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Research Involvement
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COMMENT
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Empowering patients in family medicine research: a case-study of patient partner involvement in educational and knowledge translation activities

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Abstract
Family doctors are encouraged to involve patients as equal partners in research and teaching, but examples of how to do this well are still quite rare. Our project, called the Canadian Primary Care Information Network - Learner and Patient partnership (CPIN-LEAP), set out to show what genuine partnership can look like when developing learning tools for family medicine residents.

What we did. Two patient partners sat on the core research team from day one and helped write the successful grant application. Guided by two national engagement frameworks, we invited nine additional patients to co-design the project's key products. Together, this team created an online learning module that walks residents through six essential communication skills, and they also drafted eye-catching posters and brochures that invite patients to send feedback after a clinic visit.

What worked well. Patient partners said they felt respected, influential, and relevant. Their ideas made the resident module more practical, especially the real-life scenarios and plain-language tips, and ensured that the community posters spoke directly to patients' concerns. The finished module has already been added to the University of Ottawa's Department of Family Medicine's Innovation Portal and clinic participants will be encouraged to display the posters and brochures.

Challenges we faced. Recruiting enough French-speaking partners proved difficult in our predominantly English-speaking city, even after we specifically targeted Francophone community groups and social-media pages. Coordinating meeting times was another hurdle, because many partners juggled work, caregiving, or appointments; we solved this by mixing in-person workshops, short evening videoconferences with flexible email feedback.

Why it matters. Working side by side with patients led to teaching and knowledge translation materials that reflect real-life worries and priorities. The process shows that deep partnership is doable, but only if projects budget

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for patient time and stay flexible with timelines. This case study illustrates practical processes and lessons learned from patient partner involvement.

Plain English summary

Family doctors are being encouraged to include patients as equal partners in research and teaching, but practical examples of how to do this are still rare. Our project called the Canadian Primary Care Information Network – Learner and Patient Partnership (CPIN-LEAP) set out to show what genuine partnership can look like in family medicine. From the very beginning, two patient partners helped shape our ideas and write the successful grant. Later, nine more patients joined to co-create the project's main materials: an online learning module for residents about patient-centred communication, and bilingual community posters and brochures encouraging patients to share feedback about their care and learn how to get involved in research. The educational module helps residents reflect on what matters most to patients in patient-centred communication during clinical encounters, while the community materials invite patients to make their voices heard. Patient partners said they felt respected and valued, and their suggestions made the educational tools more practical and easier to understand. Working in both English and French, we faced challenges finding enough Francophone partners and coordinating schedules, but flexible meeting formats helped overcome these barriers. This experience shows that meaningful patient-researcher partnerships are possible when time, flexibility, and funding are built into the project from the start.

Keywords Patient-oriented research, Patient engagement, Medical education, Patient co-design

Background

Primary care supports health across the life course and serves as the first point of contact for prevention, diagnosis and long-term health support [1]. Patient partnership strategies, including patient-centred care, are especially relevant in primary care, where years-long clinician-patient relationships enable sustained collaboration [2]. High-quality primary care now centres on patients as equal partners, a model linked to better outcomes and stronger patient trust [3]. In the family medicine context, where patients with multimorbidity may come to clinics with a myriad of interconnected health issues, improved trust and communication between patients and healthcare providers is especially impactful [1, 2]. Accordingly, the field of family medicine is at the forefront of developing methods for engaging patients to become their own health advocates and promoting patient-centred care.

In contrast, patient-centred research is still underdeveloped in the field of family medicine. Despite a wealth of review articles on patient engagement in emergency medicine, critical care and translational research [4, 5], family medicine research lags behind, both with respect to peer-reviewed research publications and the availability of practical recommendations [6]. Only three of the 28 projects funded by Ontario's patient-oriented research funding agency (OSSU) have included a researcher with a family medicine affiliation as a co-applicant [7]. OSSU is a provincial organization that supports and funds patient-oriented research initiatives across Ontario [8]. While family medicine research and education literature on communication emphasize patient-centred concepts, patients' actual experiences or perspectives are often omitted [9]. However, when patients do actively engage in family medicine research, both patients and researchers report tangible benefits, such as higher impact research findings [10]. This represents an important gap in effectively empowering patient research partners within primary care - there is no current road map to amplify patient voices and feedback within primary care research. Patient-centred research is a powerful tool to support effective and efficient patient-centred care, which is especially critical in the context of resource constrained health systems.

Context

The Department of Family Medicine conducted the Canadian Primary Care Information Network - Learner and Patient partnership (CPIN-LEAP) project beginning in 2019 (see CPIN-LEAP study website [11]). The project aims to integrate patient feedback into resident teaching and formative evaluation, promoting patient-centred care and learning. Originally designed as a quality improvement initiative, this project leverages the Canadian Primary Care Information Network (CPIN) digital patient engagement infrastructure to inform resident learning, emphasizing patient-centred communication capacities. CPIN is a Canada-wide primary care research initiative that uses digital infrastructure to collect and synthesize patient feedback in support of resident education, patient outreach messaging, and quality improvement activities. Given CPIN-LEAP's focus on patient-centred communication, the project subsequently sought additional funding from the Canadian Institutes of Health Research Strategy for Patient Oriented Research (CIHR-SPOR) program. The resulting EMPOWER initiative was developed to support knowledge mobilization activities within CPIN-LEAP [11], with the goal of translating the study's insights into tangible curriculum changes in the University of Ottawa family medicine program, thereby improving healthcare practices and patient outcomes. This project received ethics approval from the Hôpital Montfort Research Ethics Board (REB) (File ID 19-20-07-014), the Bruyère Health REB (#M16-20-005), and the Ottawa Health Science Network REB (Protocol 20190544–01 H).

Objectives

This *Comment* article presents a case study of how patient partner (PP) involvement was embedded within a larger family medicine research program. The purpose is not to evaluate outcomes, but to describe the processes, roles, and practical lessons associated with involving PPs in grant writing, educational resource development, knowledge translation, and academic dissemination. We use established patient engagement frameworks to structure descriptive reflection on what worked well, what was challenging, and what may be transferable to other primary care settings.

Theory of patient engagement

This project was developed using two frameworks for patient engagement in research: Canada's Strategy for Patient-Oriented Research (SPOR)-Patient Engagement Framework [12] and Carman et al.'s Patient and Family Engagement Framework [13]. The SPOR Patient Engagement Framework was developed by the Canadian Institutes of Health Research (CIHR), in collaboration with patient partners (PPs) and patient engagement experts. The framework outlines four guiding principles conducive to patient-oriented research:

- Inclusiveness: integrating diverse patient perspectives to ensure research meaningfully reflects patients' lived experiences.
- Support: providing patients with the necessary resources, flexibility, and culturally safe environments to facilitate their full and meaningful participation in research.
- Mutual Respect: involving researchers, physicians, and patients acknowledging and valuing one another's distinct expertise, recognizing both scientific knowledge and the experiential insights gained through lived experience.
- Co-Building: realized when patients and researchers collaborate from the outset of the research process to identify priorities, co-develop research questions, and jointly create and implement solutions.

The Patient and Family Engagement Framework [13] specifies a continuum of patient engagement in health care decision making and policy priority setting. It has also been extended as a lens to evaluate engagement levels in health research [14]. The continuum outlines patient engagement as a spectrum from patient Consultation (feedback sought after decisions are made), to Involvement (preferences are solicited before decisions are made), to Shared Leadership (PPs lead decision making). These frameworks were selected because they are nationally recognized, co-developed with PPs, and commonly used in Canadian patient-oriented research, allowing our experience to be situated within an established and widely applicable structure. Throughout the manuscript, "PP" refers to patient partners involved as collaborators rather than research participants.

Prior to research onset, we worked with two PPs to develop each stage of our research process in alignment with SPOR Guiding Principles [12], and the Carman et al. Continuum of Engagement [13]. Other considerations, such as feasibility, financial requirements and impact on the project timeline, were also discussed. Table 1 summarizes how patient partner involvement was operationalized across project stages, using the Carman et al. Continuum of Engagement [13] and SPOR Guiding Principles [12] as interpretive lenses.

The table illustrates where engagement activities aligned most closely on the Carman et al. Continuum of Engagement [13] at each stage; it does not imply that SPOR principles were absent at other stages (e.g., mutual respect) but rather highlights where specific principles were most explicitly operationalized.

Incorporating patient voices in research

Granting

Given the focus of the CPIN-LEAP research project was on bringing patient voices into teaching family medicine residents, we felt it was important to co-develop a strong patient knowledge translation plan. The goals of these activities were two-fold: (1) to better communicate the findings of the CPIN-LEAP study, and (2) to affirm the importance of patient involvement in family medicine research and training by showcasing how patient feedback was being used. To fund these knowledge translation activities, we applied for support through the CIHR-SPOR program. Given that this grant built on an existing project and we had already partnered with two PPs to develop the CPIN-LEAP project materials, we invited them to take formal leadership roles in the granting process. We first discussed the draft objectives verbally over the phone with one Francophone and one Anglophone PP; both partners provided real-time edits and re-prioritized deliverables. We finalized consensus on scope, timelines, and success indicators through an iterative email exchange, after which the agreed-upon objectives were submitted to the granting agency with both partners listed as co-applicants.

Table 1 EMPOWER patient oriented research engagement framework

Research Stage	Activities	Carman et al. Engagement Continuum(13)	SPOR Guiding Principles
Granting	• PPs actively engaged to write grant • PPs consult on research objectives and desired outputs • PPs are named as leaders on the grant application	Involvement Shared leadership Shared leadership	Co-building, mutual respect
PP Recruitment	• A knowledge mobilization specialist is engaged to promote patient recruitment • Specific recruitment of Francophone PPs	Involvement Involvement	Inclusiveness, support
Output 1: Creation of a PCC Educational Module for Residents	• PPs provide offline written input on PCC Module • PPs join virtual focus group to provide oral feedback/participate in group discussions • Final versions of materials are shared with PPs	Involvement Involvement Involvement	Inclusiveness, mutual respect, co-building, support
Output 2: Creation of Patient Knowledge Translation Materials	• PPs invited to in-person community workshops to collect feedback on patient-targets brochures and posters • A separate French-language workshop is held • PP satisfaction with activities is formally measured • Final versions of materials are shared with PPs	Involvement Involvement Involvement Consultation	Inclusiveness, mutual respect, co-building, support
Output 3: Academic research publication	• PPs review the drafted publication and provide input • PPs are named as co-authors	Shared leadership Shared leadership	Co-building, mutual respect

Note: PP = Patient Partners; PCC = Patient-Centred Communication

Patient partner recruitment

To recruit PPs across the Ottawa region, we implemented multiple strategies that aimed to be accessible, inclusive, diverse, respectful and grounded in community empowerment [15]. In summary, we recruited PPs through a combination of bilingual online outreach, engagement with community-based organizations and centres, an institutional PP program, and informal word-of-mouth networks; PPs supported recruitment by advising on messaging, venues, and accessibility rather than recruiting participants directly.

A knowledge mobilization specialist supported recruitment by adapting materials for community audiences, liaising with community organizations, and advising on accessible dissemination strategies. We strived to engage both English- and French-speaking individuals equally. However, given the challenges of recruiting Francophones in a minority-language setting, we intentionally prioritized outreach to French-speaking communities. This focus reflected both the bilingual academic and clinical context of the project and that Francophones represent a linguistic minority in Ottawa whose perspectives are often underrepresented in health research.

We posted bilingual study posters and recruitment emails on Facebook groups and community websites commonly used by Francophones. These platforms were chosen for their strong community engagement, with a high number of followers and frequent daily posts, which were expected to maximise study visibility and interest. We also targeted Facebook pages of visible minority Francophone communities, recognizing that visible minority groups are often underrepresented in health research and face structural barriers to participation [16].

We contacted Francophone community centers in Ottawa's east-end and the Vanier neighbourhood, as well as bilingual centres serving both language groups, and disseminated recruitment materials electronically or as hard-copy displays in key communal areas. We also submitted a request to advertise the study through the Montfort Patient Partner Program, which serves as a key institutional channel for engaging Francophone PPs. While no participants were recruited through this platform, this effort reflected our commitment to leveraging existing bilingual patient engagement structures within the region. Word-of-mouth snowballing was also encouraged: colleagues, students, and potential participants shared the invitation through their personal and professional networks [17].

In our study, online recruitment substantially broadened reach and was the most time- and cost-efficient; however, in-person or offline recruitment ultimately yielded better enrolment. Many potential participants first learned about the study online and expressed interest but preferred a virtual, rather than in-person, workshop. The main barriers faced while trying to recruit from community organizations were linked to traditional administrative processes, some of them required supervisory approval even though a "patient partner" is neither a volunteer nor staff. Similarly, academic-institution recruitment was hindered by lengthy form-completion processes. Thus, this added challenges to recruiting in communities where we did not have existing relationships. It requires more time to work with organisations to carry out the steps each organisation requires to reach out to its constituents.

Building long-lasting relationship with targeted organizations, aligning outreach with local events, and meeting potential partners "where they are" will likely enhance future recruitment efforts. By combining (1) bilingual online outreach, (2) direct engagement with community centers and (3) informal promotion through personal networks, we successfully recruited a diverse panel of PPs. While in-person recruitment suited many older adults, online methods may be more effective for younger participants and those with mobility constraints [18].

Patient partner perspectives presented as quotations were collected through informal reflective feedback captured contemporaneously during workshops, meetings, and manuscript review, rather than through formal interviews or qualitative data collection.

A patient partner's perspective: I found the recruitment process great. I got a lot of information ahead of time, including a really clear description of the expectations of patient partners. This cleared up a lot of uncertainly and helped me navigate the process.

Output 1: Creation of a patient-centred communication (PCC) educational module for family medicine residents

The first output of the project was a self-paced, two-hour educational module for family medicine residents, designed to support PCC skills development during clinical encounters. The module complements the structured patient feedback tool created in the previous CPIN-LEAP project. When a resident receives their aggregated patient feedback, their preceptor can link specific survey items to the matching PCC competence within the module or suggest a full module refresher.

The module is organized into six core competences conducive to PCC: (1) active listening, (2) empathy and emotional intelligence, (3) effective patient education, (4) navigating tough discussions, (5) cultural humility and (6) feedback and self-reflection. These competencies were identified through a triangulation of the College of Family Physicians of Canada's Patient-Centred Approach guidelines [19], published literature on patient-centred communication, empathy, health literacy, and feedback in primary care [6, 9, 19], and interviews conducted with PPs during the CPIN-LEAP project.

As a team of PPs, educators, and researchers, we mapped concrete skills to each competence, prioritizing patient-led research and illustrated with simulated patient care scenarios. At times, patient and physician perspectives conflicted, as patients often emphasized emotional understanding, while residents and clinical preceptors valued efficiency. It was sometimes challenging to give equal weight to patient, resident, and preceptor perspectives, given our recognition of the strict time constraints during appointments, especially because our legitimacy as a resident teaching tool was contingent on presenting a realistic guide to building PCC skills. For example, while patients showed a clear preference for holistic care, preceptors highlighted the constraints of 15-minute appointment windows and single-issue billing. To resolve these issues, we focused on feasible, evidence-based strategies that could be implemented within time-limited visits such as purposeful non-verbal communication, the teach-back method [6], and the SPIKES framework [20]. These strategies addressed several practical tensions between patient priorities and appointment time constraints; however, we note that some systemic constraints (e.g., short visit lengths and billing structures) remain beyond the scope of educational tools alone.

After the initial resident learning module was drafted, it underwent two feedback rounds. Round 1: residents, academic preceptors, family medicine physicians and PPs (the Feedback Committee) annotated the module asynchronously; "easy fixes", such as formatting and wording, were addressed. Round 2: the Feedback Committee met virtually to discuss nuanced issues. For example, whether a physician should invite a newly widowed patient to speak about their deceased spouse. When physician and patient views diverged, the team worked to integrate patient, educator, and feasibility considerations, recognizing clinical time constraints while ensuring patient priorities remained visible. We also asked structured questions to the Feedback Committee, to gauge the usefulness of interactive slides such as "PCC Dos and Don'ts" and prompting participants to suggest barriers to implementing PCC in clinical settings. The final English version was professionally translated to French; Francophone residents, physicians, and PPs vetted meaning and tone, and bilingual voice overs were added. Our aim is to embed the PCC Educational Module as an integral resource within the family medicine residency curriculum. Using residents' patient feedback reports on communication skills, clinical preceptors can assign focused learning tasks (e.g., selected chapters or interactive exercises from the module) and document follow-up goals in each resident's electronic learning plan.

A patient partner's perspective: I feel a sense of ownership over the materials created during the project. As I interacted with researchers over the course of the project, I think our relationship deepened, and by the end they probably felt more compassionate towards patients, knowing there was a face behind the names. I'm proud to have helped make that connection. It's also important to me to have made a positive impact in the lives of doctors and their patients.

Output 2: Creation of patient knowledge translation materials

In this phase of the project, PPs co-designed bilingual knowledge translation materials through facilitated workshops, with the goal of raising community awareness of CPIN-LEAP and demonstrating how patient feedback informs family medicine education. This section summarizes the co-design process and then describes the workshop design, content development, dissemination strategies, and revisions and approval steps.

These workshops emphasized plain language, accessibility, and patient-identified calls to action, while enabling PPs to shape both content and format. We sought to raise community awareness of the CPIN-LEAP study and to highlight the value of patient feedback in healthcare education and patient-centred care. Our target population was the Ottawa community at large, current patients and their families in particular, given the broad reach of family medicine. Consistent with our REB-approved protocol, the format of the knowledge translation materials was deliberately left open so that PPs could co-create them during a workshop series.

Workshop design: Before the workshop, the research team prepared bilingual facilitation slide-decks and drafted two samples of knowledge translation materials, an infographic poster and a trifold brochure, to serve as visual prompts rather than prescriptive templates. Nine PPs ($n=4$ Anglophone; 5 Francophone) attended two one-hour evening workshops, each opened with an overview of CPIN-LEAP and a reminder that verbal consent to participate and to audio-record discussions was optional (see Additional File 1).

Content development: The infographic and brochure were produced using Canva software [21], following plain-language and patient health literacy design guidelines such as a lack of medical or research jargon, bolding important words, and calculating the SMOG readability level (Simple Measure of Gobbledygook), to guide plain-language revisions, a validated tool that estimates the years of education needed to understand written text [6, 22–24]. The patient feedback focused on clarifying the "call to action", reducing technical study details (sample size, recruiting centers) and shifting the title from "Patient Voices in Family Medicine" to "*Your* Voice in Family Medicine", thereby foregrounding the reader. They also recommended adding a one-sentence statement on concrete impact (e.g., "Over XX patients in Ottawa have already shaped how new doctors communicate."). An unexpected design idea was to commission multiple versions of the materials and rotate them through clinics to maintain engagement and avoid knowledge translation fatigue.

Dissemination venues: PPs suggested posting materials in community centers, libraries, doctor's office waiting rooms and on the back of consultation room doors, where patients often spend unoccupied time, as well as launching a short-form social media campaign.

Revisions and approval: Following the workshops, the research team incorporated PPs' content and design edits; no additional formats were requested. Revised English and French versions were circulated for PP approval. In retrospect, PPs may have felt more comfortable making format changes if they had not been presented with two examples of possible KT materials, which may have stifled creativity. However, we chose to include these examples as a conversation starter and feel that these examples effectively encouraged discussion and supported patient contributions.

A patient partner's perspective: The co-creation sessions were a really good environment to share my opinions, and I felt heard and validated. I think that the session's facilitation could have been more open-ended, and that would have allowed me to be more creative in my ideas and answers.

Output 3: Academic research publication

As part of this case study, we describe PP involvement in academic dissemination. Four PPs were full contributors to the writing stage of this manuscript, providing substantive feedback on content, clarity, and framing, and participating in iterative decision-making about revisions. Draft sections were circulated iteratively, and PPs provided written comments, suggested rewording for clarity, and highlighted where additional context was needed. Their feedback ensured that the language remained accessible and that the emphasis on patient priorities was not lost during editing. Patient partners also reviewed the final draft, confirmed their agreement with the framing of the results, and chose to be named as co-authors, thus retaining shared ownership of the work.

Discussion

This case study illustrates both the opportunities and challenges of embedding patient partnership across all phases of a family medicine research project. One of the main successes was the degree of shared leadership that emerged. Patient partners contributed not only to idea generation and co-design of study outputs but also to the academic dissemination of findings, a stage where patient involvement is often minimal. By co-authoring this manuscript, PPs reinforced the principle that experiential knowledge and lived experience are equally valuable forms of expertise.

At the same time, challenges were evident. Recruitment of Francophone partners in a minority-language setting was difficult, despite targeted outreach. This reflects broader structural barriers facing Francophone and other underrepresented populations in research, and it highlights the need for sustained partnerships with community organizations rather than project-specific outreach. Another ongoing challenge was the coordination of meeting times across individuals with caregiving responsibilities, employment, and schooling constraints. We addressed this by offering a flexible mix of in-person, virtual, and asynchronous opportunities for engagement;

however, flexibility required additional planning and administrative support.

Our findings highlight several lessons learned. First, budgeting for patient time and contributions was essential. Providing honoraria validated the expertise of PPs and supported consistent engagement. Honoraria were budgeted at CAD $500 per partner, based on institutional standards for multi-meeting engagement and in alignment with the CIHR-SPOR Considerations when paying PPs in research [25], which emphasize fair recognition of time and expertise rather than reimbursement of expenses. No additional expense reimbursements were issued as all engagement activities were conducted locally or virtually. Second, iterative feedback loops built trust by consistently sharing draft materials, modules, and dissemination products, thereby reinforcing transparency and respect. Third, adopting national frameworks such as the SPOR Patient Engagement Framework [12] and the Carman et al. Continuum of Engagement [13] provided useful guidance for aligning engagement activities with principles of inclusiveness, co-building, and mutual respect.

Finally, PPs described a sense of ownership and pride in the outputs, noting that their voices shaped both educational tools and community-facing knowledge translation materials. This is an important indicator of meaningful partnership, moving beyond tokenistic consultation toward genuine co-production. This project demonstrated that patient co-leadership in family medicine research is both feasible and impactful when grounded in shared values, adequate resourcing, and deliberate flexibility.

It is important to note that this descriptive case study focused on implementation processes and did not systematically collect PP demographic characteristics such as education level, income, or health literacy. This limits our ability to assess how partnership experiences may vary across socioeconomic contexts and highlights the need for adaptation in settings with literacy or resource barriers. As such, future initiatives should explore how this partnership model can be adapted for settings with literacy barriers, lower socioeconomic resources, or additional linguistic diversity. Potential strategies include using oral rather than written feedback mechanisms, visual or audio-based materials, community facilitators, and partnerships with trusted local organizations. Further work is also needed to understand how patient engagement approaches can be tailored for Indigenous, newcomer, and non-dominant language communities.

Conclusion

In summary, partnering with patients from grant-writing through dissemination enriched every output of the CPIN-LEAP project. Our experience demonstrates that patient co-leadership can strengthen both the relevance and accessibility of research outputs, from resident education modules to community-facing knowledge translation materials. Genuine co-leadership is possible within tight primary care timelines when engagement is budgeted and supported. Looking ahead, embedding patient partnership as a standard rather than an exception could help normalize patient-led improvement in family medicine education and research.

Abbreviations

CPIN-LEAP	Canadian Primary Care Information Network - Learner and Patient Partnership
OSSU	Ontario's patient-oriented research funding agency
CIHR	Canadian Institutes of Health Research
SPOR	Strategy for Patient Oriented Research
REB	Research Ethics Board
PII	Patient-partner involvement
POR	Patient-oriented research
PP	Patient Partner
PCC	Patient-Centred Communication

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s40900-026-00841-4.

Supplementary Material 1

Author contributions

MJV led conceptualization, methodology, project activities, data collection and manuscript writing. SD was responsible for conducting project activities, data collection and manuscript writing. MI and AA each conducted project activities, drafted a manuscript section, and reviewed the entire manuscript. EL and KPG advised during the conceptualization, methodology and project activities, and manuscript writing and review. SJ, WH and DA each participated in conceptualization, methodology and manuscript review and editing, as well as project oversight.

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Data availability

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate

This project was conducted in adherence to international guidelines and regulations including those in the Declaration of Helsinki and the ones followed at the University of Ottawa. This project received ethics approval from the Hôpital Montfort Research Ethics Board (REB) (File ID 19-20-07-014), the Bruyère Health REB (#M16-20-005), and the Ottawa Health Science Network REB (Protocol 20190544–01 H). All patient partners gave informed consent prior to participation.

Consent for publication

Consent for publication was sought from the two individuals whose individual data (quotes) were used for publication.

Patient contribution box

Patients and family caregivers were active partners from start to finish.

Stage	How patients were involved
Idea generation	Two patient partners helped shape the original research question and grant aims.
Grant writing	Patients were listed as co-applicants and edited the funding proposal.
Study design	Patients chose the six communication skills for the resident module and selected workshop formats in co-development with the research team.
Material creation	Nine partners co-authored scenario scripts, approved graphics, and simplified language for community posters and brochures.
Data interpretation	Partners reviewed survey results, highlighted key lessons and decided which findings to share publicly.
Manuscript writing	All patient partners reviewed drafts, suggested wording changes and agreed to be named as co-authors.
Dissemination	Partners approved final educational materials and helped inform dissemination strategy in clinics and community centres.

All patient partners received honoraria, could contribute in English or French and gave informed consent.

Competing interests

The authors declare no competing interests.

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