind of folks we're looking for, these are the kind of things you want them to do and allow them to put some names forward. And then I think what we'd end up doing is having some kind of process or interviews or something. CVHEdU10,p.5 16. …it's primarily been somebody within our faculty, either a researcher or clinician who has said I think this will, this is a good idea and I know a client I've worked with who I think would be really comfortable in contributing or attending this meeting or that kind of thing. CVHEdU11,p.5-6 17. Helping people to understand the goals for the students. What it is that we want the students to gain from this. So meeting beforehand, interviewing people to **find out what their expectations are and making sure that they are not unrealistic and that they align well with ours.** CVHEdU14, p.6 18. …**identify key informants or the individuals within their cluster who would provide a really good perspective.** …**it would provide a key to the clients group, to the patient groups so that the gatekeepers** … CVHEdU17, p.3 19. …**even within organizations can sometimes have a very particular position on things, and sometimes can even pitch themselves against each other. So I think that as engaged with organizations, we need to be very mindful of that potential for that kind of ideological separation there or agenda or exclusive focus that sometimes may not be necessarily very supportive of the broader educational needs of students. But, having said this, I do not want this to be considered and understood as a discouragement to engage with organizations, I think it just needs to be carefully thought through, how this can contribute into a cohesive and well-balanced educational experience.** CVHEdU20, p. 3
Confidence Good communicators	20. …they have the onus, but also **they have the confidence and the extra training through their peer support roles to feel comfortable coming to a class of 80 and talking about hallucinations or etcetera. So that takes a special person and maybe we will only get the special people come in to talk** or to … **another classic example is when we do stroke. A lot of people have speech disorder and either just can't verbalize what they need to say effectively. So all of those people are excluded. Yet, for physiotherapists to learn how to communicate effectively with people who can't communicate verbally would be such an asset, but they are the most difficult people to have come in.** So, certainly there are some physical barriers as well as kind of confidence and sensitivity barriers …so, confidence and the nature of their problem may preclude them, their ability to actually speak. CVHEdU16,p.6 21. …you have to be very careful and encourage people to share what they're comfortable sharing. But I think, you'd wanna be mindful of only engaging with people who do feel comfortable sharing, so you'd wanna encourage people who do not necessarily volunteer and I do think it will take some work CVHEdU15, p. 8.

Representation	22. I think organizations that are more willing to give direction and willing to take direction, and …from the groups they work with or who probably find it easier to contribute somehow to student education. CVHEdU14, p.3 23. …my fear is that if it was sort of an organization that was actually more run by people who don't actually live with those disorders themselves, it might become more of a prescribed kind of education that's just another variant of [unclear] here. CVHEdU14, p.4 24. …with this course, there was a fabulous content in there … in no place was there any community representation. So it was all about Aboriginal health and there was none indigenous person that was involved in any of the curriculum delivery or development. There was no contextualizing of health care experiences or anything in that curriculum. So other than that, it was a star start. **It was great, but there was no indigenous people actually talking about themselves. It was other people talking about them.** CVHEdU13, p.4 25. A mix of community members from **different walks of life**, some are advocates for those who are disenfranchised but also I think **it's important to have a good representation from those that are really marginalized**… CVHEdU13, p.4 26. …so we've tried to create subset and then take **representative subsets**, whether it's folks from the downtown, whether it is immigrant women in Surrey, whether it is case of juvenile, or arthritis, whatever else is. And then we sort of almost use that and then in my approach, if we can get enough samples from those different groups, hopefully we would be able to nail it. That's not a bad approach. Still, I don't think it's ideal. CVHEdU21, p.7
…committed, willing and adaptable. *…someone who wants to reach out to the medical student as a learner.* *it's a real privilege for students and they get a window into what healing really is.* *…they are there for the students.*	27. … **you'd have to find someone who is committed, willing, and adaptable.** CVHEdU19, p.5 28. **The ones that are the best are ones that have the ability and the skill set to be able to reflect on it. So they've actually moved through the trauma and are able to see in a different light. And they are not so damaged or so hurt that they can that they are lashing out at the health care professional**. But **that's really difficult when you got an angry, or a person that's been traumatized and hasn't worked through their stuff, so they are blaming.** So you need someone that has come through that and can understand and **wants to reach out to the medical student as a learner.** …**It's a real privilege for students and they get a window into what healing really is.** Not in wellness, not in just the pill that they give, right? So that's to me that's the best that they bring, **the best ones are also pretty good communicators** I think, so that **they are able to tell their story in a way that the student hears and understands.** So, yeah, that's what they bring. So I think they bring that experience and a story and **they know enough to make meaning of it and they are able to support the students in understanding that they are there for the students**, that they are there for the students and they want to give of themselves and get back. So it gives them something that makes meaning for their experience CVHEdU13, p. 5 29. **I am a strong believer in drawing on the community in the process of educating the students. I think that students value it and appreciate it, I think it creates richer educational experience and I think it connect the university to the public in ways that we need to be connected. I see a huge potential of this direction as we move into the future. I see also what are the areas we need to be careful, and part of it is that we thoughtfully designate the sort of zones which we want to involve the community and that they map very well with the areas of their expertise**, if you will, and their capacity to provide input where a) others cannot, and b) where we can be confident that this is going to be a really comprehensive, deep, full contribution. So, **I don't think that community members can replace many people who are part of the educational system in many of their roles. But I think there are certain parts where they can be at least as effective, if not more effective, than some of the academics.** CVHEdU20, p.9

Compensate / recognize / honour their expertise*	1. …we can't be expecting people to be volunteering. CVHEdU02,p.10-11 2. I think **predominantly people need to feel appreciated and like they're making a difference so that it was somehow valued and it did make a contribution so they need to hear from the faculty members and the students what was helpful and what worked well so they need to have that feedback and it needs to be specific.** CVHEdU03,p.10 3. …when we develop this more equal distribution of power and recognize people's expertise, part of that is getting paid for your expertise. So that opens a can of worms.CVHEdU04,p.9-10 4. We should value people's time however we do it, so for some people they don't care about being paid but you can only use volunteers so much. …And it isn't just the academic that's recognized for that. **So we have to have processes of recognition and respectful recognition on the work done.** …So a recognition of work across a number of domains so that would be recognized as authors of work, recognized in terms of payment, however else we recognize people. CVHEdU05,p.7 5. I was really shocked to get this email and see that this person didn't feel … their input was being respected, respectful, respect was the word they used. That's a big word so I'm just like oh no, we have to take care of that. CVHEdU05,p.13 6. …**we give out awards each year** for a top number of preceptors and we have criteria that we use to assess them and **we make those awards very public as part of our graduation ceremonies. When the students come back we have a Dean's reception and we invite them** …recognition system… CVHEdU06,p.6 7. I think there need to be some resources cause it can't be, it probably wouldn't work if it was up to me finding the patient and driving to their home and picking them up and getting them to the lecture and giving them $10.00 out of my pocket for their time or whatever. So it's like the standardized patient… CVHEdU08,p.6 8. …**we need to pay them for their time** and maybe for their transport …**it shouldn't cost them money**. I think from a kind of engagement with the university I don't think we can be paying people for their time but I think **we need to pay them for their inconvenience in some way.** So that may literally be $10 or $15 dollars like clinical skills does now for standardized patients. And then I think **there are probably symbolic ways that we can recognize people like have an informal or formal event at the end of medical school and invite everyone every year and have the students thank them at that event for participating in their education. I think we don't recognize how important that is.** I think giving these people an opportunity to have a tour of the medical school at some point, understand how this mysterious process works I think would be a valuable thing. I think **letters and certificates matter to people. A Christmas card from the Dean matters to people.** Like I think it doesn't have to be expensive, I just think it has to show that organization recognizes that they're important in some way. …**students said a few things about how important they were to their education, I think that would be huge** I think in many people's lives. So I think it's those sorts of symbolic things as opposed to we're gonna pay people $100 bucks an afternoon for coming and sharing their lives. I think then we might get the wrong people in fact. CVHEdU08,p.8 9. Well we thanked them and sent them some gifts and other things like that and they invited us back next year. CVHEdU09,p.7
Thank them publicly (e.g. graduation ceremonies, develop awards) Need to pay for their inconvenience Recognize how important their contribution is to education Feedback from students about how important they are to their education	

	10. there's different levels of recognition. One is do we recognize through some, the moment we recognize through some payment of expenses but not much more so we're really looking for a lot of volunteers. And we do have some people who are actually professionals. I mean I think our, the leaders in our standardized patient group are actually professionals cause they're doing a piece of work for us. So I think it would depend. I do think there has to be recognition. If there's not, if there's not monetary recognition there has to be some other kind of recognition. CVHEdU10,p.7-8
	11. …**pay people for their time and their expertise** in our department. We **offer recognition like a clinical faculty appointment** etc. **which I don't think we could do outside of our profession but there's certainly other ways that we can recognize people's contributions.** I think, I don't know, I would be interested in **asking people what would be the most meaningful way of recognizing their contribution and their time.** …**We have people who contribute to the program who refuse payment who say this is part of my job and I'm paid elsewhere**… CVHEdU11,p.6
Tuition credits	12. Sometimes through **payment**. Sometimes certainly in **documents**. Sometimes through **involving them in social occasions**. Sometimes on our **website**. …everything from **lunch** to sometimes for example if they were really involved over a long period of time and it added up to the **tuition for a university credit**, we've done that…CVEHdU12,p.7
	13. …ensure that they are gonna be heard and they are gonna be respected, and they are gonna be honored for what they share. CVHEdU13, p. 9.
Respite for caregivers	14. how do we remunerate folks. Well, to some extent providing a title. Some people would value that beyond pay. So it could be considered a clinical faculty member. That might be acceptable. I think here it might be a controversial suggestion. Access to kind of cutting-edge practitioners. So you might provide easier access whatever that looks like. It could be, depending on level of condition or disability, it could be support for caregivers. So if I think about some of the folks I work with, they tend to be severely disabled and have loved ones who are care providers so providing a little bit of respite. CVHEdU17, p. 6.
Gift cards	15. ….students spontaneously made cards, and … would be "thank you", and all the members of the class signed it and they gave the card to the prof, and asked the profs to get them to the patients who had participated. **And it is very touching, because this is something that students really gave of their time to thank patients for coming in, and putting up with them for two hours.** So, I think little things like that go a long way to expressing our gratitude for the contributions that they are making. I mean we do little things …, give out **Safeway cards**… CVHEdU16, p.5-6
	16. At the bare minimum, there would be, it needs to be some kind of recognition, certificate, diploma, honorary something or the other, up on the blog, up on the website, thank you so much … as long as they agree to it. Like I'm not sure quite frankly, that everybody would want to have their names posted on the website but maybe some people would. But frankly I think money is important. And when people spend three hours in the classroom with students or when they … and they've already prepared for that three hours with five hours of work the way they should be honored for their time is with money. CVHEdU15, p.11
	17. …**for people to become really part of the curriculum, it becomes problematic. Some people are getting paid to do that, and other people not, and just because you are patient does not mean that you should not be getting paid.** CVHEdU14, p.6-7

They need to feel valued, respected, important – that they're making a difference	18. …**it would be very powerful for the advocacy group to be able to tell, it's a concrete evidence that they've done something, and they are changing something.** I guess I'm thinking, **it's not unlike donors to any charitable organizations, what you do for them, is you recognize them, you hold events**, you put up the [unclear], or whatever. It strikes me the same concept would work. These patients working with this group would achieve that change, "we are going to give them community member of the month, we are going to revere the [unclear] award for…" **it has to be perceived as valuable**, and not just another kind of exploitation. …they **wanted to somehow give back or make it better for people. I think tapping into that really important human feeling and just doing the communication that what they are trying to do is valued, respected, important, and produced change.** CVHEdU19, p. 6
Community faculty appointments… find ways to *honour their teaching*	19. ..for this **community faculty, give appointments, find some way to honor their teaching.** For example, [name]. It would be great for him to be like an honorary instructor or you know honorary degree. …It's really hard to bring those kinds of things forward. We tried to do clinical faculty, for example through the College of Health Disciplines and through family practice. But now family practice is not recognizing those community instructors, validate these appointments anymore. **It may just be honorary things but I think it's important to acknowledge that in the education system** so they don't do that anymore and I think that's important that we do. …**you have to pay, you have to pay, you have to and it should be the same as what you pay anybody else.** CVHEdU13, p. 7-8.
	20. it almost depends on the individual you are dealing with and the problem that I have with that reaction is that I actually think there should be sort of **bands or minimum or maximum levels of reward or compensation** …**you need ranges of things that are available to you and then you need to decide at what level you are going to compensate these people in order to do those.** CVHEdU18, p. 7
	21. It depends on what you like them to do, if you want them to come to classes and basically be involved, and travel to, and take a lot of time, then I think it's reasonable to say there is some form of compensation. CVHEdU20, p.5-6
	22. There is a full range of things available to us from simply acknowledging it and celebrating it, and making other people aware of it. …We also have the ability to make honorary appointments in some areas and for some people that's quite important to them. So the recognition through not honorarium, through not financial compensation, but through an appointment at the university that has no compensation but recognizes the role that they're playing. CVHEdU18, p. 8
Barter system, vouchers	23. …a **barter system** where patients particularly effective at this, also get a reward, it's **vouchers** of this, or it's some kind of recognition. I bet the voucher **London Drugs** would be useful than most things for many people. CVHEdU19, p.11
	24. …**to somehow better describe the gratitude that the students and those who educate them have towards the patients**, not necessarily monetary ways, not necessarily … but somehow to be a little more convincing on this argument. **People deeply care about health, health care, and I think most people are probably willing to contribute in ways that don't upset their lives, interfere with their things, but sometimes I don't think they feel invited enough or appreciated enough for being part of that process.** CVHEdU20, p.6

Develop genuine, mutually beneficial partnerships with community*	1. The idea to set up that committee so that it had a **community co-chair and a university co-chair** was brilliant. [Name] worked very hard to defer regularly to this community co-chair. They were very confident, this was not patronizing at all. CVHEdU01,p.11
Address power	2. Well again the people at the advisory board remind us time and time again that we're prone to the following kind of mistake. Because in our daily lives **we're expected to have answers, because we're expected to be problem solvers, we perhaps naturally think that when we move in, and I, yeah when we move in, that's a good phrase, to a community or we have a meeting in a community, we assume that it's our job to be the problem solvers, to be the decision makers**, and CAB has told us so many times, **you engage community voices too late in the process over and over. We write documents and then ask them for their input. We do not write documents with community members.** Now that's improving because good heavens, we may be slow learners but we are learning. So I think that when you talk about going into the community, first of all you're going in early, **you're not sort of going in with the mouse trap built saying do you think this will solve your mouse problem, but rather do you have a mouse problem? Is it, or do you have other problems that are much more serious than that?** We'd start at a much earlier stage and that's from a research perspective. **From an educational perspective, how fascinating would it be if you didn't go in with a ready made curriculum and say we need someone to come in on March 11 and talk to our students about what it's like to live on income assistance. Would you do that for us please? Which is very late in the game. In other words we've figured out everything we want to do, but we just need a person and we think you're it.** …These, **the curriculum renewal town halls, when they get drawn up at the community advisory board, the boards stop rolling their eyes.** CVHEdU01,p.14
Share responsibility & leadership	
community defined needs	3. you would have to talk with the people themselves about what they would need. So if I was doing **true community based work, you'd have to figure that out together** what that should look like. The university doesn't go over here and figure out what that should look like. They would **do it in concert with the community agency**. CVHEdU05,p.10
…true community-based work, you'd have to figure that [needs] out together… do it in concert with the community agency.	4. …**we have to be able to see these partners as our equals at the table.** CVHEdU05,p.12
The organization will tell you how you might help them.	5. **where you have your meetings, how you schedule those meetings in terms of timing. Are you taxing the organization in any way? Are you actually giving back to the organization for that information?** And **it might not be in payments**, it could be in other ways in kind. … **the organization will tell you that how you might help them.** …So it's also **figuring out systems of reciprocity that make sense for both places.** …So **what does the relationship of reciprocity look like and who defines what reciprocity looks like?** CVHEdU05,p.12
Rental fees to pay the organization	
…figuring out systems of reciprocity that make sense for both…	
It's not always about payment…it could be in-kind.	6. …**it's not always in payment** but **it could be in-kind.** So somebody who's wanting to pursue some part of, some piece of training or education and/or education and we could do some thinking about those kinds of things as well. …could **have a taste of one of our programs one of our courses or maybe not have to pay tuition for that course…** CVHEdU05,p.15
Tuition credits	
There's ways of giving back that are a little outside the box.	7. it's got to be a multi-sided strategy where you are kind of seeing people who are kind of already doing it, you are getting a sense of what people could share. And the **building capacity idea**, which is actually your idea, I don't … I've never…, I'm learning that from you that might be more about getting to know people, seeing people's experiences and then almost planting a seed, where .. you mentioned something like, "that's really important", or "that's really significant", or "your experience is really unusual", or "your experience is really common", "what do you think about engaging in a panel"… CVHEdU15, p.10
Develop relationships / personal connections / networks	
It can't be to make UBC bask in the glow of their noblesse oblige…they should do it because it's the right thing to do and not because it's a good photo op.	
University is a place of privilege	
Share knowledge / expertise	8. how they could make contribution, and how **it needs to be done carefully so that they are not exploited.** CVHEd-U-15, p. 3

Create "win-win" partnerships True partners Prepare students *…it's not about going to the community to acquire knowledge, but working with the community to have transformations in identity and values…* Build trust, identify what's important to them Create dialogue reciprocity	9. **not using community organizations simply to meet the needs of students.** CVHEdU15, p.5 10. whenever we need you we come does have a smack of a certain arrogance. CVHEdU16, p.7 11. That's something that we should actually be talking about too, … the importance of relationship in learning and teaching. Then that might be one way of ensuring that there is this kind of **mutual respect**. because we change the way we talk about learning. If **it's not about going to the community organization to acquire knowledge, but working with the community organizations in order to have transformations in identity and values as well as constructing knowledge with people and engaging with people and building relationships with people.** That's something that we should actually be talking about too, **the importance of relationship in learning and teaching**. CVHEdU15, p.6 12. …**you have to build trust, you have to build rapport. You have to make sure that it's important for them. And it's a real stepwise approach I think in terms of getting them talk about what's important to them and identifying ways that they think they could best help. So it's creating a dialogue or opportunities for conversation.** …an **investment of time to get to a level where you could really have an exchange of trust**… CVHEdU17, p.7. 13. … **so it's reciprocal** … CVHEdU13, p. 13.
Preparation, training and support to work within the university culture* *It's not just about doing an ABC primer* *Gradual entry*	1. …there's a reality of how universities work. …We've got rules and procedures in university that will drive us all crazy, but at the end of the day if we try and bypass any of those, it's not going to work. And so how do you get people who can also appreciate that and it does require the right type of thinker who's able to engage in that. CVHEdUPilot,p.5 2. …**the level of intensity that I encountered that accompanies pretty well everything related to medical education within the school**, our curriculum discussions, our tutor, we even called them tutor support meetings …**it's not just about doing an ABC primer**, it might be a good thing to do, who knows, depending on the work we ask them to do, **it's not just about taking an instructional skills workshop or a reading a very good chapter from Biggs and Tangs book on university teaching. ….using each other with some very skilled facilitation that doesn't try to sort of speak unto them, but rather normalizes the nervousness they would feel, the sense of intimidation that I've certainly felt and I imagine most of us at some point, even very experienced people when working with students in intense settings, that might be a really useful vehicle and we'd learn a lot from it.** CVHEdU01,p.8 3. …**gradual entry** into a system comes with a really skillful knowledge of when and how to turn to that patient and say over to you, you run with this section now. …a **safety net** of sorts, the higher up the level of involvement you went. For a patient to tell their story that takes courage, that takes clarity, in and of itself that's rare. **For a patient to teach something that they think a student might be examined on and that their progress might be determined by or that they might evaluate now I could see many patients saying 'Is anybody else gonna read this?' At least in the early going, where are the safety nets here? Good heavens I felt that and probably still do on a regular basis frankly, the number of times we like to bounce things off each other is still significant.** So in addition to maybe that the small group teaching in groups and talking about what it's like and what they're going through, to have that in the words of language of **instructional skills workshop**, sort of **co-facilitation model where you're brought in, given some responsibilities and then gradually given more responsibilities…** CVHEdU01,p.9

Context *it is hard just to kind of put a call out and invite people and put them in a room and say so what should we do with our hematology block… we wouldn't do that to a bunch of gastroenterologists*	4. …[Name] thought at one point they [community advisory board] should understand the details of the four years and he went somewhat painstakingly for about 45 minutes through the four years and how it's laid out and I was sitting there thinking this is proof that some people can't be bored by anything sort of thing. But I was very wrong. **They ate that up and really appreciated the fact that [Name] took the time to explain something to them so that they could have a better sense of what they were trying to affect.** CVHEdU01,p.15 5. But **there'd be people who may be interested in getting engaged that need some support in how you organize a session for a group if that's what they're going to be doing is something that's akin to a guest lecture.** …**so if they were going to tutor students for example over multiple sessions, then engaging them in the same type of orientation or preparation that we do for our small group tutorials for when clinicians participate or new faculty participate**, then there may be, that may be appropriate. **To be engaged in very specific tasks like admissions interviews, we already have an orientation process for that so they would participate in the same process as anybody else. And whether or not there's some merit to connecting with other non academics, so other consumer collaborators or patient collaborators and doing it with that group so that they can share experiences with a light group as opposed to a group that wants to buzz through it more quickly.** …**To be engaged as on these more higher level involvement, {pause} I guess part of me thinks that the people would be most interested in that higher level involvement probably have more skill at that than we do {Chuckle} and could probably teach us a few things but I suppose that there are other people who might need a bit of preparation related to how curricula are planned if we were going to engage them as really meaningfully in curriculum design or re-design and so forth than there may need to be some preparation that was related to what constitutes a curricula, what are the standards that we're trying because we have independent educational standards and interprofessional educational standards and university graduate studies standards and so forth and so understanding that contextual thing or all the balls that we have in the air when we're trying to document a curriculum and move it forward so there may be some need there to be prepared to take to be meaningful engaged instead of as a curriculum designer or a contributor instead of when you see the opportunity to express your opinion do so.** CVHEdU03,p.9-10 6. …the skill set and I think that CTLT could be quite helpful in helping us to set up some sort of orientation so people have a sense of how things work within a university. CVHEdU04,p.8 7. …you don't want that to be a set-up for the person who comes in, you want it to be respectful engagement, right. And so you also, if you're gonna bring patients/consumers into the classroom and involve them in work, you also have to provide safety for them. And I think there could be a trick in that, **especially if it's at all sort of controversial content** or content that carries with it. So I teach racism, I teach about discrimination, stigma, it's {s/l rife} for problems unless you do it right so **I would never bring anybody in without really preparing them well for the classroom.** CVHEdU05,p.8 8. …**basic teaching on instructional skills** …**just understanding our culture, who we are so that they can see what role they can play within that culture.** …Certainly in terms of assessment, **how do we assess individuals, what are we looking for, what are the outcomes that we're trying to achieve with throughout our curriculum…** CVHEdU06,p.5-6

	9. **I think we can be socially responsible in a way by looking at health statistics and trying to respond to social needs. I think social accountability is a little bit harder to show that you're actually accountable to those people in those groups. …it is hard just to kind of put a call out and invite people and put them in a room and say so what should we do with our hematology block, but I think, and it does a disservice because we wouldn't do that to a bunch of gastroenterologists, what should we do with the hematology block. So but if we could provide people some training and I thought that if it could be done at a faculty level or even at a university level, but at the university level the people may be run off their feet but some way that we could sort of have a manner to bring substantive questions like, 'we're thinking of doing this or this, please give us a perspective' and I think there'd be some value to that rather than just pulling a couple of patients that are that kind of usual suspects who may be willing to respond.** CVHEdU08,p.4
SP program model – autonomous, patient run	10. **They would certainly need training... the clinical teaching associates and standardized, and standardized patient program as far as I can see seems to be run by the patients and or the standardized patients, they've become an incredibly important group to us but they're also pretty autonomous. They do their own recruitment, they do their own training. So that would make me think that the way to go about this would be to find out what it is we, what it is we want to do and find three or four people somehow or other and that we can bring in, work with and get them to develop their skills that were needed and then allow them to then grow that.** I would start everything small. The standardized patient program grew very, from very small beginnings. **But I think we need to be very clear about what we're looking for...** CVHEdU10, p.6
	11. …**give them an understanding of how things work and what would be the most, the biggest bang for their time in actually having an impact in our programs and in the education of the health professional students…** CVHEdU11,p.5
It's important they understand where the points are in the system that they can actually influence. Mechanism for sharing the added value	12. …**if you are actually asking them to sit on committees and make decisions about curriculum, about assessment, about practical or clinical experiences, then I think they need to bring in some more information to the table. And so, it's almost, situation dependent how much information they bring, and then get into questions about who do you choose from the community** …**that's where I start to get into questions about should we be choosing people who have more information, or should we be training them if we are asking them to make decisions in those kinds of areas.** CVHEdU18, p.6 13. I think the persons require **some background as to how their engagement will contribute**. … **The prep work is almost greater though when you get to level six where we actually want their unscripted input. But it's much more important than they understand where the points are in the system that they can actually influence.** CVHEdU21, p.7
	14. …**secretarial or administrative support to develop a curriculum, to develop their ideas to structure whatever sessions that they are gonna put on,** …**it's a value-added contribution not just an added contribution.** Cause I think that **if they got a sense that we thought it was a waste of time, then it would be a real insult to them.** So we have to create a culture that it is important and **make sure that we communicate that to them**... CVHEdU17, p. 5-6.
Self-efficacy	15. …**it takes support and practice** …**it's not just about technique or style or some skills for how to share their experience and how to engage in conversation, but it's actually for them, the work that they need to do is to see themselves being educators in a medical school, to see themselves as capable of engaging a whole bunch of medical students in a conversation.** …**to bring the curriculum to life**… CVHEdU15, p. 9

…bring the curriculum to life…	16. I know some professors on campus who are terrible teachers. So, it's almost like we are saying "if you are gonna do level six, you have to actually do more than what we do sometimes", but I'd like to think of that idea which would be, that we provide the support and practice and engage them. And it would be kind of like this ongoing as they're becoming university educators, right? And they have these contributions to make and they are evolving and developing into this role. CVHEdU15, p. 10 17. …**some people would need, at least a bare minimum of training on things like minutes and agendas** …**we don't want to be teaching them content, we don't want to be teaching, but we want to teach them process so that they can know, for example, when to offer a suggestion or a motion if it's a motion type meeting.** CVHEdU02,p.17
Accommodate special needs / Create safe environment*	1. …**for vulnerable populations I think it's quite important to work, for them to work with students in a setting in which they're comfortable.** …**the other barrier there is that the vulnerable populations are also fragile populations and so there are times in an interaction between a vulnerable person and student where that may unravel because there's things going on in the vulnerable person's life. So I think the, for both parties making sure that there's somebody around to help them.** …**there's a mentor or supervisor around as well just to make sure it's safe for everybody**. CVHEdU10,p.9 2. …sometimes about comfortability of people who very, who want to participate but feel very vulnerable about that participation and if they come and they get burned they're never coming back again. And we've seen that happen not just with individuals but whole communities. CVHEdU12,p.6 3. …**being reassured that will not impact** [laughing], **on their health care**… CVHEdU20, p.5 4. …**furniture arranging and everything that will not set up that hierarchy**, **create comfort for the speakers** … CVHEdU13, p. 9. 5. …**it has to be safe for the community members** so, sometimes that safety is created by showing them about all of the stuff that medical students have learned but also that is something that is gonna be recognized and heard or validated, so they don't wanna be a token… CVHEdU13, p. 7 6. …**even though it's very difficult sometimes for people to come to university. And it's very difficult for people to come to university classrooms, I still think that's the other side of the bridge that has to be built, because that shows that at university, this perspective is valued and there is a place for that particular person, or that particular community organization in this space.** So I don't think **it can't just be about university students going out into community organizations. We have to figure out ways of creating space here.** …**safe spaces for them, or honored spaces for them.** CVHEdU15, p. 12 7. People who are marginalized often have things doing that are happening between 8 and 4. … they're not available at times that the rest of us might be available. CVHEdU02,p.10 8. my sense is that to make this work the needs are gonna be, need to be addressed quite individually for the community members. And likewise for the university… CVHEdU02,p.19 9. **their lives are often chaotic by virtue of economics and addiction and living situation and all kinds of stuff.** CVHEdU14, p.6 10. if you have relationships with a couple of key people, they could also help you recognize people who might be interested in being involved, or might have something special that needs to be shared and you could also work with encouraging them to do it, or ask them, "who would you feel comfortable talking to about this?", or "would you prefer small groups instead of the whole lecture theatre or do you want to take on a hundred students at a time?", "what feels most comfortable to you?". So, some of the stuff need to be negotiated. CVHEdU15, p. 10 11. …**sorting out when is disability is too much, when does it actually preclude the person from being able to participate** at all, and how do you deal with that? CVHEdU14, p.8

	12. … **some people who we can really learn from at university, would feel very uncomfortable even coming to university.** And I think **some people who we would learn immense things from would feel uncomfortable sitting with us in classrooms.** And if you think about all the different professions that in the world, I mean there is probably not one profession that's more highly regarded than health professionals, although that's not necessarily true across the world, it's certainly like of the professions out there, it's the tops, right? So that I think would be incredibly intimidating to some people. I mean, who knows! I don't know if I could stand in front of 200 medical students and blabidiblah about my experiences and you also have to remember too. And I know I mentioned this already but how we wouldn't wanna position someone like that to be just kind of be the object, right? It's not an appendix … so how is it that we see that person's experiences, or that person's difference, or that person's … what that person is sharing as a whole person, not just the person with diabetes, it's Bob and whatever. CVHEdU15, p.12
	13. …I think there is a very big range of the support that we can give people. And sometimes people's presence… I'm just thinking of some of the people with aphasia in our group who have really much more severe aphasia and don't actually participate all that much. And yet, they are not, I wouldn't see them as token at all in terms of the amount of engagement that they have and the lessons that they do, the information that, what they can contribute maybe very very of small relative to what other people can contribute but it is still meaningful. It's just where that line is, because it's a very, I mean on the board of [Association] it sort of became, we can't have people with these problems and I'm thinking wait a minute, you can't just like, we can't [unclear] everybody out just because you have to speak a bit slower. So it sort of needs to be looked at from both sides. CVHEd-U-14, p.8 14. … but sometimes you may not have home, or you might be ill, or you have a relative that's died or all of those things that come into play, so **the university really needs to be flexible and form curriculum that can change things around**. [Name], my speaker, gets called up, **he always answers to community first**. That's critical. So that means **you have to have a really good set of backups**… CVHEdU13, p. 9. 15. …**figuring out what kind of support they are gonna need to be able to do this** …**making sure that those needs are really identified upfront clearly and we can always manage them somehow**. CVHEdU14, p.6

University Leadership & cross-discipline collaboration Integration of Health good timing	1. **the Integration of Health is giving us an opportunity**. …**I think we have leadership now, be it at the Council of the College or at the Health Dean's table, of individuals who do believe that involvement of patients and clients is really critical…** CVHEdUPilot,p.11 2. …**this could translate into something that's incredibly valuable to the university but also to society as a whole.** CVHEdU06,p.12 3. …**this is not a bad timing** to think about it, especially cause we've been having so much talk on like the health, the health organization, yeah {I: Oh the integration} the integrated and health organization, right. CVHEdU07,p.13 4. I mean at the philosophical level I think where most of the Deans are right now, say **philosophically the idea is quite good**. CVHEdU09,p.14 5. …use that then the student feedback in a demonstration project would then begin to influence others in Faculty because students have a huge amount of kind of influence over curriculum direction and what's working for them and what isn't. CVHEdU10,p.8-9 6. … **given that nobody knows what the Faculty of Health looks like right now or what it's going to do, but there's a sense that it needs to be embedded in things that run across all the schools, I think the opportunity is there right now within the current environment of our social accountability stuff to embed some of this stuff in the Faculty of Health from the beginning.** …**there's an opportunity to put a stake in the Faculty of Health and I think it's n ow.** CVHEdU10,p.10-12 7. …**work together with a common approach or a combined approach** … CVHEdU11,p.5 8. …one thing that I think came out at some of the integrated health talks and things is that although we're interprofessional and there's a lot of different professions and it's wonderful that we all work together, sometimes it doesn't make sense for everybody to be at the table for everything and there's certain projects or certain areas where it makes sense for it to just be four of the professions, that that's the most logical fit. But I think it's also important for everybody to feel like they have some involvement or contribution or opportunity as well to benefit from things that are happening. CVHEdU11,p.8
timing right with Flexible Learning	9. I was very struck on reading your … the document you sent me; **how much parallel there is to the initiative UBC is calling Flexible Learning** where one of the most interesting parts is collect student- generated content. And what I mean by that is **breaking the assumption that the professor instructs and there is nothing to learn from the other direction.** It's so the analogy is perfect, but, it strikes me that **the new wave in education is precisely around realizing that education is a multi-way conversation**…CVHEdU19, p. 1

Raise profile of & build on existing programs / partnerships Develop business case Build x-disciplinary ownership Fundraise	1. …if we could shape what this might look like, be willing to engage in investing in a unit or invest in the fundraising around such a unit. …So basically what I'm saying is that this really needs to be a pan health professional program initiative with responsibility and ownership by all the health professional programs and not just one of the faculties. CVHEdUPilot,p.11 2. For example, like our community patient fair. Would that be an avenue or would that be a venue that we can actually bring in a few like-minded people to start thinking about strategically plan for something. …bring a few more brains together and try to see what are the opportunities, how we can see some funding and to get something more profound to happen and really make a bigger bang. Can we actually create some kind of new, some kind of initiative to really bring the awareness of the university to the further consumers be part of the decision making people and …demonstrate that kind of evidence to the decision, I mean to the level or to the senior level of administration as well. CVHEdU07,p.12 3. I think infrastructure support, making it okay, giving some models or some examples of how this worked and if people are starting to write cases in the undergrad MD program now, number one and two and three, like being able to sort out a little bit of a few pilots or finding some early adopters… CVHEdU08,p.7
Language	1. [Name]'s use of language was almost never medical. If he ever used an educational term, he would define it, he would almost apologize for it. …the way that he did that work, that indicates the potential size of a barrier for sure just in who we are and how we conduct ourselves. CVHEdU01,p.11 2. … **your choice of terms actually influences the input that you get**. CVHEdU21, p.6
Make it easy	1. …**the harder part is making it real, operationalizing it** …**so that the process isn't as difficult** as, the nay sayers will say it is. CVHEdU02,p.19
Infrastructure technology	1. phones and cameras and video cameras and skype and all those types of things if I can attend a meeting sitting in Ottawa or Washington or New Westminster because I can't make it to the UBC campus, they should be allowed to as well because that 45 minutes isn't something that they can spare in their day just because I can't. I think you need some just basic, just in terms of equity I think you need to level the playing field. CVHEdU02,p.10

6. What are the barriers to authentic participation of patients and community members in HPE? (Interview Question 7)

UBC is a place of privilege. The relative high level of power and privilege held by the university was the main barrier to authentic participation of patient and community members in health professional education identified by university informants. Informants recognized that universities are intimidating places by virtue of being institutions of scientific investigation and higher learning with authority to grant advanced degrees. The unequal distribution of power and privilege was thought to be a barrier at many different levels, such as between the university and community, members of academia and members of the public, health professionals and patients, etc. In the case of marginalized / vulnerable populations the issue of power was thought to be magnified by stigma and low self-efficacy.

Informants also identified the need for a cultural shift within the university to sharing power. The unique knowledge and expertise of patients / community members needs to be valued by the university.

Table 6a. Community barriers to authentic participation of patients / community in HPE

Power & privilege *…we're intimidating* *…they are people of interest because "there's something wrong with them."* *It's a place of perhaps some of the highest privilege you'll ever find anywhere.* *…appreciate how unfamiliar we might be…* *Universities are very uncomfortable places to be… they're learning environments so we are all about very high expectations and assessment. We are constantly judging things.* *…we treat them as diseases as opposed to people…* *Privileged university environments*	1. …**we're intimidating**. **We have a whack of advanced degrees. We typically don't have trouble expressing ourselves in public. We run meetings. If we have an opinion we state it, sometimes without invitation.** CVHEdU01,p.10 2. …**there was no way of avoiding the reality that they had a chronic illness and I didn't or my student didn't**. CVHEdU01,p.11 3. …**from the community members' perspective, they will have stereotypical views of for want of a better phrase, us, members of the health professions education community**, …**my lack of understanding is probably matched by your lack of understanding of me** … But **treat me as a learner**. …Now **let's start the partnership that way**. **And in so doing I'm actually trying to break down their stereotypes of me and I think that is, that's potentially one of the barriers that the university, I'm just looking out our window, it's a remarkably affluent place. It's a place of perhaps some of the highest privilege you'll ever find anywhere. How, and to even just set foot on it in comfortable ways must be very very difficult.** CVHEdU01,p.12 4. …**appreciate what how unfamiliar we might be and our customs that don't make sense to us but we've learned to live with in academia** CVHEdU03,p.11 5. …**there's always a fear with patients of retribution or not getting the care they need or not wanting to be the squeaky wheel** …**an assurance would have to be and it would have to be demonstrated and practiced that this would in no way would stigmatize them or make it a difficult situation.** CVHEdU04,p.10 6. …they do **not feel comfortable with sitting with groups of people who have like different power compared to what they have.** …**often in fact we are being deemed and perceived as people having a certain kind of power.** …**like a mind shift that we need to help and support our consumers to see it in that way. And I think it's kind of how we present ourselves to them as well, really seeing them.** I mean in fact it's important for us to really see them as the expert. CVHEdU07,p.7 7. **Universities are very uncomfortable places to be.** …**they're learning environments, and so, we are all about very high expectations and assessment. We are constantly judging things.** … **that makes it really difficult for some people from the outside to come in and understand our community.** CVHEdU18, p. 8-9 8. …our language, and our demeanor is not necessarily well positioned to include them in that, in a meaningful way. **We treat them as diseases as opposed to people**…CVHEdU21, p.8 9. …**we get tremendous power hierarchies that the medical profession drives**. …**the taller the building, the more in place the power structure is.** CVHEdU21, p.9 10. **…bringing people from disadvantaged spaces into privileged university environments and having them often speak about their own victimization to our learners triggers me.** CVHEdU12,p.3
Lack of mutually beneficial, trusting long-term relationships *…UBC parachutes in and parachutes out…*	1. …**our relatively short term engagement or the short duration of a curricula or a term or a course or a module doesn't respect the way a community might want to engage with the university** …**students are going to come and go quite quickly so it's who actually develops and fosters the relationship with that community so that there's enough trust there that it's okay for students to come into that community for the short period of time** because **I have heard people express displeasure that UBC parachutes in and parachutes out**… CVHEdU03,p.11-12

	2. …there's so much research going on in the Health Sciences on First Nations reserve to have a seminar series where people come and talk about their researchers and the population that's impacted. What are the two groups getting out of this because First Nations group are quite resistant to being guinea pigs. CVHEdU09,.p.7-8 3. **It's exhausting for the sites because every week they basically have to get a new group of students who don't know anything and they get worn out. So then the question is if they went to a long-term care facility and to a women's shelter, do they get similar sorts of experiences?** CVHEdU09,p.10 4. …**developing relationships where everyone trusted and had the same vision and the same intention for outcomes** …**develop a relationship which was I guess mutually beneficial.** CVHEdU11,p.7 5. "whenever we need you we come" does have a smack of a certain arrogance. CVHEdU16, p.7 6. All of **these relationships take time**, and **they need constant tending** CVHEdU15, p. 10 7. …in **a way that can be sustained over years as opposed to over an initiative and then disappears which I can see is the frustrating part for the community**. CVHEdU14, p.9
Representation*	1. So are these primarily people who are already retired and that skews your sample CVHEdUPilot,p.9
Objectify / exploitive	2. …**you have somebody with a very unique journey through the health care system that feels very passionate about letting students know that they were not treated well and so they've got a story to tell** …**are we objectifying people that we bring is a little bit different…** CVHEdU02,p.5
…we need people that really have a good understanding of who they're voice to…	3. …**the caution is you have to keep checking to make sure they really are the voice, they really are representative.** …**we need people that really have a good understanding of who they're voice to**… CVHEdU02,p.8-10
	4. …**for instance for the dental clinic on Point Grey, I've often said to people this is very strange clinical environment** …**it's important to get away from Point Grey. I mean Point Grey is a screwy place. It's, no one comes to Point Grey for health care. It's just anyone who lives on Point Grey.** CVHEdU09,p.9-10
	5. the Dean has an external advisory board, when I arrived, of the 12 people on the external advisory board there was not one person from the Aboriginal community. How can this be? {Chuckle} There wasn't one person of color? …but how do you infiltrate the environment with the very things that one says they care about. CVHEdU12,p.9
Community based learning experiences that are culturally different from the students.	6. …**let's make sure that they're having some of their learning experiences in community based sites that are culturally variant from their own experience but also are working with historically disadvantaged populations.** …**I'm sure it still happens in medicine with our medical students who can have a very similar experience to their own background and many of them come from extremely privileged backgrounds so they can work with patients who perhaps as learners who perhaps don't have a great deal, especially around the economic one or other forms of marginality.** I mean they probably do experience a fair range of cultural diversity. CVHEdU12,p.9

Stigma, Self-efficacy Vulnerability	1. …**they figure they just can't do this, right, this is beyond their scope**. This has been, **I'm not able to do this kind of thing**. There's **fear that they're going to be put in a more vulnerable position.** There's fear of **that power hierarchy that can play out in weird ways** CVHEdUPilot,p.9 2. So the just bringing people into class or bringing people into tutorial …It takes a lot of skill, and again, **courage**… CVHEdU01,p.3
confidentiality	3. Well even **from lower socioeconomic class, the first is safety and for them to walk into an institution, let's say we're having a meeting even I think that level of comfort would be tricky.** …**acclimatize them to it…** CVHEdU02,p.11 4. I mean to me the largest is to be in a large group or exposed to a large number of people and exposing yourself. It's an incredibly vulnerable population anyhow and you're asking them to sort of come out and I know even with students initially when we were doing the simulations and three and four would be in the simulation while their 40 classmates were watching, they had such trepidation and even when you bring the simulation equipment into the hospital, doctors and nurses are nervous about it because we're all fearful of being shown to be inadequate or looking silly or people will laugh at us. …And I guess along with that a very real issue is the confidentiality and the anonymity if at all possible for clients in whatever way, shape or form. CVHEdU04,p.10 5. …they might come up against discrimination and racism in the classroom stigma. That's been the biggest one [barrier] actually. CVHEdU05,p.9 6. …finding somebody who has that, who wants to invest that, who's interested enough or feels they have something to contribute and they want to be involved … CVHEdU11,p.7
Time	1. people feeling that they're adequately prepared and supported and being able to upfront let people know what would that look like, which again though involves time, and do they have time. CVHEdUPilot,p9 2. We spoke about timing, and timing not just in terms of valuing their time but understanding that they're leaving something to engage in this... CVHEdU02,p.11 3. And the admissions interviews is actually quite hard work relative to coming in for a class for a couple of hours. So they will, they come, they do an orientation plus at least a half day and preferably they would interview for a whole day because we have them do in teams and that can be quite a big commitment for people who are dealing with fatigue and issues like that. CVHEdU03,p.4 4. So what they want to provide and what we're willing to give up precious time for {Chuckle} in terms of formal curricula time or whatever might not always match, so there's maybe a bit of a barrier there which is potentially overcome by taking the time to have a really good conversation so that everybody, so that you can identify where the mutual interests are. I think the location of the university is sometimes a barrier because we're way out on this point and so I think there'd been people who were really interested who can't, it's a big trip. If you live in the Fraser Valley and you'd like to do it and it's 90 minutes here and 90 minutes home and 90 minutes in the session or two hours in the session. CVHEdU03,p.11 5. And I think I mean we also need to think about like the timing of the day. Not that everybody can come during day time. CVHEdU07,p.6 6. I think barriers are people's time. It always takes more time to include more people in things and I think there's a different expectation so when we ask people from our professional community if they want to contribute to something, there's the sense that they're invested in their profession and there's an exchange of time and energy and contribution. CVHEdU11,p.6

Compensation not to interfere with disability allowance mindful of university policies	1. …is this purely volunteerism? I have no idea. You know much better. Do people expect some kind of compensation? I'll use that broad term and what would that look like? And to me, it's everything from, cause this is just the right thing to do so I'm giving back, to free parking (laughs), to food, to some stipend. And I have no idea what expectations are around that sort of thing and that might vary from place to place. CVHEdUPilot,p.9 2. …**not to impede on their disability allowance** as well. So and at the same time we have to be **mindful of what are some of the policies within the university…** CVHEdU07,p.6
Trust (lack of)	1. …trying to involve recent immigrants, right? Signing, if you're just signing a consent form for somebody whose recently arrived or somebody who is a refugee, these are things you don't even think about. They're not signing anything. …our, the work around Aboriginal Health has told us that in spades that the respect and the trust is very hard to gain. CVHEdUPilot,p.10-11 2. I can think of several of them, the recent revelations of medical experiments having gone on residential schools, certainly don't help open up by the community. There's **a huge issue of trust**, there's a huge issue of, "**what are you going to do with the information that I give you?** What are you going to do to me, if I am part of that process? Am I going to perhaps not get some treatment because you may want to assess what happens if I'm not getting a treatment, if I am part of that, if I'm involved." **Confidentiality**, I think it's a huge issue. Quality of care received, "will my doctor, because I've been seen by a student, will my doctor still give me the same level of attention?" CVHEdU20, p. 6
Supply & demand Burnout	1. …it's also hard to **impose upon some population every week** send another group of students. **Eventually they get burned out**… CVHEdU09,p.7 2. if too many different departments or groups or contacting and aren't a kind of a cohesive, then I think that people can just say okay that's enough, like this is, **it's too much or too disorganized or we're repeating the same thing over and over…** CVHEdU11,p.7

Table 6b. University barriers to authentic participation of patients / community in HPE

Paradigm / culture shift in the university to sharing Power *…academics have ruled the roost…health professionals have ruled the roost…* *When you walk into somebody's home you are no longer the boss.* *…we like to control.* *…culture eats strategy every morning for breakfast.* *value other people's knowledge…even if they're not formally educated.* *…people are so afraid that they'll [patients / community] will run the show…*	1. **the paradigm shift. You have established institution where academics have ruled the roost and you have the health care institution where health professionals have ruled the roost** …**When you walk into somebody's home you are no longer the boss. You haven't, disrobed them and made them anonymous and made them the patient** CVHEdU04,p.11 2. It's the classic story of **when you give somebody a microphone you can't tell them what to say** …**that's probably why more people don't engage with patients in curriculum or leadership positions is I think they have an agenda and the idea that somebody's gonna come in and not fit into it and make me sort of deviate from it or not focus on what I need for my paper and is I think challenging cause we like to control.** CVHEdU02,p.11 3. …**gradually been bringing the whole awareness of like consumer involvement in teaching and you've been doing like different, using different vehicles to do it. Maybe actually kind of involving them in teaching, involving them in different committees and involving them in different events and having different people to come and to look at it and to know about it. I think that those are like very good direction that we're actually gradually shifting some of the culture.** …**it's a matter of power**. It might be also a matter as to **how we see the value of different stakeholders.** …to make it like a big initiative that we can actually together push this envelope further and maybe do some **cultural shift to higher level as well.**CVHEdU07,p.10-12 4. one barrier is that **the broader faculty or the broader university needs to value this**, so if it's, what did I hear, **culture eats strategy every morning for breakfast.** So I mean **if the culture of the university is that, or the culture of the Faculty of Health Sciences, the culture of the Medical School is that you're kind of not that important, that becomes clear and so there may be a flurry of activity at the beginning and then it'll tail off. So I think you need broad support. I think the dean needs to be supportive. The dean may need to be present. There needs to be some resources put towards it otherwise it's gonna be something interesting that we'll remember that we tried once.** …**the barriers one are cultural at the university.** CVHEdU08,p.9 5. … **universities sort of are like cathedrals, the more reformation came the thicker the walls got and I think universities are a little bit like that**. …**a culture of kind of affluence**… CVHEdU08,p.16 6. …**there are significant barriers which are based within the culture of medicine** and I think **we're trying to move from a very historic paternalistic model to one that's much more engaged and egalitarian** …**them being seen as equal partners rather than as tag-ons**. CVHEdU10,p.8 7. I suppose **it's both attitudinal and structural**, so I think **we'd have to have people working at the organizational level within the university, understand and value other people's knowledge, other people's contribution.** It sounds so simple but you and I both know that's still very difficult to have some people believe, **value people's knowledge, particularly if they're not formally educated**. So **there's a real class issue often located within this.** …**people are so afraid that they'll run the show** or something. No no, so it's attitude {unclear} was the attitude, then brings the structural change. I think **to the general public person, not even to the patient, the general person who doesn't operate in our learning environments on a daily basis just, it's just a foreign land to them.** CVHEdU12,p.6

…it's [university learning environment] *just a foreign land to them* [the general public]. *…until the values and the culture change… when we actually value these voices…and they are necessary as our educators in our program…the power difference is always gonna be there…* *To support folks coming from the outside and getting them into the university environment in any one of these levels requires partnership.* *Fear and vulnerability on one side and paternalism on the other.* *My gut tells me be willing to sacrifice a bit of controllability and replicability and efficiency for messy teaching moments with real people.* Factory model of health care *…we have an emphasis on acute care, chronic is an after-thought, and wellness isn't really in the picture.*	8. It takes years to change behavior and attitudes…CVHEdU17, p. 7 9. I think you can talk about power differences. And **you can talk about sharing power which is still, always a problem**, right? Because you're the one that's sharing it. So there is a lot… I think **there is a lot you can do to create space, share power, talk about sharing it, talk about power differences. But frankly, I don't think they ever go away** because **until the values and the culture change.** So, I think, like in a hundred years **when we actually value these voices and when we … they are necessary to teach us, and they are necessary as our educators in our program until we get to that point, the power difference is always gonna be there** and until the values, their significance in our medical program actually changes. CVHEdU15, p.12-13 10. **And so I have to say my strategy would be infiltration strategy. Get patients to come in at level one or level two as often frequently as you can, and then keep probing until we get at level three, and then keep probing until we get at level four.** CVHEdU19, p. 7 11. …**as educators we get into this comfortable mode of how do I most easily teach my material** in a way that I think is gonna benefit the students the most. **Once you hit that stride, it's hard for people to change**, and part of the reason that there is lack of change I think, is **too much additional work is piled on**. So, we are too busy to make the changes that we require. So, **to support folks coming from the outside and getting them into the university environment in any one of these levels, I think requires partnership.** With the educators who provide the programs. So, I think, **there has to be kind of an organic fit there and a shared will to make things happen.** …**identify those educators who are really excited about a particular area and support them in creating the partnerships** … CVHEdU17, p. 5. 12. **Fear and vulnerability on one side and paternalism, word carefully chosen, on the other.** …**actors trained to be patients with a certain … I can see that's much more controllable, much more systematic, it's much more replicate-able. But in some ways, there is something badly wrong with that concept, that an actor is enough rather than actually [laughing] {I: the real thing?} the real thing!** …**my gut tells me that be willing to sacrifice quite a bit of controllability and replicability and efficiency for messy teaching moments with real people.** CVHEdU19, p.7-8 13. …**we have a factory model** [laughing]. …**the idea that we as a health care system or as a university could learn anything from the indigenous peoples, is not an idea that's really taken hold.** …**not enough team-based**, and certainly not… and frankly I think there is a, **there is an emphasis on sickness care rather than health care.** …**we have an emphasis on acute care, chronic is kind of an after-thought, and wellness really, isn't really in the picture.** CVHEdU19, p.2 14. I have the job of trying to let's say, encourage people facilitate people, lead them to see a new way of doing things… CVHEdU19, P.3
Fear of tokenism / doing it wrong Time	1. … **tokenism**, **it actually doesn't deliver**. CVHEdUPilot,p.10 2. …**you don't want tokenism** …**there's a part of me as an academic, I'm busy, I'm busy, like I just want to get on with it, just send the people**. **But I do know in my mind that it should be, that you should be really careful about who you bring in and what do they understand about, yeah what, cause you want to be clear that that person can bring to the table what you need at the table and that this environment in which we work is safe for that person and that they come feeling like not only do they have something to offer but that they're appreciated by us** on the other end. CVHEdU05,p.8-9

UBC's pretty old school…sometimes you're not ready to invite people in because you can't offer the safety that's needed for them… representation	3. …**UBC's a pretty old school environment**. You're almost I guess in some ways I just want to say that **sometimes you're not ready to invite people in because you can't offer the safety that's needed for them yet**. … **a lot of people come to these things, a lot of patients, they go and then they feel totally useless. Like they go to the meeting and they're just kind of the token kind of person.** They're not, **they don't feel like they can engage with the conversation because it's not their area of expertise**. So you want to be sure that when you invite people in that it actually is that, and I always say that's an unsafety cause **they walk away feeling what was that for?** And I think that happens a lot. CVHEdU05,p.16-17 4. …**it can feel like tokenness. We need an Aboriginal person. We need somebody who's from the gay/lesbian or transgendered community.** We need somebody from the somebody from that and **it feels sometimes like we're populating a committee to make sure that we can say that we've had everyone's perspective**… CVHEdU08,p.6 5. even in my the associates like, even in representation, oh yeah it's like we need one of them and one of them and one of them and then we'll have the conversation then we're fine. When in fact that's not what you and I would be talking about if we're actually talking about mutuality and counting people's knowledge and voices in the education of health care professionals. CVHEdU12,p.6 6. It's a sort of mandate it, then it's gonna trickle down, it would look really different. Well, it need to look different in all kinds of places, it would certainly meet with more resistance I would think in some places than others. I'm just imagining curriculum committees that would need to have patient representation on them, but we have actually talked about that in our school before, as to whether or not we should have patients involved in our programming somehow, but invariably it seems to me it turns to some kind of token notion rather than genuine notion. CVHEdU14,p.9
Competing Agendas of special interests	1. …**there've been occasions that consumers might kind of raise different issues that clinicians might not totally agree on and I feel kind of difficult sometimes to try to balance it and try to kind of please multiple parties.** I mean even though I try to acknowledge the fact in fact yes, I mean **we all have come with difficult perspectives and we all see things a little bit differently and I also have to admit as a matter of fact I cannot address everything that everybody kind of brings to the table.** CVHEdU07,p.9 2. …**some of these disease specific groups they're heavily funded by the pharmaceutical industry and so one worries a little bit about how independent they are because I think sometimes the pharmaceutical industry funds some of these groups because they know that they'll advocate for new pharmaceuticals**… CVHEdU08,p.5 3. …**the challenge there is that we have a particular approach to teaching communication skills and physical exam skills and a patient correcting someone around that may not actually be congruent with what we're teaching…** CVHEdU08,p.5-6 4. I would hesitate on that [patients or community representatives being part of the decision making process of what happens when we teach our students] because we've got a few community people who are patients who are trying to influence. …so my experience has been in that is that you have to be really careful that a person isn't pushing their own agenda and if you don't do it that this person has written to President too complaining that we haven't done what she wants…. CVHEdU09,p.5 5. **There are probably 600, we do not have enough days in the year for a curriculum to accommodate that.** But I think the fact that **there is a patient voice there that needs to be listened to. We somehow need to regularize that in medical thinking.** CVHEdU21, p.4-5

Translating community expertise into meaningful learning	1. So the just bringing people into class or bringing people into tutorial, people with addictions and again it's not easy to find someone who can stand up in front of an entire class and tell their story of addiction clearly and in ways that are educational. How to take that expertise and turn it into an educational experience for students is not something that most of the people on the [Committee], to use them as an example, would display. …We can't expect necessarily our [Committee] people and others in the community to know that. Although some do, some would be wonderful. But there is, just like we need to be educated regarding the circumstances they deal with, they can use, we'll call it professional develop, in the to use a common word the translation of what they know into effective educational experiences and to just assume that bringing people together will work is naive. CVHEdU01,p.3-5 2. …how best to access people in the community and you may need to provide people like me ideas or options on how to do that. So I may look at this and say yeah I'm gonna get a student, or I'm gonna get a patient I mean to come in during my session but I think you, I may need to be helped about who to make the call to or I've got an idea of a patient, what to say to them or what information I might need and all that kind of stuff because you probably want a somewhat consistent approach. CVHEdU08,p.9 3. …**in some cases we're the barrier to getting people outside and the students will occasionally be a barrier to those too because if they think they missed something then another group, 'I'm not paying the same tuition, that's not fair.'** CVHEdU09,p.10 4. …the time that people have invested into it is worth the outcome that what's produced or what's generated from it is worth everybody's investment. CVHEdU11,p.7 5. Education of both sides, so there needs to be some capacity development as well. So that what you are able to contribute makes sense. CVHEdU13, p. 11.
Risk management / Liability	1. …just being uncomfortable that they may not have that full skill set that you're looking for or that you get them involved and then you find out that there's problems with one or more individuals, how do you extricate them, how do you manage to get them out with causing problems or even be challenged with issues around equity and diversity, these kinds of things. So people would have some angst around that I'm sure. CVHEdU06,p.7 2. …**consideration of liability**. …**something happens then who's responsible** …**those legal sort of things that an institution will have concerns about.** CVHEdU06,p.7 3. **…have to be very careful about all of the issues, from supporting of learning, all the way through how the person who's come from the outside, is engaged, and how they're treated and how they're compensated and all those issues right through to the risks that we bare both from the professions and what the students do and they go out, as well as institutional risks, it's complex area.** CVHEdU18, p. 9
Funding	1. if we had this kind of unit, I'm mean if we're going to do this well, we do it well. We don't do it in a haphazard way and if this is a brand new unit, what in the world would be the cost of this thing, and in a fiscal environment like we have right now, it would probably mean, I suspect we'd need to go and get fundraise, we'd have to fundraise around something like this. But I think this would be a terrific development opportunity. CVHEdUPilot,p.10 2. They said it can't happen and I thought is it because the words [Program] are trademarked or something so we can't call it that but we could still make it happen or something but everybody said no, it couldn't happen. So we can't use that skill set once the funding goes away from it. CVHEdU03,p.8

	3. …how we are able to reimburse them for their time and their expertise and I think that could be a barrier as well. CVHEdU04,p.10 4. Well first of all I don't think people should do it as volunteers. I think we should pay people for their time. This is a problem in the university. {Laughs} So where do you get your money to do it? Like we work with a very limited budget for example in nursing and it's not like you can just say oh we'll rearrange things and take the money. Most of the money that comes to nursing is for faculty salaries. There isn't a cream for, and I wouldn't say it should be cream either by the way, I would say it should be an essential part. CVHEdU05,p.6
Institutional Bureaucracy *Do business a little bit differently*	1. …**can't we just come together and somehow figure out a framework for ensuring that it never is this person that has to wait for their cheque or why can't we figure that out? I had a person who waited three months for their cheque from the community. That should not happen. I'm sorry, that is not okay. This is a person living on the edge of nothing.** So things like that. So **we need to look at funding arrangements differently. We need to be able to get our head out of this kind of traditional way of doing things and kind of think a little bit outside the box.** …**we might re-create and have the courage of our conviction and our commitment to truly community based work to actually maybe do it a little bit, do business a little bit differently.** CVHEdU05,p.10-11

7. What structures would facilitate patient / community involvement (Interview Question 8)?

Informants consistently identified the need for patient / community involvement to be part of the university's mandate with support from the upper echelons of the university. There was widespread support for creating an office or unit that could be a "clearing house" to build and maintain relationships, manage recruitment, training, support, coordination and evaluation of patient involvement activities. Faculty development, preparing students, training patient educators and establishing mechanisms for communicating and jointly solving problems with community partners were also thought to be critical university structures to facilitate patient / community involvement. There were some suggestions that the current integration of health initiative is a good opportunity to begin building and implementing the structures to support a more systematic approach to patient / community involvement. The Standardized Patient Program, UBC Learning Exchange, Community Service Learning and co-op programs were put forward as potential models for patient involvement across disciplines.

Table 7a. University structures to facilitate engagement

Institutional commitment / mandate / resources* *…you make it almost part of your reason for being.* accountability	1. The Irvine K Barber Learning Center has as its **mandate**, it's got a number of phrases associated with it, but one of them is to reach out to the province, the country and the world, it's not an uncommon mandate, but Ike Barber himself was completely committed to that mandate, especially to the province. … **So you pick your people properly, you put a structure in place like that, you use technology and you make it almost part of your reason for being**. And the Barber still does that. **It's that level of commitment**. CVHEdU01,p.13 2. …**you have to almost make it as part of somebody's performance, somebody's or unit's performance review** so it's not just a good warm fuzzy thing to do to engage community members or the public, but that **you will be evaluated on your ability to do that** … **it needs to be at the Dean's level or it probably also needs to be at the executive level but I think then they need to demonstrate what they've done.** CVHEdU02,p.15-16
…it needs to be at the Dean's level… *….it needs to be at the highest level.*	3. …**everybody would have to be on board right up to the executive VP's President level**. … **the receptor sites have to be willing to, they have to be primed and ready. Otherwise we're just bringing in people and not just to use the word token too much, but it's not just a gesture to demonstrate we're doing something.** We really need to be primed and willing to do something. And I would say right across the arena, **it's not just education. I would say research, I would say HR, the students' portfolios, like they all need to be open to this because I think community members probably have plenty to say affecting all four or five of those areas**, right. …I think **is relevant for everyone** … **it would empower us in our decisions if we knew that community members actually did support us in these decisions.** CVHEdU02,p.13-14 4. …**it needs to be at the highest level**. …**need some interface with the executive level and if not the executive level certainly the Dean's level**…CVHEdU02,p.14 5. …**just getting people in the same room and talking together**. **The problem with it was none of that was mandatory** … even with integration of health, **we all are siloed disciplines and we have our accrediting bodies and we have to own our curriculum.** …It's got to be then looked at carefully as to how it will be **brought throughout the curriculum**. CVHEdU04,p.13-14
Practice academic collaboratives model	6. …**but we create teams where we can kind of create that synergy together so it's not a one-off thing.** …**ensure that those are the seamless processes for people** … **So this is about student learning and informing our curriculum so what we have set up now is that the collaborative isn't just about providing business as usual, it's about reciprocity, learning processes across involving consumers, involving our organization, the organization, the agency and informing our curriculum. And then, and then when the student placement is ensured, right, we have the students in that environment, we support that clinical faculty from our end and they provide us the service as well.** …**I think there's real merit in those collaboratives for informing the curriculum, providing placements, good placements, and getting good consumer feedback.** CVHEdU05,p.13 7. **It needs to start at the upper levels of the university, so I think the first thing to do is to get your president excited about something like this and then the Vice President or in the reverse order, so you talk to individuals like the Provost or the VP Academic** these kinds of individuals. They're very much involved at the upper level of the running and administration of this university. So that they can see the value that you're trying to, **the Deans is a great group as well, the Committee of Deans**. …**a tract is created that allows, that gives these individuals recognition and title within the university allows them to be compensated**… CVHEdU06,p.9-10 8. …we have to do quite a bit of like cultural shifts so to speak to get everybody to buy into this idea. …after all I mean the whole Faculty doesn't really run by the two of us. CVHEdU07,p.6

Business / corporate involvement with the university a possible model? (e.g. large community orgs that represent multiple patient groups)	9. …**the university have been involving a lot of the community partners in decision making. I mean I use the word community partners in the very broad sense. I mean I'm referring to a lot of like business partners, a lot of like sponsors or big corporate in terms of like helping the university to search and to find directions on how to strategically position the university. Yet at the same time I'm also wondering, interesting, I mean if that's the case then why won't they involve like the other kind of consumer groups as one of those stakeholders in their kind of broader community consultation process.** …**we've been involving a lot of like big corporate in the university discussion table. Can we actually involve like consumers in that discussion table as well?** …**I mean they are a very strong advocacy group and they represent many many different organizations that can speak to consumer issues.** CVHEdU07,p.11 10. structured in such a way that whatever efforts that we bring in, whatever time that we contribute being recognized as part of our workload… CVHEdU07,p.14 11. …**we need to have some institutional support to allow it to happen…** CVHEdU08,p.6-7**there needs to be some resources committed to it at the institutional level to say it's important but to be to make it happen**. CVHEdU08,p.12 12. … **seeing those people as real community partners**, and probably having the infrastructure and leadership so that it isn't just dependent on one person. …**you need to build it in a way that it isn't just dependent on one champion.** CVHEdU08,p.14-15
Adjunct model Hidden curriculum	13. ...**we have to operate under the notion that most people, if you discuss these things with them in a non-threatening kind of caustic way, most people see the value in doing it this way. Now the problem is finding the space to have the conversation because in terms of if we put it under the wide umbrella faculty development, the converted come and the rest don't. So it's really difficult to change outlook and practice once people are kind of institutionalized into historical ways of doing things cause I don't have, I don't know. I mean you work at it a brick at a time or I also think that you get similar minded people with whom to work and maybe you even do purposeful plants at senior tables, the senior leadership tables and so you're not the lone star raising this.** …**so some of it has to be at that political level internally and in an institution in order to move the agenda forward, otherwise often people are actually seen as oh what's she on again or what's he on again or not this again or not that again and there's this kind of shut down and people sometimes give up.** They're not willing to keep trying to do it, so well **I guess it's like a community of practice in a way or a community of like-minded people that'll help carry the agenda forward in an institutional environment.** CVHEdU12,p.8 14. So **you could have that no students, I'm speaking broadly and it's very difficult or more difficult in some disciplines, degrees, programs and others, no student could graduate from the University of British Columbia without a community based experience**… CVHEdU12,p.11 15. The **model of adjunct or people seconded from their current jobs in their professions to actually contribute actively**… CVHEdU20, p. 1 16. **…we need something like a president who says, "this is important**, we need to celebrate a year of the something or other", even though that doesn't go far enough. CVHEdU15, p. 13-14 17. **there needs to be something central that's some kind of unified budget entity**… CVHEdU16, p.6-7

University office / unit Prep the patients Prep the academics X-disciplinary unit to select, prepare, evaluate Students choose Build and maintain relationships* *One stop shopping*	1. **A formal unit whose role was really to focus on this, and depending on the level where the patients or clients are involved, that unit would be responsible for the preparation not only of the patients but also of the teachers or academics or committee members**, … **it would be for all the health professional programs**, right? It wouldn't belong to medicine. It wouldn't belong to nursing. It would really be **a unit that all of them buy into whose responsibility would be to do just that, to identify the individuals, to do the preparation, to prepare the academics as well, to be able to do the evaluation**… CVHEdUPilot,p.7 2. …**meeting multiple goals** …**in terms of interprofessional collaboration or communication or team work or as well as learning something about particular social vulnerabilities** …**there'd be multiple learning goals that could be met if there was a group that was planning those things collectively.** …**there should be a little bit of students being able to kind of choose or find a fit or match to some of these things. So it's how do we take enrichment opportunities and baseline opportunities and make everything work.** …**the organizational bit of it within the kind of the structural restraints and stuff is the part that I think can be overwhelming**. {Chuckle} CVHEdU03,p.12-13 3. So I guess part of it is that **there's someone who has responsibility for, or a group of people who has responsibility for sustaining the relationship** …**if it's the university and different organizations or communities, then if somebody's job was to sustain the relationships**… **I think from a community perspective that may be one way to go because there's an office or a one stop shopping or one place to go.** …**there's one office or one number or one person that they start with at UBC.** CVHEdU03,p.13-14
Organizing framework University-wide committee Oversight and authority Office that would manage recruitment, training, coordination, recognition, etc. Linked to other departments An office where faculty can call or projects could be approved *a clearing house*	4. …the **College of Health Disciplines initiatives within interprofessional education that that would be an ideal area where this whole component of community engaged involvement and preparation of health care professionals could be embedded.** I mean off the top of my head **you need kind of an organizing framework, but then within that I think it would be important to have a more global university wide committee that helps to guide individual units and how they enact that.** …**there has to be someone with oversight…** CVHEdU04,p.12 5. …**to have some branch of one of these current offices that would manage these types of individuals at least initially so that they are appropriately hired or recruited as volunteers but they're recognized for their contributions and then they're linked to various departments depending on what their interests are, depending on how they're best matched in terms of who they are and what they wish to contribute. So you would have to set up someone to manage or some department to initially initiate this process, establish the links and make sure that they are linked out to other departments or can we put together special instructional skills workshops just for individuals like this.** … **having a basic understanding of what medicine's curriculum is or nursing or pharmacy or forestry or whatever it is, just so they can see where they best fit in**. CVHEdU06,p.10 6. …**an office that faculty can call or at least projects could be approved**… CVHEdU08,p.7 7. **There should be a better clearing house on campus for medicine and dentistry and nursing and pharmacy and other in social work and physical therapy and things like that.** Where are they going because I think, when I was in Southern California, at the [University], **it became quite clear that some populations were getting a ton. I mean everybody was going to this one area and other populations were getting nothing and the group that was getting a lot sometimes just got exhausted. I mean they were getting impacted by every single school because they were close and you could walk there.** CVHEdU09,p.11

SP model *…if we're looking at embedded things within a curricula then we need a resource that we can service it from.* *…you can sit people down, take them through a course, tell them all the different things, but it's different from experiencing it and it's different form learning it, working with people from those groups.* liaisons *FoE prof development & community engagement unit a potential model*	8. …**recognition that the engagement process would be valuable enough to be seen as a core curriculum requirement rather than as a nice to do add-on. And I'm not sure we're there yet.** …**embed it in the core, right in the core science and in the core patient care because if things are done off on the side separately and if they're not integrated with the other things, I don't think it penetrates the consciousness of young students the same way.** …**embed it as a core, integrate as a core requirement.** …**we have standardized patient trainers and we've got leaders and we've got recruitment process and a training process and an evaluation process of that group.** I would think **if we're looking at embedded things within a curricula then we need a resource that we can service it** from. So **I would look at standardized patient model to think what that resource would look like** …**here's the person you go to, the leadership group who have access to people from cultural, different cultural groups that will come in and help students learn about cultural competence**. …**you can sit people down, take them through a course, tell them all the different things, but it's different from experiencing it and it's different from learning it, working with people from those groups.** …**we're putting people through the courses but it doesn't change the behavior. And so can we develop things with key groups that will help change their values and their behavior.** CVHEdU10,p.9-10 9. **a couple of key people who are the liaison or the communicators around either end**… CVHEdU11,p.8 10. …**a chair or somebody from the College or somebody like yourself who ultimately liaises between what those sorts of discussions and you the organization if that's what it was related to.** …**I would probably jump on board with anything that made sense for the program and made sense for our students and things like that but if there were opportunities to be involved and to share those sorts of opportunities with our students and with the other health professions, then I'd be very keen.** CVHEdU11,p.9
need an inventory *Connoisseurship… welcoming, problem-solving, facilitating entry to UBC*	11. **…a unit called professional development and community engagement** with the assistant dean and part of that is to help build the structure of the kinds of things we're talking about because if it didn't have a home, if it didn't have a place it was going to continue to operate of the people who are good willed and interested in this. **So first create the structure and then I think you need people within that unit to be it's all about who's there and then to be reaching out and I'm not talking about reaching out into communities at this point, reaching out to faculty around how they might work with that unit in relation to their courses and the kinds of things they do in professional developments so that the unit could be seen as helpful to them.** …**we hired a person, an administrative person if you will, with a wealth of community based experience to oversee that**…CVHEdU12,p.12-14 12. …**some other entity or centralized body to report on their progress, their experience.** So, you might build a [unclear] that way. **Then you might from that centralized, be able to send faculty, or make the faculty part of the team to provide supervision or support for the students**. CVHEdU17, p. 9. 13. **There is no inventory of practice sites and who is at them, when. There is no curriculum inventory, so we don't know who is doing what when. And it sounds down but you can't possibly coordinate, [laugh] don't know what you are coordinating, so that makes my first comment. We actually need an inventory.** …**The thing I hear more about UBC than any other thing, it doesn't matter who you are talking to, it's incredibly difficult finding out who you are supposed to deal with who can answer your questions.** …**one voice, one advocate, but in both ways, but the idea, I picked the word connoisseurship on purpose. A warmer, welcoming, problem-solving, facilitating, entry to UBC would be a big start.** CVHEdU19, p.8-9.

Coordinated strategy Co-op program model *…a process that allows for thoughtful engagement.*	14. …**having some sort of coordinated strategy would certainly work well**. …**to avoid exactly what you are saying, a particular business or organization gets call from UBC and they say "well, we already talked to UBC", ah, "but that was Arts, we are Science"**, …**It takes a long long time to develop them, and there is the issue of trust. There is the issue of confidence** …**a process that allows for thoughtful engagement**…CVHEdU20, p. 8 15. to have **a facilitator**, I think, for sure, that can… that understands all of those things and **maybe even not one facilitator but a couple of facilitators, that could work with an advisory** that, with a very transparent process that you have people contribute over a few years… the position to somebody else but there **is the idea that and it's an important role and that you are compensated for it somehow if you are part of this and so it's structured enough that you actually are given specific roles**, things to look at, and so not necessarily to develop stuff, but maybe that making come out of it, but to inform, or **to have some knowledge about what's happening**, and idea of what needs to be improved. So these probably be specific, **definitely need to be mediated, because you need someone kind of understands that …the health professional system as well** CVHEdU13, p. 11-12.
Select / Prep / train students *…position students so they are receptive to consumers as teacher.* Training for students	1. …delivered in a respectful manner **so you also prepare the students** CVHEdU05,p.10 2. …**we need to position our students in such a way so that they'll be receptive to our students, to our consumers as a teacher.** …**prime our students in such a way to help them to appreciate in fact no, they're actually a very variably teacher, even much more important than many of your prof and they can teach you and share with a lot of words of wisdom that none of us can speak to.** CVHEdU07,p.7 3. **we'll need to think about some training for the students**, we need to think about some training for the faculty and I think **we need to prepare the student**… CVHEdU08,p.7-8
…it's not like you're in court. Remind students about professionalism *…at every moment the student is taking into account the needs of the organization and the needs of the people in the organization*	4. **we probably shouldn't do too much of it because we want it to be special enough that the students pay attention. If it's just oh here's Wednesday's lecture, who are they bringing in today, I think it may lose its value**. …**There is an important reason to pay attention when there's somebody who's coming in and talking about their cancer or how their child died or something and I think the students will get that but we may need, the trick will be to remind them without the students feeling like we're belittling them and their professionalism but I think we may need to remind them in some way and maybe that's a student to student thing.** CVHEdU08,p.10 5. …**need a little direction and shaping their energy…** CVHEdU08,p.16-17 6. If we go to the [Place] there's a dental clinic there. I mean there's a clinic this Saturday. I mean I know someone's gonna have to step over someone who's just injected themselves. I mean the students always come back oh my God this guy just injected. Okay, you're on East Hastings, that's the way it is. CVEHdU09,p.14 7. …**the trouble with students is if they go to a place and it doesn't work the first time then all students believe that that's not a place you ever want to go.** CVHEdU09,p.15 8. …**when you start these things is that students initially will be quite selfish and what you'll hear them say is I got to do this, I got to do that, I got', I mean they're very selfish**, what's the point. And I said **as we do these things you're gonna hear the transition from oh we really helped a lot of people today and I need to go tomorrow because if I'm not there they don't get care**… CVHEdU09,p.18 9. ….I would guess, **we would need to brief our student body in terms of respectful dialogue…** CVHEdU16, p.5 10. …**there needs to be a lot of students preparation certainly before they are going to a community**… CVHEdU13, p. 7.

…and that the student knows that it's not simply another experience for them to check off their list…	11. …**careful in our placement about some students**, some overly parental, but **some students aren't ready to be in certain environments** the same way when we have medical students fly into remote communities and so on so **there's a whole readiness aspect**… CVHEdU12,p.14 12. …**at every moment, the student is taking into account the needs of the organization and the needs of the people in the organization and that the student knows that it's not simply another experience for them to check off their list** like "Great, go out. Do 10-hours a week in that organization blablablah. See what you see and then come back and tell us." CVHEd-U-15, p. 5
Prep / training for academics Faculty development *…how do we engage 21st century digital native students, when our faculty are digital immigrants or refugees…* Prepare faculty to prepare their students	1. … **you can start to see the vulnerability and how do you intervene**? CVHEdUPilot,p.8 2. …**some preparation around that and how would you include them and how would you set an agenda that actually makes sense.** …**if you're going to have your patients be evaluators, there's a whole preparation that needs to happen there as well, about what their role would be and depending on the setting.** CVHEdUPilot,p.8-9 3. I think we just need to be primed to it. It may not be even the topic that we're on right now but it needs to, I think that you need an openness to be hearing whatever comes through. CVHEdU02,p.11 4. …**how do we engage 21st century digital native students** {Laughs}. **when our faculty are digital immigrants or refugees**… CVHEdU04,p.13 5. …**allowing them to have that understanding of that patient and pharmacy's role in that and their role in educating our students to care for those individuals I think would be really key. We haven't done enough of that to be honest.** CVHEdU06,p.9 6. …**sensitive our faculty to the fact that the patient perspective is important and it's valid and there are resources to support it**… CVHEdU08,p.6
F. of Ed community based practicum a good model *…a shared will to make things happen.* Select interested faculty	7. I think we also need some preparation for the faculty to be able to kind of know what's inbounds and out of bounds as far as what questions can be asked to kind of prepare the class to remind the class that it may be okay to have your laptop up when I'm talking but it isn't okay to have your laptop up when a 68 year old woman comes in to talk about her cervical cancer. CVHEdU08,p.7 8. **…we'd have to have people who had an openness, who they themselves could feel vulnerable and who are willing to be in communities and participate and see how life is lived** … **it's much more about faculty than students. Students you and I both know come with a huge amount of caring and a huge amount of curiosity, and a huge amount of desire to be community engaged**… CVHEdU12,p.7 9. …**if you're going to have people come into these community based environments to do the supervision of the practicum is they have to know something about the community based environment. So then it means that we had to educate the supervisors** … **when we did exit interviews last year we found that the most positive thing about our program was the community based practicum learning experience.** CVHEdU12,p.12-13 10. …**a shared will to make things happen.** …**identify those educators who are really excited about a particular area and support them in creating the partnerships** …**lightening their load for a semester so that they can develop their course** CVHEdU17, p. 5.

Prep / training for patients*	1. …**a little bit of understanding of just how it all fits**. …**giving them preparation and understanding of the context** …and **meet with the chair of the committee and be able to hash out where are and how does this group work**… CVHEdUPilot,p.7-8
Depends on role	2. …**we have to be prepared to support them, support them with helping understand us**. **If there's any organization that's complicated they haven't met UBC yet.** CVHEdU02,p.9
Pedagogic principles	3. …**they'd have to have a sense of the accrediting bodies we report to, some of the format of what happens within the university and how things get approved and the lines of approval and then some of the committees or task forces that exist where they would be most valuable to sit in on. I mean I could really picture them at both our UPC, the Undergraduate Program Curriculum Committee, and the Graduate Program Curriculum Committee providing insight and input to some of those components.** CVHEdU04,p.8
Committee: culture, context, group dynamics, politics	4. I **try to prepare people for that [discrimination / stigma] possibility** before they come in, **talk through how they might handle that when it arises** cause it wouldn't be like I just take over or something, we'd do that together. You can have sometimes, **I'm sorry to say, we'll have disrespectful students. It can happen.** CVHEdU05,p.10
	5. …**how to speak to the bigger crowds**, how to disclose in despite of like 30, 40, 50 or even 100, 200 people. CVHEdU07,p.6
	6. …**How do you handle students who might be insulting or incredibly inappropriate**? …**to have a sense of the other courses and be able to help students make links across courses** … **If this educator, community educator person with diabetes could say something like "I know you guys have just done the theory of such and such, and I know that one of the things you've been focusing on is blood thinners and the way that this works, well, actually in my experience, this is what happened. It was completely unusual, or in my experience, this is what happened and it was a case-book of exactly what we expected"**, CVHEdU15, p. 9
How to speak to large groups	7. …**some trainings around who they are going to be dealing with**. So that they deal with ways that are respectful as well. CVHEdU18, p. 9
Mechanisms for 2-way Communication*	1. …**you need to have an opportunity for people to get together to talk about what's working well and what isn't working well**. CVHEdUPilot,p.9
Debrief	2. I think **being clear** about what people want and what they expect and listening to that, creating **open communication** dialogue and again just being clear that you've got the right fit. Also being clear about when things aren't working, like being willing to be **transparent, open, flexible**. And being really **clear about expectations** and then when those expectations aren't being met, or at least ensuring that there's **some kind of forum for being able to talk about if things don't go well.** So **being receptive to the feedback, inviting feedback, following up**. CVHEdU05,p.9
Clear roles / expectations	3. …some of the principles that we can identify from there. CVHEdU07,p.10
	4. **an open honest forthright more than one probably conversation** about what the, **transparency is really important** …**So it's not a guessing game for anybody** …**let's be mindful of all the practicality pieces when we're asking people often to do free labor for us in a privileged environment** CVHEdU12,p.6
	5. …**lines of communication are open**. CVHEdU12,p.14
	6. … a place to sort of communicate ideas, pass messages on... CVHEdU02,p.17
	7. …establishing your relationship where one can give **honest feedback in both directions.** CVHEdU14, p.6

"Hands on" Advisory Group University Asset Map accountability	1. you'd have to have **a really very well thought out advisory group** who would be very advi-, **but very hands on advisory, not just sort of a token advisory. You'd need to have a very good interface with the various professional programs to understand what their needs are, where the opportunities are. You'd need to basically create those preparation spaces for the patients as well as the academics.** …**getting a lay of the land would be really important, is where are some pockets to build on and to connect with and to get people involved with, and what would be the needs of both sides around this so that, some of it could be a hub and spoke.** CVHEdUPilot,p.12 2. …it's not about which cancer you have, or which body part, it's actually about the person. …If we can sort of get that appropriate table of sufficient size but not too big to be able to listen to. CVHEdU21, p.13 3. …**hold the Faculty of Medicine or any of the health sciences accountable and make sure that they are responding to their needs.** …**invite community people** and panels **to be part of having input of students that come in and also what kinds of students are graduating, but actually to assess and evaluate that.** CVHEdU13, p.10
Faculty Rewards	1. …**we can measure publications and grants and it's all good. I'm not cynical about that, except it's in and of itself inadequate.** …**he gets up in the morning to improve the lives of the people in the downtown eastside and** how do we as a school, **how do we as a university, as an institution acknowledge that as opposed to acknowledging a number of publications and other things which is so easy to measure.** …**So the remarkable amount of work that we've been talking about in this interview that's required to do this well, to get patients, to get community in as active participants in education, the work required to do that is not work that we currently know how to reward well.** And I'm not saying we should just do things for the reward, but **if the reward system is not in step with this at all it annoys people**. CVHEdU01,p.12-13 2. …**contribute towards my promotion and tenure**… CVHEdU07,p.13-14 3. …**there needs to be some recognition that the easy way is to write a patient problem in your pajamas on a Saturday morning. The hard thing is to actually get somebody to come and speak and that takes a lot more work and there needs to be some kind of recognition of that.** CVHEdU08,p12
Mechanisms to document & disseminate outcomes, build evidence base to support patient involvement	1. **…very strong evidence to speak to that this is something we should seriously consider.** CVHEdU07,p.10 2. …what's been tried before if anything, how effective things have been, what people have come up with as far as this might be really cool and then it would be maybe up to me to say, bring back to my department to say here's some ideas… CVHEdU11,p.8
Student input	1. …we'd bring in the final test to the students… CVHEdU02,p.17

Table 7b. Community structures to facilitate engagement

Community-based / experiential learning Avoid too many layers / interfaces UBC Learning Exchange Prep students, develop partnerships Community-based practice sites *…think, feel taste, hear the issues of real people in real places.*	1. … **you don't want to create too many layers** of various things, but is the, so maybe my question and I'd have to throw back to you, **is it possible if one had a unit that is sitting in the university but where it is very clear that the governance is going to be a true partnership? Do you need then an interface with some other convening group in the community where people could go to learn more about this opportunity, or could it be really organization by organization directly to the unit that's sitting within the university but that is definitely a partnership model?** CVHEdUPilot,p.13 2. …**because that was a program that existed there was a, they had already developed an orientation about what community service learning was, they had developed partnerships with different communities or organizations and so they could provide that. We didn't have to create that every year…** CVHEdU03,p.12 3. …**you need a structure where there are lots of distributed community-based practice sites** … **experiential**. **I think if people could think, feel, taste, hear the issues of real people in real places. And I'm specially thinking about the vulnerable populations.** …**if we are really trying to reach the vulnerable, the disadvantaged, the isolated, we can't just start early enough**… CVHEdU19, p.8 4. … **the first step in terms of providing something that these individuals would value which would attract them to come and then enter the dialogue and build those relationships.** …**what would be the carrot for these folks to pull them out of the wood work, and then provide that, and go from there.** CVHEdU17, p. 7-8.
Community-based unit an office to coordinate a contact person in the community to recruit and facilitate Outreach *I don't think that if we build it here, they will necessary come.* *…we need an insider's perspective.*	1. I think **I'm kind of conflicted by would you create a structure on campus, like physical structure and that would be sort of the place, or using my previous paradigm about safety and leaving things in the community, would we go there** … **it be something that we'd build out in the community and have it pipe line back or do we build it on campus and I think it makes more sense to have it out there.** CVHEdU02,p.16 2. there probably needs to be **an office of some kind**. I mean I think the challenge is it's gonna be, **if you're wanting to include, and I understand this, include more than say medical students which I think makes sense, the whole issue of coordination between various schools is challenging.** … **there needs to be some sort of a presence and some person who's the contact person in the community for this sort of thing probably**. **If it's about marginalized groups in the most dense population and marginalized group in the downtown eastside it might make sense to have somebody there who's the point person who [Name] is known as the person that will come and get you and bring you up to the campus or is the person that if you have any questions about or if you're interested she's the one to talk to. Cause nobody's gonna go to the Carnegie and log, go onto the website to find out about this. I mean so there may need to be a presence in that particular community.** For the Arthritis Society you don't, you could have a, it probably would help to have a person but **I think you need to have a person for the most marginalized populations. And then if you're looking at ethnic populations, you may need somebody with a sensitivity of the ethnic, those particular ethnic populations.** … **it seems like quite a lot to build a structure to access those groups and it would be great if there was something there already** CVHEdU08,p.12-13 3. … **go beyond the institutional model to go to folks**. … **we need to reach out to folks** … **I don't think that if we build it here, they will necessarily come. Essentially you have the trusted advocacy person, or a group who makes and introduction or tells us about maybe what would be important to these people as an initial attraction and then build the trust, or provide that service, whatever it is, or remuneration, what I'm not sure, and get them to come and build the relationship from there.** .. **getting into their communities and their churches**. …**we need the insider's perspective.** CVHEdU17, p. 7-8.
Funding	1. … **anything that can make community organizations a little bit more stable is gonna be important in terms of funding long term relationships** CVHEdU15, p. 14

8. Benefits to Community (Interview Question 9)

The opportunity to shape student learning and ultimately improve health care were seen as the main benefits to the community. Partnership with a recognized educational institution was also thought to validate the work and expertise of community organizations and those who are asked to share their knowledge with students.

Table 8. Benefits to community

Shape health care education, research, and practice *…input into what our students are learning…* *shaping attitudes… informing priorities* *…to contribute to the future generations of therapists and doctors.* *…to inform some change in the training of our students… bring students' attention to something that they feel has been missing…*	1. … **input into what our students are learning…** CVHEdUPilot,p.14 2. Maybe the research piece as well. CVHEdUPilot,p.14 3. …**shaping attitudes as well as skills**, skill development of health professionals and **informing priorities** or, I guess **informing goals and priorities in terms of what the health needs are for whatever particular group they're representing**. CVHEdU03,p.14-15 4. I think they'd have a much better appreciation for what universities are doing in terms of education. CVHEdU06,p.11 5. … **this is an opportunity for them to provide back to the community, to contribute to the future generations of therapists and doctors.** CVHEdU07,p.15-16 6. …**a positive influence on the education of health care providers** and at some point **maybe there'll be evidence that graduates from UBC are more likely to want to work or at least be sensitized to the issues of those communities.** CVHEdU08,p.14 7. …**you give them a group of learners and it enables their story to be heard and it allows them to see from the learners what influence it has over them.** CVHEdU10,p.11-12 8. A lot of people feel very strongly that they need to work with vulnerable populations. CVHEdU10,p.9 9. …**to be able to share their experiences I think is meaningful for them as well to be able to feel that they may have, their experience may have some impact on this whole group of students who are learning to become a health professional who will care for other people** … CVHEdU11,p.3 10. **the opportunity** for those organizations **to inform some change in the training of our students** …**bring students' attention to something that they feel has been missing**, … **clarifying misconceptions about what their organizational role is, what the needs of the clients that they serve are**. CVHEdU11,p.9 11. …**they have a voice**... CVHEdU13, p. 5 12. …**if there is one message that this group has got across to people in every health care group we've spoken to, it's that we keep changing and getting better, and making progress for the rest of our lives.** CVHEdU14, p.11

Better health care*	1. … **helping us produce health care professionals that serve their constituents better**… CVHEdU01,p.15 2. … **may even light a spark that would bring and add services to those communities.** CVHEdU02,p.17 3. …**higher level of care…** CVHEdU05,p.15 4. …**improvements in the care…** CVHEdU06,p.11 5. But we've tried to get our students outside the building and I think the benefit has been they see patients very different than the ones who come here, again for all those reasons, ability to pay, traveling and all the other stuff. And so they recognize that there is a need. CVHEdU09,p.19 6. …**there's lots of evidence that relationship building between health providers and patients has a direct impact on that patient's health, it's better for them.** CVHEdU10,p.3 7. …**could get better care** and but I also think for **motivating the future health care professions in general advocacy.** CVHEdU16, p.7-8
	8. …the first thing that comes to mind is that they would be changing things for future people like them, in terms of **having their needs better met with health services**. CVHEdU15, p. 14 9. …**they were happy to participate if they thought that at the end of the day they were giving back to their community** …**they're influencing their own community.** CVHEdU21,p.7-8
Validate their work*	1. There's also then being able to report back to the community that they actually have a role in being able to help shape. CVHEdUPilot,p.14 2. **To have that validated by a medical professional. This is something that is really valuable and it's important.** CVHEdU13, p. 6 3. …**with some of the community health workers that were coordinating and supporting the courses that actually advanced their career**. **Because they were recognized for another set of skill set.** …**it's good to be attached to an institution that is recognized. Because then they are recognized too.** CVHEdU13, p. 7. 4. …**community development** …**it's developed capacity for teaching but also knowledge generation in the community.** CVHEdU13, p. 6. 5. …**recognition that they have the expertise and they have something to teach**, and then I think something that would go along with that also is that in **having that expertise and being recognized, maybe that would help solidify and stabilize the funding**, because then, I mean again, their role is significant. **They have the expertise in participating in the preparation of future medical personnel, and we need them.** So, it helps also to help them stabilize and not so caught up in short term funding. I mean, **every time you do a round of funding, you have to re-justify yourself**, right? So, so **it would help them, it would help honor what they are doing, to show that they are in partnership with the medical school.** CVHEdU15, p. 14-15

Empowerment	1. …that they would participate in the change. I think people who have been marginalized and haven't had their voices heard feel like there's nothing they can do and even if they were mistreated or untreated that now they've been able to be part of the change so that they can be, can influence the future. CVHEdU02,p.17 2. So it helps everybody and I think it's great for consumers cause many consumers have told me when they actually get to know a little bit about our program they're like oh boy that's quite a challenge and that must be really hard on students or that must be so I think it helps both parties. CVHEdU05,p.5 3. **We never know how much knowledge we have and it wasn't until we were teaching students** and their questions and we were sharing what we had. **So it solidifies their sense of worth and their knowledgebase.** CVHEdU13, p. 5 4. …they learn about how much they actually have to offer… CVHEdU13, p. 5. 5. …solidified her voice so that she is able to speak up and advocate for herself. CVHEdU13, p. 13
Community Service	1. …the organization itself also would be informed by that process and the growth of the organization would be informed by what's going on there because you also get, when you've got students involved you've also got that other piece happening which is so exciting which is the students actually provide, you know, input as well like in informal, both informal and formal ways. CVHEdU05,p.15 2. …**we don't just look at these sites as resources for learning because that's a little bit I would say imperial kind of thinking. I mean if they're not gonna benefit somehow, that's why the thing in [place] is we went there to help them with dental care because it's an hour and 45 minutes from [place] and it's a pretty remote area. And they actually started responding quite nicely with giving something back to us too**, so. …**the ultimate result is that the kids do better in school and so the elementary school likes that**. CVHEdU09,p.11 3. what was interesting this summer is that the [place] and the [place] clinic were both driven by recent graduates, people less than three years out who were coming back and one, the person in [place], the organizing dentist was actually a guy who graduated two years ago and the one in [place], one of the organizing guys was a dentist who, a dental graduate from three years ago and we had four recent grads who came back and volunteered CVHEdU09,p.19 4. They'll hire many of those students. That's why they came forward many of them to the meetings and so on. They said you know we've been hiring your students for years as educators, many of them health organizations and we'd love to have your students doing practicums with us and so on. So I think that what's in it for them sometimes they get a fair amount of labor… CVHEdU12,p.13
Providing witness / feeling like someone cares	1. …their response was quite interesting, it was that '**you are witness to our suffering and when you go back home you will understand about our suffering and you'll be able to speak about Uganda or Indonesia or whatever with knowledge and when people say oh they're just a bunch of whatever, you could say well wait a second, I actually spent time there and I know them.'** …**providing witness as much as anything and saying to those groups we value you and that in itself is probably worth something.** CVHEdU08,p.13-14

Appendix A

Role	Unit
Associate Professor	School of Audiology and Speech Sciences
Principal	College of Health Disciplines
Dean	Faculty of Dentistry
Dean	Faculty of Education
Associate Professor	Dept Educational Counselling Psychology & Special Education
Associate Dean, Health Professions	Faculty of Medicine
Undergraduate Director, Family Medicine	Faculty of Medicine
Associate Dean, Equity and Professionalism	Faculty of Medicine
Executive Dean, Education	Faculty of Medicine
Director	School of Nursing
Director, Undergraduate Programs	School of Nursing
Curriculum Coordinator, MOT Program	Department of Occupational Sciences & Occupational Therapy
Head	Department of Occupational Sciences & Occupational Therapy
Associate Dean, Academic	Faculty of Pharmaceutical Sciences
Head	Department of Physical Therapy
Associate Head, MPT Program	Department of Physical Therapy
Associate Provost, Academic Innovation	Provost's Office
Vice Provost Academic	Provost's Office
Dean	Faculty of Medicine
Associate Director	School of Population & Public Health
Associate Director, Aboriginal People's Health	School of Population & Public Health
Provost &Vice President Academic	Provost's Office
Total	22

Appendix B: Key informant (university) interview questions

1. To begin with could you say a little about your position / role at UBC [to give us some context]?
2. What are your thoughts about the need for health professional student to be educated differently to make them more responsive to the needs of society?
3. What examples do you know of patients / community members being involved in the education of (health professional) students at UBC?
4. What are your thoughts about the role that patients / community organizations and their members could play in educating (health / human service students at UBC?
5. [Refer to information sheet on levels of involvement]. Here is a range of ways in which patients and community members have been involved in the education of health professionals (examples include selection of students, curriculum development, teaching, assessment, program evaluation, strategic planning). Which of these are of most interest / relevance to you?
6. What needs to happen to enable and support community members to participate in health professional education?
7. What are the barriers to authentic participation of patients and community members in health professional education? How might they be overcome or reduced?
8. If UBC were to partner with community organizations, what would need to happen at the university to facilitate involvement? What kind of process or structure in the community would facilitate the authentic involvement of patients / citizens in health professional education?
9. What would be the benefits to community organizations if they were involved the education of health professionals at UBC?
10. Can you think of other people that would be interested in patient and community involvement that we should be talking to? (and name, contact)
11. I've finished my questions. Are there any other points you'd like to make?

Appendix C: Information for key informants to go with interview questions

*Patients have always been important in the education of health professionals, but their role has usually been as passive aids to learning. Active involvement of patients as educators has increased over the past 20 years as a consequence of government and professional policy directives relating to public and patient involvement in healthcare, moral imperatives related to social accountability, and the desire to broaden curricula to include the psychosocial aspects of health, promote patient-centred care and include the voices of those who are experts by experience. Patients are mainly involved in curriculum delivery and, to a much lesser extent, curriculum development and student assessment. In other professional programmes such as nursing and social work, a greater range of educational roles is found.

****Examples of patient roles in health professional education along a spectrum of involvement**

Level 1 Involvement: Patients involved in creating learning materials used by faculty (e.g. paper-based or electronic case or scenario; course materials; videos). Examples: real patient problems as basis for case-based learning; virtual patient cases (may involve video of patient); use of patient narratives.

Level 2 Involvement: Standardized or volunteer patient in a clinical setting. Examples: standardized patients widely used to teach and assess communication and clinical skills; clinical teachers may encourage volunteer patients to teach and give feedback; students write up patients' stories.

Level 3 Involvement: Patient shares his/her experience with students within a faculty-directed curriculum. Examples: patients invited into the classroom to share experiences of chronic illness, disability etc.; community-based patient / family attachment programs; Senior mentor programs.

Level 4 Involvement: Patient-teacher(s) are involved in teaching or evaluating students. Examples:

Teaching associates trained to teach and assess specific clinical skills (e.g. pelvic or breast exam); parents give feedback to students on communication skills.

Level 5 Involvement: Patient teacher(s) as equal partners in student education, evaluation and curriculum development. Examples: patient educators involved in multiple programme areas. Patient educators collaborate in educational decision making (e.g. curriculum objectives, assessment criteria).

Level 6 Involvement: Patients involved at institutional level in addition to sustained involvement as patient-teacher(s) in education, evaluation and curriculum development. Examples: Patients given a formal position in the institution (e.g. Consumer Academic). Patients involved in institutional decision making (e.g. student selection, reviewing funding applications).

*Note: We use the term patient for the sake of brevity, to include people with health problems (clients, consumers, people living with [condition], community members, their care givers (including parents and family), and healthy people (community members, lay people, well women etc). **Note: Patients may be individual educators or work in organized groups set up to deliver education and provide peer support. Some education may be delivered by organizations in the community.

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