Searching for Patient Involvement in Obstetrics and Gynecology Education and Training; A Scoping Review

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Thesis submitted to the University of Ottawa
in partial fulfillment of the requirements for the
Master of Arts in Education, Concentration in Health Professions Education

Faculty of Education
University of Ottawa

Acknowledgements

I would like to begin by expressing my gratitude to those who have supported me throughout the past two years of completing this Master's program. Firstly, thank you to my supervisor, Dr. Kaylee Eady, who has generously offered me patience, time, and support, provided me with invaluable, thoughtful guidance, and steered me toward professional and academic growth within the context of this program.

I am also deeply grateful to Patrick Labelle, Research Librarian extraordinaire, whose expertise and support have been instrumental in my coursework and thesis project.

I extend my thanks to my advisory committee, Dr. Julie Chartrand and Dr. Katherine Moreau, for their crucial feedback and guidance during the milestones of my thesis project. Dr. Ruth Kane also provided valuable guidance during my thesis proposal defense as my co-supervisor during Dr. Eady's maternity leave.

I would also like to sincerely thank Dr. Peter Milley, the former director of the Centre for Research on Educational and Community Services, for providing me with research experience, encouragement, and kindness throughout my studies.

Beyond my academic and professional mentors, I owe immense thanks to my family and my partner for their continuous encouragement and support. Thank you for listening patiently as I rambled on about research, even when it didn't make sense to you, and for always believing in me even when I doubted myself. You reminded me that the only person placing pressure on me to finish this program was, in fact, me.

Abstract

Background: The active involvement of patients in Health Professions Education (HPE) fosters partnerships and enhances patient-centred care. While reviews have explored this topic broadly, patient involvement in Obstetrics and Gynecology (OB/GYN) education and training, an area of care that addresses sensitive issues, remains poorly understood. Synthesized evidence is crucial in guiding research priorities.

Objective: The purpose of this scoping study was to comprehensively synthesize English and French evidence on patient involvement in OB/GYN education and training. The following research questions were addressed: (1) How is patient involvement in OB/GYN education and training conceptualized? (2) What is the nature and state of research on this topic? (3) What are priority areas for future research?

Methods: With the support of a Research Librarian, we developed and executed search strategies in EMBASE, Education Source, Academic Search Complete, Web of Science, MEDLINE, ERIC, APA PsycINFO, and CINAHL, utilizing Covidence to facilitate screening and publication selection. Included publications detail patient involvement in OB/GYN education and training within medicine, nursing, and midwifery, published in English and French. We conducted a complementary search of reference lists and relevant educational and professional websites. We iteratively developed and piloted a data extraction form in Excel, extracting data from all included sources.

Results: After screening 3,085 titles and abstracts and reviewing 147 full texts, 34 publications were included, with 11 added through reference list reviews, for a total of 45. Patient involvement was primarily used as a tool to enhance HPE programming, ensuring content meets patient needs, and supporting competency development. Most examples came from midwifery, followed by medicine and nursing. Patients were typically positioned as information sources, sharing their lived experience. A key gap was inconsistent reporting, with many studies lacking essential contextual details about the nature of involvement.

Conclusions: Patient involvement remains a passive focus in the field of OB/GYN and requires more targeted research. Particularly, the field would benefit from clear reporting standards and a shared framework for evaluating involvement that captures its contextual complexity.

Keywords: health professions education, obstetrics, gynecology, patient involvement

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Part 1: Introduction to my MA Thesis by Article

Preface

For my thesis project, I conducted a scoping review to summarize and critically reflect on the existing literature on patient involvement in Obstetrics and Gynecology education and training. Given that this methodology centres on literature synthesis, I opted to use the thesis by article format to avoid the redundancy of a traditional literature review, which is often required in other formats. This format also aligns well with the practical implications of my work for the field of Health Professions Education, as the "ready-to-publish" structure supports timely dissemination.

While I have led and executed all aspects and stages of this project, I have benefited from the integral contributions of several collaborators. My thesis supervisor, Dr. Kaylee Eady, provided consistent oversight and expert guidance throughout, and served as the secondary reviewer during the study selection process. I also worked closely with Patrick Labelle, the Faculty of Education's Research Librarian and an expert in scoping review methodology, during the early stages of the project to develop robust search strategies and gain a better understanding of the scoping review process. Patrick continued to support the project by answering various methodological questions. Finally, my thesis committee members, Dr. Julie Chartrand and Dr. Katherine Moreau, offered valuable feedback during the various milestones of my thesis, helping me engage more deeply with the concepts underlying my research.

My thesis by article is structured in three parts. This first part introduces the topic through a global overview of the problem and research objectives. It outlines my rationale for selecting a scoping review methodology and includes a reflection on my positionality and epistemology as a researcher and graduate student. Some general contributions of this research to the field are presented.

The second part presents the scoping review process itself—the article. I begin with a more detailed introduction to the topic and problem, expanding on the study's background and key concepts. I proceed with a comprehensive account of the methodology and findings. I then interpret the results within the context of Health Professions Education and Obstetrics and Gynecology, and offer recommendations for future research and practice in the field.

The third and final part concludes the thesis with reflections on the key insights gained throughout my time in the Master's program and from conducting this research. It also outlines

next steps for presenting and disseminating the findings, as well as practical applications for what I've learned through this review.

Description of the Problem and Rationale

Patient-centred care, which emphasizes shared decision-making and the integration of patients' perspectives into care (1), has become a prevalent concept in the health professions, with several regulatory bodies and professional associations incorporating it within their core values and accountabilities (2–4). The involvement of patients in the education and training of health professionals is an approach that gives particular prominence to this concept, as patients participate in shaping the practice of health professionals (5,6). Education builds foundational knowledge, while training allows learners to apply this knowledge through practice. (7). Patients may be involved in either of these processes in roles that can span over a continuous spectrum between active and passive. At the more active level, patients serve as autonomous collaborators alongside program administrators. Their roles may include teaching or assessing learners, contributing to curriculum development, or even taking part in the selection of program applicants (5). In more passive roles, their contributions are confined to specific learning objectives, such as simulated or standardized patients portraying a person with an illness they do not have, or real patients having their personal stories represented in case-based learning materials (6). These roles can offer valuable opportunities for learners to apply knowledge and develop reasoning skills. Patient involvement can help align health care more closely with patients' needs by fostering empathetic, communicative health professionals (8). As competency-based education becomes increasingly adopted in various regulated health professions programs internationally, such as nursing, medicine, and midwifery (9,10), it is critical to employ teaching and assessment strategies that reflect real-world performance. These strategies should foster the development of competencies we require from health professionals providing care to our communities (11).

Practitioners working in Obstetrics and Gynecology (OB/GYN) provide care focusing on the female reproductive system (gynecology) and/or provide care to pregnant people and babies during pregnancy, childbirth, and postpartum periods (obstetrics). These practitioners are required to learn procedures such as pelvic, breast, and rectal examinations, as well as labor and delivery procedures, and thus, communication, active listening, empathy, and respectful practice are skills that should be honed (12). These skills are reportedly developed through patient

involvement in Health Professions Education (HPE) (5). Although these notions highlight a need for patient involvement within the education and training of practitioners working in OB/GYN, little is known about the current scope of evidence to support this practice, nor the patient involvement practices that may be in place. This presents a problem for advancing research efforts and for creating and implementing learning experiences in OB/GYN education and training that involve patients. To address this gap, I conducted a scoping review to comprehensively synthesize the existing English and French literature on this topic. Such work is necessary to meaningfully advance patient involvement in this area. This review focuses on OB/GYN education and training for physicians, licensed and registered practical nurses, registered nurses, nurse practitioners, and midwives, as these are the most common professions represented in OB/GYN care teams.

This review contributes to the field by mapping how, and to what extent, patients are involved in OB/GYN education and training, and identifying gaps that may inform future research and educational development.

Research Objective and Questions

The purpose of this scoping study is to comprehensively synthesize English and French evidence on patient involvement in OB/GYN education and training. To guide this investigation, I addressed the following research questions:

1. How is patient involvement in obstetrics and gynecology education and training conceptualized?
    a. What are the theoretical bases for, purposes of, and definitions of patient involvement?
2. What is the nature and state of research on patient involvement in obstetrics and gynecology education and training?
3. What are the priority areas for future research on patient involvement in obstetrics and gynecology education and training?

Why a Scoping Review?

As I began thinking about my thesis project, I was initially interested in conducting interviews with health professionals and/or academics involved in OB/GYN education and training and related research to explore their patient involvement practices. However, as I began searching the literature to inform the development of my research proposal, I quickly realized

that the foundational knowledge in this area was sporadic, limited, and marked by inconsistencies in theory and terminology. Without a clear understanding of the existing evidence, new research questions emerged, and it became apparent that I first needed to map what had already been studied. This led me to pursue a scoping review as a necessary first step to inform future research that would make a meaningful contribution to advancing knowledge in this area.

A scoping review is a type of evidence synthesis used when the landscape of a research topic has not yet been extensively summarized (13). Its goals can include examining the nature of the literature, assessing the need for a systematic review, summarizing research findings, and identifying research gaps (13). It is particularly useful for understanding developing topics in a field, such as that of patient involvement in HPE. This exploratory approach to evidence synthesis provides a broad understanding of a topic by analyzing available published literature. As my primary goal is to shed light on the gaps in research on patient involvement in OB/GYN education and training, a developing topic that has yet to be reviewed comprehensively, I have conducted a scoping review using Arksey and O'Malley's five-stage methodological framework (13). The authors emphasize that their primary goal with this framework was to identify gaps in the literature, which is why this framework is well-suited to my research questions and to advancing this topic. By adhering to this framework, I have rigorously gathered and analyzed relevant literature, highlighting themes, common research questions, and frameworks used. This process has allowed me to summarize the current state of knowledge and has revealed where future research efforts should be focused. The synthesized landscape will guide researchers in targeting specific areas of patient involvement in OB/GYN education and training, and help practitioners and educators develop evidence-based patient involvement efforts.

Positionality

How I Came to Study This Topic

In harnessing patient and caregiver perspectives, valuable insights emerge that can inform recommendations for both the foundational education and ongoing development of health professionals. By amplifying patient and caregiver voices, we can help bridge the gaps that hinder individuals from accessing quality care in environments where they feel empowered and supported, thus leading to better health outcomes. My commitment to contributing to this research stems from a deeply rooted passion for sexual and reproductive health. Exploring topics

such as contraception methods, menstrual cycles, reproduction, and hormonal changes ignited my interest in understanding the diversity of health experiences. Through engaging in conversations with peers, I discovered the profound joy in listening to others' health narratives. My recent role as a postsecondary Clinical Education Specialist further solidified my dedication to patient narratives. As I listened to students' health concerns and guided them through navigating healthcare systems, I witnessed the pervasive gaps in healthcare accessibility. I gleaned invaluable insights into the factors shaping their trust in healthcare systems. Notably, I observed that trust often hinges on health professionals' non-technical skills (i.e. communication, emotional intelligence, critical thinking, etc.) (14). These realizations led me to explore the concept of patient involvement in HPE, which supports the development of non-technical skills (15) and fosters awareness of the challenges patients may face when navigating the healthcare system (7).

My HPE Aspirations

In aspiring to a career in HPE, whether through curriculum design, assessment strategy development, or program evaluation, I recognize the significance of involving patients and caregivers in the education and training of health professionals. The initial development of skills, defined as individual, observable, and measurable behaviors (16), and of competencies, defined as observable and measurable patterns integrating knowledge, skills, attitudes, etc. (17), is a vital period to instill person-centred values. These values allow health professionals to view the patient holistically as a person and not only as a client receiving a service (18). Whereas person-centred care emphasizes the whole individual, patient-centred care is more closely aligned with the philosophy of meeting the needs of patients in health care (1). Fostering partnerships between health professionals, patients, and caregivers is critical to the development of values from both, person-centred and patient-centred philosophies.

I approach teaching and learning as a reciprocal process, where teaching is the facilitation of learning, and learning is the absorption of information that leads to a change in behavior (19). I believe educators, learners, whether they be future health professionals or practicing professionals engaged in professional development, as well as patients and caregivers, each bring valuable perspectives. In my view, meaningful education (i.e. knowledge development) emerges, and training (i.e. application of knowledge) becomes more relevant when these three parties engage in equitable, person-centred collaboration. By positioning patients and caregivers as

invested partners in the educational process, we can enrich education and training, ensuring that they remain grounded in lived experience, and that health care effectively addresses the needs of patients and health professionals (8).

My Epistemology

I adopt a social-constructivist lens, whereby learning takes place through social interaction (20). In the context of HPE, this means health professionals from diverse training backgrounds come together to learn with, from, and about each other. Ultimately, this collaboration should lead to holistic, patient-centred care, an approach that considers the various dimensions (social, physical, emotional) of a person, ensuring that patients are treated as whole persons, rather than being reduced to their illness. I acknowledge that health is shaped by social determinants, including access to care and health literacy, and that the relationship between health professionals and patients plays a critical role in both access to services and the effectiveness of care. I also align with pragmatism; recognizing that involving patients and caregivers in HPE is practically beneficial as it fosters understanding of the needs and experiences of those directly impacted by health care delivery. Collaboration between educators, learners, and patients or caregivers promotes the integration of diverse perspectives within HPE, supporting the development of systems that are responsive, practical, and oriented toward meeting real-world needs. My decision to conduct a scoping review reflects both my social-constructivist and pragmatic orientations. Scoping reviews build on existing literature and acknowledge that knowledge is constructed through ongoing dialogue within the research community, a central pillar of constructivist thought. At the same time, the goal of synthesizing evidence to inform future research aligns with a pragmatic orientation, which values knowledge for its practical application and usefulness in addressing real-world problems.

Acknowledging my Limitations

As a white settler educated within Canadian academic institutions, my perspective is often grounded in a Western biomedical framework. I acknowledge that this orientation might influence the framing of this review, which is inherently shaped by biomedical discourse. It also may inform my understanding of education and training, as my experiences have been shaped almost entirely by Western, Catholic-influenced educational systems, where discussions of culture were often limited to surface-level representations. This background may shape not only how I interpret literature, but also how I might conceptualize learning and knowledge, often

under-engaging with non-Western ways of knowing. I also recognize that scoping reviews, by privileging published and indexed literature, may unintentionally marginalize or exclude knowledge systems and practices that are not widely represented in Western academic contexts. These factors may create limitations in my work. I encourage researchers and health professionals, as well as myself, to continue expanding our awareness and incorporation of practices and perspectives that exist beyond Western paradigms.

Potential Contributions

Through this research, I provide a comprehensive summary of existing published and indexed evidence within the OB/GYN education and training of physicians, nurses, and midwives. This can enable future research that is tailored to gain new insights while preventing non-constructive duplication of study designs, populations, and methods. This is significant because the field has raised concerns about a lack of collaboration and tendencies to work in parallel, hindering research advancement (7,15). Importantly, this research can help advance both theory and practice as it provides an understanding of current conceptualizations of patient involvement in HPE as well as the current state of knowledge and practice. I identify clear gaps in the literature, highlighting areas that require further investigation. The findings can assist potential program administrators in HPE to understand how patients have been involved, the extent of their involvement, and any reported outcomes. This knowledge is crucial for developing or updating educational programs, tailoring them to the needs of the end-user; the patient (8). Moreover, I list recommendations informed by the synthesis of the literature.

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Part 2: Searching for Patient Involvement in Obstetrics and Gynecology Education and Training; a Scoping Review

Introduction

Numerous scholars define patient involvement in Health Professions Education (HPE) as the involvement of patients and their family members or caregivers in various facets of the education process for health professionals (1-5). This involvement leverages patient expertise derived from personal experiences (6). The primary rationale for involving patients in HPE is to foster a genuine partnership between health professionals and patients, thereby advancing the goal of patient-centred care (2). Patients engaged in HPE experience feelings of helpfulness, relief, and increased self-reflection, leading to empowering and therapeutic effects (7,8). Health professionals from all specialties also benefit from patient involvement, gaining confidence and patient-centred skills, such as improved communication and reduced ethical biases (9). Significantly, patient involvement positively impacts health outcomes through increased patient-centredness in health care (2) and empowerment of patients (1).

Obstetrics and Gynecology (OB/GYN) care is unique, as it is characterized by sensitive health topics and procedures, including genital examinations, pregnancy and delivery, abortion, and discussions around contraception and trauma (10). Yet, issues in OB/GYN care are multiple. The diversity of Canada's population adds intricacy to the field. Newcomers, for example, may be unfamiliar with Western OB/GYN practices and may carry personal or religious stigmas toward sexual and reproductive health (11). This area of care is also shaped by a history of patriarchy and the frequent disregard for women's autonomy (12,13). The birthing process has become increasingly medicalized (12), to the extent that some women struggle to exercise their right to bodily autonomy, particularly when declining recommended medical interventions during pregnancy (13). Care is often centred on the physical well-being of the mother and fetus, while other dimensions of a woman's experience are overlooked (13). Although most healthcare institutions formally recognize pregnant patients' right to autonomy, health professionals are not always adequately trained to support them in making informed and empowered decisions (13). Pregnancy is also a key period for patient education, as pregnant patients may experience a range of health conditions before, during, and after pregnancy. However, due to limited dialogue with health professionals, many do not seek help (14). Therefore, pregnant patients' perspectives must

be prioritized in OB/GYN care, with shared decision-making and empathetic communication serving as foundational values in professional practice.

The intimate nature and history of power dynamics within OB/GYN care underscore the critical need for patient involvement in the education and training of its practitioners, ensuring that the care provided meets the needs of patients. Nevertheless, the current state of research on patient involvement in OB/GYN education and training, in both English and French, remains largely unknown. While several reviews have addressed patient involvement in HPE more broadly (1-4), none have specifically examined OB/GYN and its intricacies.

There is growing recognition of the need to push beyond the narrow boundaries of our understanding of patient involvement in HPE and to shed light on the nuances within areas of practice. Obstetrics and Gynecology stands as a unique focus in HPE, warranting comprehensive examination and advancement of patient involvement practices. While English is the dominant publishing language (15) and therefore an essential inclusion criterion, French is also widely used in HPE and professional practice across numerous countries. Including French-language literature ensures a more comprehensive synthesis that captures diverse perspectives on patient involvement. Thus, synthesized evidence, in both English and French, is imperative to guide research priorities in OB/GYN education and training.

Study Background

Health Professions Education

Mennin (16) states that "Health professions education is a complex continuous process in which students learn to care for fellow human beings across a wide range of cultural, political, and economic conditions." (p.763) This definition emphasizes the importance of actively involving those living in these social conditions in the education and training of health professionals. The social constructs Mennin (16) describes not only shape HPE but also influence the healthcare system more broadly. This perspective aligns with my previously stated epistemological stance, which acknowledges the socially constructed nature of knowledge and the value of incorporating diverse lived experiences in teaching and learning processes.

Education vs. Training. A philosophical distinction is to be made between education and training in the specialization of OB/GYN. Whereas education reveals a broad understanding of theory and experience, training focuses on applying specific practical uses to theoretical knowledge (6). In other words, practitioners working in OB/GYN who are educated may find

ways to use their knowledge to holistically ground their practice in values, meaning they can integrate ethical principles, empathy, cultural awareness, and shared decision-making into their clinical decisions. In contrast, practitioners working in OB/GYN who are trained might utilize their training to refine their practical skills, thereby increasing patient safety and the efficacy of care. Ideally, a well-rounded practitioner working in OB/GYN is both educated and trained. Moreover, as I argue in this study, the education and training of these practitioners should involve patients, as they can shape both the foundations and practical applications within the competencies of health professionals. These competencies are measurable and observable patterns of knowledge, skills, and attitudes (17) which should be demonstrated in health professions programs to ensure safe and effective practice that meets patient needs.

Patient Involvement in HPE

Health Professions Education emphasizes the development of the competencies necessary for professional practice. While much of this focus is placed on technical competencies, it is often assumed that those deemed non-technical, such as empathy, cultural awareness, and communication, will develop incidentally. However, patient involvement in education and training offers a meaningful way to intentionally foster these essential competencies throughout the learning process (18).

Active vs. Passive Involvement. The literature on patient involvement in HPE frequently focuses on passive involvement, such as simulated or standardized patients, or patients volunteering their experiences to groups of health professions students (19-21). While these roles may seem less impactful than those involving patients in curriculum design or learner assessment, Towle et al. (1) introduced a *Spectrum of Involvement*, which posits that these more passive roles exist within a larger continuum. In this framework, “active patient involvement” explicitly excludes roles where patients act out symptoms they do not have, such as simulated patients, standardized patients, or patient actors, and emphasizes roles where patients portray themselves. This delineation is challenged by Rowland et al. (4), who caution that limiting involvement to nontraditional or highly active roles, such as patient teachers, risks overlooking the diverse and nuanced ways patients can contribute meaningfully across a spectrum of involvement. Given these nuances, efforts to define the concept of patient involvement in HPE precisely, as seen in published reviews (1-4), may have inadvertently contributed to overly narrow interpretations of what constitutes meaningful involvement.

Nevertheless, Towle et al.'s (1) conceptualization of patient involvement can help advance the field beyond the previously limited efforts, emphasizing authentic partnerships where patients actively contribute to the educational and training processes of health professionals. This offers unique insights and fosters understanding of how patient-centred care can shape practice. At the core of patient-centred care are values that should be mutually upheld by both patients and health professionals, including "shared decision-making, individuality, respect, a holistic approach and communication" (22). These values serve as foundational pillars for the collaborative partnerships envisioned by Towle et al. (1). In the context of education and training, a holistic approach means embedding these values into teaching and learning through co-creation and the integration of diverse perspectives, ultimately benefiting learners, the healthcare system, and, most importantly, patients. Exploring patient involvement in OB/GYN can provide a more comprehensive understanding of its impact on both education and training, as well as patient outcomes.

Towle et al.'s framework demonstrates a patient-centred approach through its use of person-first language, distinguishing itself from others, such as the International Association for Public Participation's (IAP2) Spectrum of Public Participation (23). Whereas Towle et al. place the patient at the centre of role descriptions, for example "Patient(s) involved at the institutional level…" (1, p.65), the IAP2 spectrum presents itself as institution-first. One of their statements, "We will implement what you decide," appears patient-centred, but ultimately reinforces institutional power, as the institution retains control over the implementation rather than fostering an authentic partnership in which patients share rights and responsibilities around the implementation. I also believe that Towle et al.'s conceptualization of patient involvement offers practical applicability, as the degrees of involvement provide implementable steps which can be found below the italicized degrees of involvement in the continuum table (Appendix A). If a program administrator, for example, wants to involve patients within their education or training processes and has established the degree of their involvement, they can determine the resources required to implement the outlined steps from the continuum within these processes. The framework does not require programs to pursue active involvement; rather, it offers a stepwise approach that facilitates achieving an active level of involvement if appropriate for a given program. This flexibility allows implementers to start with a feasible level and, if desired, progressively increase involvement in alignment with available resources.

While some researchers focus on the concept of patient involvement in HPE itself, others focus on perspectives of implemented involvement. For instance, some have explored medical students' perspectives on patient involvement (24), as well as patients' satisfaction with their health professionals' practices and education (25-27). This research provides a general idea of some benefits of including patients within HPE. Aye et al. (28) used adolescent simulated patients to assist third-year medical students in learning the adolescent medicine curriculum in Malaysia. Over 95% of medical students reported gaining a deeper understanding of the issues faced by this population, and more than 97% appreciated the opportunity to work with simulated patients (28). It was apparent that the students reflected positively on their experience and that it increased their knowledge and confidence in the care they would provide (28). Medical students from a Fong et al. (6) study also pointed out the paramountcy of learning how patients navigate the healthcare system directly from them, as well as how real encounters solidify their learning. Further, Bennett-Weston et al. (2) concluded that early contact with patient educators can lead to lasting "patient-centered professional identities" (p. 296) for health professions students, indicating a factor of sustainability in patient involvement efforts. These findings support the concept of patient involvement in HPE as crucial to health professionals' holistic learning, although they do not indicate the optimal degree of involvement for maximizing benefit. To foster holistic understanding, the learning process should intentionally integrate varied perspectives and human dimensions.

Tokenism. The use of patients' experiences without involving them in the design of the education system or research can be problematic. This issue, known as tokenism, is particularly pressing as many institutions now include patient involvement as a formal requirement, often without a commitment to authentic partnership (29). As a result, institutions usually involve patient-based decisions in meeting standards or professional objectives, while retaining the ultimate decision-making power (29). In the context of health research, for example, tokenism is further perpetuated by a common misunderstanding of the difference between qualitative research and meaningful patient involvement (30). This confusion can result in researchers believing they are meaningfully involving patients, when in reality, they are using patient voices as data in the implementation stage of the research. An additional challenge arises when funding is contingent on the submission of a detailed research proposal or when ethics approval is required before patients can be engaged in the early stages of project development. Without

access to preliminary funding to compensate patients from the outset, researchers may delay involvement until later stages, at which point consultation or partnership is no longer effective or meaningful, and thus becomes tokenistic (30). McCutcheon and Gormley (31) suggest that without patient involvement at all levels of education, the potential for tokenism arises due to power imbalances between academics and patients. Majid (29) identifies unequal power as the most significant dimension of tokenism, underscoring that academics in educational or administrative roles may have ulterior motives for involving people of colour in their work. These motives, such as furthering the goals and ideas of academics, can lead to tokenism or exploitation, hindering the authentic incorporation of patient perspectives at the institutional level.

Terminology. The lack of consensus on an appropriate lexicon for patient involvement has also posed challenges for those conducting reviews in HPE (9). For example, the term "patients" itself has been contentious due to its implications for power dynamics between health professionals and people receiving health care (1,2). For this study, the term refers to individuals with lived experience who receive care. Without agreement on even basic concepts of patient involvement, such as terminology, researchers must develop extensive libraries of search terms (e.g., patients, clients, service users, experts by experience) and elaborate strategies to capture as much relevant literature as possible. This lack of consistency not only increases the time and resources required to conduct reviews thoroughly but also complicates the interpretation of findings. In conducting this scoping review, I had to navigate these discrepancies to gather the relevant literature. While writing my report, I also needed to remain consistent with the terms I used and their definitions to avoid perpetuating the broader issues in the field.

OB/GYN Teams

In Western societies, OB/GYN care teams are traditionally composed of physicians and nurses with specialized training in this field. In recent years, midwives have become integral members of OB/GYN care teams as well, although they are often still not part of primary care (32). Whereas physicians and nurses working in OB/GYN generally practice in clinical settings, midwives historically practiced in patients' homes and community contexts (33,34). Though midwives in Canada previously practiced more independently (35), they are increasingly being recognized as frontline care providers working with interdisciplinary teams (32). In Ontario, for example, at The Ottawa Hospital Civic Campus, midwives are members of the healthcare team

and can provide care to pregnant patients through an uncomplicated birthing process in the hospital (36). The medical, nursing, and midwifery professions are guided by their respective regulatory bodies, which establish standards of practice with a shared goal of meeting patient needs. As regulated health professions, they adopt a competency-based education approach that evaluates educational effectiveness based on the achievement of clearly defined learning outcomes (37).

Educational and Training Requirements. The path to becoming an OB/GYN practitioner varies internationally and across Canadian provinces. To provide an example of the educational and training requirements for these practitioners, I focus on Ontario's standards and regulations for Canadian learners. Obstetrics and Gynecology physicians in Ontario must first begin, or complete, a 4-year baccalaureate program to fulfill medical school prerequisite courses (38). Depending on the medical program, they may also be required to take entrance exams, such as the Medical College Admission Test (MCAT) or the Computer-Based Assessment for Sampling Personal Characteristics (CASPer) (38). Following this, aspiring physicians must complete a 4-year undergraduate medical program and 5 to 6 years of residency training to specialize in OB/GYN. Finally, they must pass both a medical licensing exam and an OB/GYN certification exam (38,39). Effective patient care in OB/GYN also relies on a diverse team of nursing professionals. In Canada, there are four types of regulated nurses who may be part of these teams: licensed or registered practical nurse (LPN or RPN), registered nurse (RN), clinical nurse specialist (CNS), and nurse practitioner (NP) (40). To be licensed to practice in the province of Ontario, RPNs are required to complete a 2-year diploma nursing program approved by the College of Nurses of Ontario (CNO, governing body for all nurses in Ontario), as well as to pass a RPN licensing exam and a jurisprudence exam (40). Throughout the rest of Canada, the same role goes by the name of licensed practical nurse. To practice as RN in Ontario, a 4-year baccalaureate nursing program approved by the CNO is required, as well as to pass an RN licensing exam and a jurisprudence exam (40). Clinical nurse specialists may also be part of the OB/GYN care team in Ontario. They are RNs who have completed additional training through a Master's or Doctoral program in nursing; thus, they have acquired skills in leadership, research, and education (40). However, CNSs have the same legislated scope of practice as RNs (40). Nurse practitioners licensed in Ontario are RNs who have practised Nursing for at least two years (or 3,640 hours) in Ontario (41), and have graduated from an NP program as well as

successfully completed NP licensing and jurisprudence exams approved in Ontario (40,42). In Canada, these types of nurses go through generalist baccalaureate programs, preparing them for increasingly complex health care (43). They can then choose to complete exam-based certifications to specialize in various fields, though none are specifically being offered relating to OB/GYN (44). As midwifery becomes more regulated throughout Canada, its educational and training paths begin to resemble those of the previous two professions, though they do provide more community-based options. Midwives who practice in Ontario can either complete a 4-year health sciences baccalaureate program in midwifery, the 4-year Aboriginal Midwifery Training Program for Indigenous students, or a post-baccalaureate midwifery program for licensed health professionals (accelerated program) (45). After following one of these programs, they must successfully pass a national registration exam (46).

Standards of Practice. On a national level in Canada, various regulatory bodies and professional associations guide the practice of physicians, nurses, and midwives. The Royal College of Physicians and Surgeons of Canada (RCPSC) emphasizes its commitment to supporting person-centred care in its 2023-2026 Strategic Plan (47), though they do not define the concept explicitly. The Competence by Design training model developed by the RCPSC aims to ensure physicians graduate with competencies aligned with local health needs (48). These competencies are outlined in their CanMEDS Framework (49), where the concept of "patient-centred care" appears repeatedly without a clear definition. While this highlights the importance placed on patient-centred care within specialty competencies, the lack of clarification risks reducing the concepts to *trendy* terms rather than a meaningful practice. The Canadian Nurses Association (CNA) reflects this focus in its mission statement as well, aiming to "make nursing better — for nurses, for patients, and for our public health systems" (50). They also present the *person* or beneficiary of care as one of the core concepts of the nursing metaparadigm. The metaparadigm, outlined in the most recent version of the *Framework for the Practice of Registered Nurses in Canada* (51), constitutes the central elements of the nursing framework in Canada. A joint position statement from the CNA, the Canadian Association of Midwives (CAM), and the Canadian Association for Perinatal and Women's Health Nurses (CAPWHN) also mentions "woman-centred" and "family-centred" practice, as well as "client-centred care" (52). These concepts are not clearly defined by any of the publishing associations. Moreover, the Canadian Midwifery Regulators Council (CMRC) states its intentions to promote patient-centred

care, highlighting partnership and informed choice as key principles of midwifery practice (53), as well as incorporating patient-centred care into its competency profile (54). The CMRC defines the concept of "client-centred comprehensive care" as "comprehensive, individualized, collaborative care that supports clients' needs and desires without expectations" (55, p.5) in a microlesson (explanatory appendix to the competency document) on *Inclusive Midwifery Care and Human Rights.* While it is essential to acknowledge that these regulatory bodies all advocate for patient-centred care or a similar concept, they often fail to clearly define the concepts they align with and to demonstrate their efforts consistently in terms of patient involvement in setting standards of practice, developing core competencies, and assessing the skills of practitioners, both during and after education or training. These shortcomings may be due to a lack of current conceptual consensus and evidence on which to base practices. Despite this, other regions, such as New Zealand and the United Kingdom, have incorporated requirements for patient involvement into their education policies (56, 57) or have been strongly encouraged by their governments to involve patients in their health professions programs (58).

Other Practitioners in OB/GYN Care

Medical students participate in OB/GYN rotations during their Undergraduate Medical Education (UGME) and thus can be involved in the care of OB/GYN patients. Their responsibilities can include tasks ranging from collecting patient histories to observing or assisting with clinical procedures. Although this group engages in OB/GYN care for a limited period and receives training that involves patient interaction, I have excluded them from this review because UGME focuses on the development of foundational knowledge and skills, while the subsequent levels of medical education and training focus on clinical practice. Additionally, a protocol for a similar review, focusing specifically on UGME, was recently published (59). Including medical students in this review would therefore risk duplicating research efforts.

Family physicians also provide OB/GYN care, although their involvement in obstetrical care, in particular, has declined in recent years as procedures become more complex and specialization becomes increasingly necessary (60). While they may occasionally provide primary OB/GYN care, patients are usually referred to specialist OB/GYN physicians. Given that family physicians are not consistently integrated into OB/GYN teams, I have also excluded them from this review.

While the OB/GYN practitioners previously discussed are those most recognized within Western biomedical contexts, they are not the only practitioners who specialize in birthing assistance globally. In many regions where midwives are less accessible, more community-based and culturally attuned carers, often referred to as "traditional birth attendants" (TBA) by the World Health Organization (WHO) (61), play a central role. The WHO previously advocated for the training and use of TBAs until WHO medically trained practitioners became widely available. However, in conducting a literature search, I found little documentation on TBAs who practice without formal or conventional training. TBAs are typically respected members of their communities, providing support during childbirth and the postnatal period for both the birthing parent and child (61). Given the limited documentation and the lack of regulation of these carers, I have excluded this group from the review.

Similarly, doulas are non-medically trained support persons who may be hired to provide emotional and physical support during birth or the postpartum period (62). As doulas are not regulated health professionals in Canada, a range of organizations exist to provide training and guidance, each with varying standards (63). Due to the absence of a unified regulatory framework and standardized educational requirements, I have excluded doulas from this review.

Despite its intimate nature and the unique vulnerability experienced by patients, researchers have yet to comprehensively study the published and available landscape on patient involvement in OB/GYN education and training. Thus, synthesized evidence, in both English and French, is imperative in HPE to guide research priorities in OB/GYN education and training, particularly given the ongoing mobilization of competency-based education.

Methods

As I aimed to summarize the existing English and French literature on patient involvement in OB/GYN education and training, I conducted a scoping review per Arksey and O'Malley's framework (64). This methodology allowed me to sort through relevant literature, analyze it, and propose recommendations around patient involvement in the field of OB/GYN education and training. Future research avenues also emerged through this review.

Stage 1: Identifying the Research Question

The first step in the Arksey and O'Malley framework (64) is to define the key concepts surrounding the chosen topic. I began by identifying the relevant practitioners for this review and establishing the concepts of education and training within the field of OB/GYN. Initially, I

brought my attention to pertinent learners of medicine, quickly realizing that narrowing the review to this profession alone would be a mistake, as nursing and midwifery also play significant roles in OB/GYN care. It was essential to determine the appropriate stages of education and training to include, given the varying intended outcomes and curricular approaches used based on stage and profession. Therefore, I decided to focus my review on the stage of education and training that led to transition to practice within medicine, nursing, and midwifery. For medicine, this is Postgraduate Medical Education or residency (65). For nursing, this includes certificate, diploma, undergraduate, and graduate programs (66). For midwifery, there are certificate, diploma, and undergraduate programs (67). Through online searches, I also found that graduate-level programs in midwifery are offered in North America, Europe, and Asia. These stages were selected to be as inclusive as possible of international processes for preparing OB/GYN professionals. I also included continuing professional development for these professions, as it directly affects their practice.

Additionally, I refined the definition of patient involvement, identifying alternative titles and descriptions to enrich the analysis of the findings. These steps were crucial in developing my search strategies, helping to focus on the most relevant databases and search terms to yield pertinent results.

Drawing on the purpose of this scoping review and the key concepts noted above, I identified the following research questions to address:

1. How is patient involvement in obstetrics and gynecology education and training conceptualized?
    a. What are the theoretical bases for, purposes of, and definitions of patient involvement?
2. What is the nature and state of research on patient involvement in obstetrics and gynecology education and training?
3. What are the priority areas for future research on patient involvement in obstetrics and gynecology education and training?

Stage 2: Identifying the Relevant Studies

Stage 2 of the Arksey and O'Malley framework (64) involves identifying the sources of literature to be searched. These sources can include electronic databases and grey literature, such as journal articles or conference proceedings, that are relevant to the topic. In collaboration with

a Research Librarian, specialized in knowledge synthesis, I developed search strategies for each selected database. The Research Librarian guided my methodology and the development of the search strategies, as well as their validation. Our process ensured that the strategies were well-refined to retrieve the most relevant results in response to the research questions determined in Stage 1.

Database Search. I noted common databases for the fields of education, health care, social sciences, and science during a preliminary literature review. I implemented my search strategies (Appendices C-J) within the following electronic databases, accessible through my affiliation with the University of Ottawa:

- EMBASE
- Education Source
- Academic Search Complete
- MEDLINE
- ERIC
- APA PsycINFO
- CINAHL
- Web of Science

I consulted the above databases to determine the appropriate syntax for each, as well as relevant search terms and subject headings. I categorized the search terms and subject headings based on their alignment with the overarching concepts of this study: patient involvement, education and training, and OB/GYN (colour-coded within the search strategy appendices). I considered and included variations of terms identified through the preliminary literature review to encompass as many relevant publications as possible from any geographical location. Many titles are given to involved patients, including patient instructor, patient educator, or patient teacher (1). These are easily confused with roles held by health professionals under the same names, where the health professional educates patients on navigating the healthcare system, treatment options, medical conditions, and other related topics.

Additionally, the term “patient” is used interchangeably with various other terms, such as “service user,” “consumer,” and “client” (68). Consequently, I was diligent in filtering the results to include publications that refer to patient involvement, without relying on specific keywords for initial filtering. I did not use the limitation filters on any of the consulted databases, as the

inclusion criteria were quite broad (described below). The initial search strategies were tested with the help of the Research Librarian and adjusted to optimize the collection of relevant results. A complementary search of reference lists from the included publications supported this rigorous process.

Stage 3: Study Selection

Arksey and O'Malley (64) describe the third stage as the point at which inclusion and exclusion criteria are established and applied to the search results. For this review, I determined that selected publications must specifically address patient involvement in the education or training of health professionals, in alignment with the research questions. Although some researchers do not consider patient simulations as patient involvement (1), I included such literature to provide a comprehensive context and substantive report (4). I also included literature that provides context for the education and training of OB/GYN learners, such as the consent process for learning activities. I excluded patient involvement in decision-making during individual patient-physician consultations, as this does not directly impact the education or training of health professionals. Since the search strategies needed to remain broad to capture as much relevant literature as possible, my supervisor and I manually screened out publications in this category. The concept of "health professionals" encompasses learners in OB/GYN education and training, including those in Postgraduate Medical Education or Continuing Medical Education, as well as Undergraduate, Graduate, Postgraduate, or Continuing Nursing Education, and Undergraduate, Graduate, or Continuing Midwifery Education. I included English and French language publications that meet the criteria to synthesize evidence representing both of Canada's official languages, in which OB/GYN education and training occur. Though I would have liked to include a more diverse language range for inclusion, this is one of my limitations. As study design is typically not a criterion for scoping reviews, where the goal is to understand the broad landscape of the literature (64), I did not select publications based on study design. I did not filter by publication year to ensure a comprehensive synthesis of existing literature. The criteria that were used are summarized in Table 1.

Table 1. Inclusion and Exclusion Criteria

Criterion	Inclusion	Exclusion
Language	Publications in English and French	Publications not in English or French

Extent of Patient Involvement	Involves patients, caregivers, or public engagement/input in the educational/training process	Patients only involved in their own health care decision-making with health professionals
Goal of Patient Involvement	Educating or training health professionals	Quality improvement only (i.e. only discussing patient satisfaction)
Learner Population	Involves undergraduate, graduate, or professional development learners in nursing or midwifery, and postgraduate or continuing medical education learners	Involves only undergraduate medical students
Care Focus	Involving OB/GYN	Not involving OB/GYN
Publication Type	All publication types	N/A

Once I completed the database searches, I exported the RIS files from each database and imported them into *Covidence*. The platform automatically removed most of the duplicates, and my supervisor and I manually removed the remaining duplicates as we sifted through the titles and abstracts, and later, during the full-text review. I served as the primary reviewer, while my supervisor served as the secondary reviewer. We independently reviewed titles and abstracts, considering the inclusion criteria and research questions. We maintained an open line of communication throughout this process, reevaluating the inclusion criteria as needed and confirming changes with the Research Librarian. Once this first screening step was complete, we proceeded to examine full texts to confirm inclusion. To find these full texts, I used the Google Scholar button extension, which linked to the University of Ottawa's online library (Omni). This made the process seamless, though some were not available through my institution. For these, I submitted Interlibrary Loan Requests (received full texts through Omni). Some of the texts were also hidden in old journal publications, for which I conducted journal searches through Omni.

Many of the selected publications were only available as conference or poster abstracts. I searched for the titles and names of primary authors separately via Google Scholar and Omni, though most did not have a full publication that I could find. If the abstracts provided sufficient information to help address the research questions, they were included regardless.

When conflicts were identified through *Covidence* at each of these steps, we discussed them to reach an agreement. Had we not been able to agree on how to proceed with the conflicts, we would have consulted a member of my thesis committee to provide an additional perspective.

No additional literature was included beyond January 1st, 2025, though the complementary search took place after this. This enabled me to concentrate on thoroughly analyzing the initially selected literature, informing my subsequent search, and ensuring that I stayed on track with the established and feasible research timeline. The search dates for each database were documented (Appendix B), as well as the reasoning for inclusion and exclusion, and the number of results at each phase of the review. Figure 1 depicts the flow of publications through the review process.

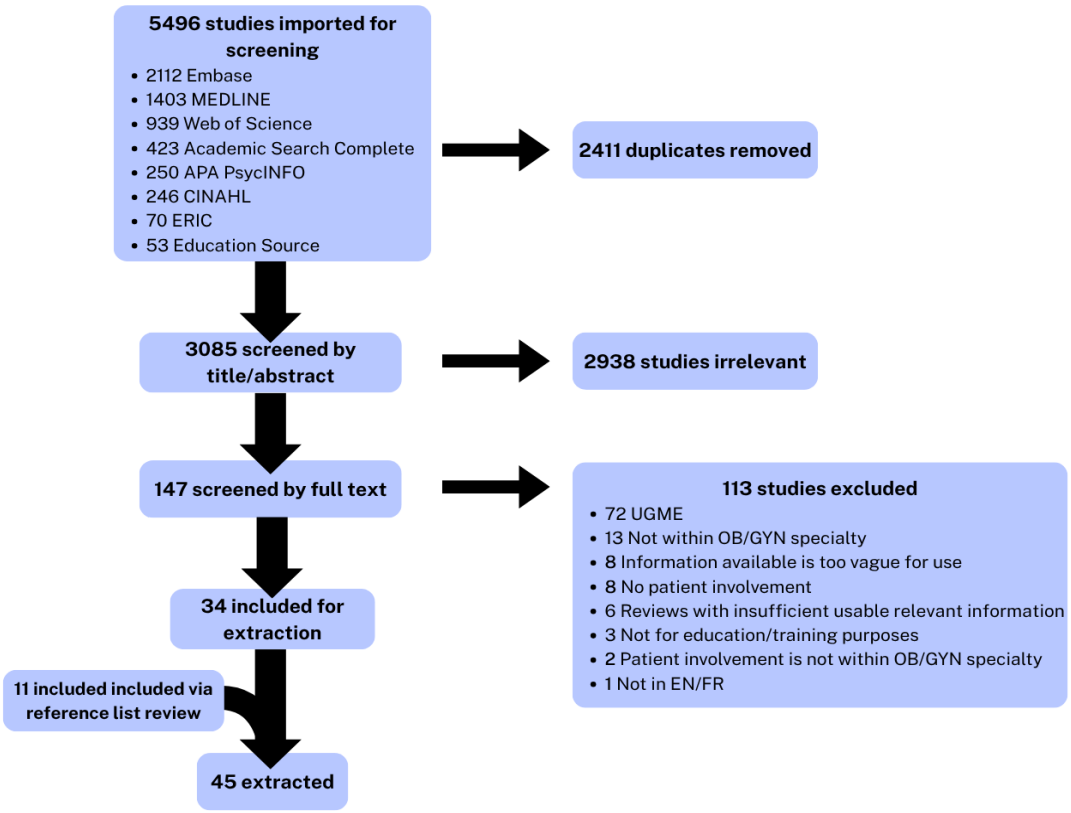
Complementary Search. As we designed the database search strategies to capture grey (non-peer-reviewed) literature, conference proceedings, theses, dissertations, and other relevant sources, we decided that an in-depth complementary search was not necessary, and the process was simplified. I reviewed titles from the reference lists of 6 scoping and systematic reviews that were included until the data extraction phase (68-73), and then reviewed the abstracts, followed by the full text if the titles seemed relevant. Once this was done, I excluded the 6 reviews from the final results as there were insufficient findings to include in this study. The Research Librarian helped inform this decision. I also reviewed the reference lists of the 34 included articles from the database search results. I included a total of 11 additional results following the review of these reference lists. I submitted a request for the full text of a 12th publication to the authors on ResearchGate, although I never received a response. Finally, I conducted a search of relevant regulatory and educational websites for relevant publications, including white papers and reports. These included:

- Canadian Association of Midwives
- The Society of Obstetricians and Gynecologists of Canada
- Canadian Nurses Association
- Accreditation Council for Graduate Medical Education
- Royal College of Physicians and Surgeons of Canada

Using the search bar on each website, I combined the terms “patient”, “client”, “consumer”, “woman”, and “community” with “involvement”, “participation”, and “engagement”. I added “OBGYN” when the lists of results became too long and most seemed irrelevant. As the

Canadian Nurses Association search bar automatically retrieves truncated versions of search terms, yielding an overwhelming number of results, I applied the "statement", "advisory", and "featured" filters (where applicable) under the *Formal Tags* drop-down to exclude news articles. I did not include any literature from this search.

Figure 1. PRISMA Diagram



Stage 4: Charting the Data

I iteratively developed a data extraction form in Google Sheets and piloted the form with five of the selected publications, representing a 10% sample. My supervisor separately tested the form using the same five publications, which resulted in several changes to better align the form with the research questions. I then became the sole extractor for the review. As I extracted data from the remaining publications and became more familiar with the selected literature, I added additional columns to ease the analysis process. Extracted data included publication characteristics, conceptual information that helped answer my research questions, as well as some further notes on pertinent points in the publications. I made some assumptions where data points were not explicit. When data was explicit, I included statements in quotation marks within the sheet. Simplifications were also made to the "Summary of patient involvement" column to

include the overarching details of the involvement without having overwhelming amounts of data to sift through upon analysis. The full extraction sheet, along with explanations of the extracted data and descriptions of prepopulated tags, can be found in Appendices K and L, respectively.

Stage 5: Collating, Summarizing and Reporting the Results

I used the PRISMA-ScR checklist to guide my reporting. I developed a descriptive summary of the publication characteristics to provide an overview of the sources of information. I analyzed and thematically grouped the data to answer the research questions, keeping in mind that the goal of the scoping review is to describe the data, not to criticize it. I critically used visual representation where appropriate to support the data descriptions.

To provide additional context to the findings, I discussed the forms of patient involvement described in the included publications in relation to a spectrum of involvement adapted from Towle et al.'s model (1), using the data to refine and update the original concepts. This adaptation was also informed by elements of Tew et al.'s (74) ladder of involvement and Forrest et al.'s (75) continuum of involvement. While attempting to categorize the initiatives using Towle et al.'s framework (column A in Appendix A), I found that some examples did not align clearly with a single level of involvement. As a result, I developed a modified spectrum (Figure 5) that better reflects the range of patient roles present in the data, one that extends beyond Towle et al.'s portrayals of patients as themselves (1) to incorporate more nuanced and pragmatic forms of involvement.

Findings

Publication Characteristics

I included 45 publications in the data extraction phase, comprising 34 from the initial search and 11 additional publications identified through the review of the reference lists. All included publications are in English and were published between 1980 and 2024, with low points in the 1980s (n=1) and 1990s (n=1), followed by an uptick in the 2000s (n=12), a further increase in the 2010s (n=18), and a slight decline in the 2020s (n=13), though the decade is only halfway complete. Most publications originate from wealthy and Western countries, such as the United States of America (n=17), Australia (n=9), and the United Kingdom (n=8). Others were from the regions of Eastern Europe (n=1), sub-Saharan Africa (n=1), Pakistan (n=1), Sweden (n=1),

Norway (n=1), Germany (n=1), Ireland (n=1), New Zealand (n=1), Tanzania (n=1), The Netherlands (n=1), Turkey (n=1), and the Philippines (n=1).

Research Question 1: How is patient involvement in obstetrics and gynecology education and training conceptualized?

Terminology Used to Describe Patients. The term "patient" may appear universal, but it is far from it. A wide range of terminology is used to refer to individuals with lived experience. Since the literature has not reached a consensus on the most appropriate terms, I found it helpful to group them according to what they represent in a thematic table (Table 2).

Table 2. Thematic Grouping of Terminology Designating Patients

Perspective	Representation	Human	Clientele	Teaching Material
- Lived experience advisor (76) - Lived experience (77,78) - Experts by experience (57,79) - Parent of a person with lived experience (80) - Person with lived experience (80) - Patient as teacher or patient-teacher (81,82) - Patient educator (83) - Patient advisor (81) - Those who are often not heard (84) - Storyteller (77,85,86)	- Consumer advocate (76) - Survivor (85)	- Woman (57,58,77,78,81,84–98) - Couple (88) - Family (84,88,89,99) - Family member (57,81,98) - Mother (79,89,98,100) - Parent (86) - Unpaid carer (79) - Carer (57,101) - Care giver (95,102) - Community (91,99,103,104) - Neighborhood (99) - Individual (82,103) - Mother-infant dyad (100) - Child (85) - Tenant (99) - Layperson or laypeople (94)	- Patient (57,77,81,82,87,90,92,94,98,100,102–106) - Acceptor (87) - User (57,87,95) - Consumer (80,84,85,104,107) - Service user (56–58,79,86,101,108,109) - Client (86,91,104) - Stakeholder (102,107) - End-user (110)	- Subject (87) - Teaching subject (106) - Simulated patient (111) - Actor (111–113) - Standardized patient (82,104,112–117) - Gynecological teaching assistant (116) - Professional patient (97) - Simulated actor (111) - Volunteer (103) - Respondent (102) - Real-life case-study (86)

Terms Used to Describe the Concept of Patient Involvement. A variety of descriptors for the basic concept of patient involvement also appeared in the included publications. Involvement (56–58, 79, 86, 101, 108, 109), being the most commonly used term, is followed by terms such as partnership (57, 79, 82, 84, 91, 96), engagement (76, 107, 109), consultation (107), and bedside teaching (105)**.**

Definitions of Patient Involvement. Most of the publications failed to define patient involvement in their context. Some themes did emerge, though, including patients using their lived experiences to teach (57,79,81,83,116); giving patients a voice to shape the initiative, program, or research (56,58,91,92,109,110); and having patients assess learners (101,116). Therefore, lived experience, providing opportunities for sharing this experience in HPE, and teaching and assessment were the key elements that defined patient involvement within this sample.

Theoretical Bases for Patient Involvement. Few publications reported the theoretical basis for involving patients in HPE activities. Some explicitly acknowledged a lack of theoretical underpinning for patient involvement in HPE (79, 101). Of those that did discuss theory, recurring themes included philosophies of service learning and active experiential learning, emphasizing community engagement and transformative learning (81,84,91,103); the "Patient as Teacher" theory (92), woman-centred philosophies (93,109), and human caring science theory (77). Frameworks addressing patient involvement were also noted, such as the Forrest et al. (75) continuum of involvement (61) and the ladder of participation by Tew et al. (57,74).

Practical Bases for Patient Involvement. A large majority of the publications discussed or at least mentioned practical bases for their involvement of patients. Some of the overarching themes were meeting patients' actual needs in services (59,76,79,80,89,95,101,102,110); making HPE more meaningful/applicable through the use of real patients (58,82,84,88,90,92,100,109); increasing patient-centredness in health care (58,81,88,101); allowing learners to practice their skills (83,95,96,111,114,117); creating partnerships with the community (84,103); increasing patient safety in health care (109); enhancing the job of teaching staff (84,109); providing social justice for patients (82); empowering patients (77); and acknowledging patients' lived experience (57,81,82,90,115). Being "with woman" (78,96) was also a descriptor of the reason for some authors to involve patients in education and training processes.

Research Question 2: What is the nature and state of research on patient involvement in obstetrics and gynecology education and training?

Nature of Patient Involvement. Different terms were used to describe the nature of patient involvement itself throughout the publications (Table 3). Many of these descriptors focused on the theme of involvement as a tool for HPE, meaning it serves a practical function rather than being philosophically meaningful. In contrast, some focused on the importance of participation through terms that describe its impact or level of involvement. Others related to interpersonal relationships. The role of patients was a theme throughout the publications, with most discussing concurrent roles that patients occupied.

Table 3. Thematic grouping of terms used to describe the nature of patient involvement

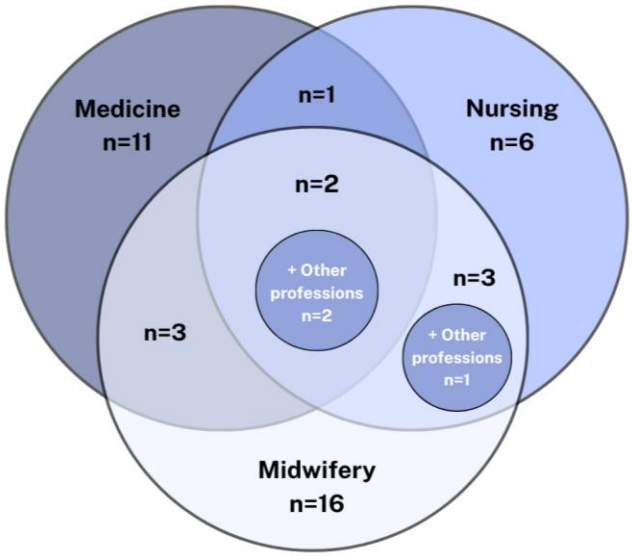
Relationship	Functional roles of the patient	Involvement as a tool	Importance of involvement
- Co-design (76,103,110) - Collaborative development (109) - Learning together (79) - Collaboration (60,81) - Participatory approach (110)	- Information source (57,76–80,82,84,89,95,96,102,103,107,108,110,113) - Research data source (89,90,92–96,102,106) - Teaching material 97–100,105,116) - Standardized patient (82,103,104,111–117) - Partner (61,91,109) - Assessor (59,82,101,103,113,115) - Educator (60,81,83,85,86,97,108) - Case study (85)	- Simulation-based experiences (104) - Simulation (117) - OSCE (112,113) - Lab (116) - Continuity of care experience (89) - Performing a procedure on a patient (87,111) - Using the patient's body as an instrument (97) - Visits or encounters (85,115) - Mock clinical encounter (114) - Interviews/focus groups (86,95,102) - Panel (83)	- Genuine engagement (101) - Meaningful involvement (101) - Meaningful engagement (109) - Integral involvement (80,91) - Active involvement (79) - Active partnership (57) - Active participation (84) - Meaningful contributions (79)

Purpose of Patient Involvement. In distinguishing the broad practical bases for patient involvement from the more specific purposes discussed in the publications, some measurable or observable items were identified. These included developing non-technical skills in learners, such as resilience (57), empathy (77,79,81,99,109), compassion (77,109), shared decision-

making (77), critical thinking (79,83,86,90,97), active-listening (109), communication (79,117), patient advocacy (81,114), leadership (90), and cultural competency (90,99); providing relational continuity (89,93); assessing learner skills (57,97,115); providing patient feedback to the learner (97,104,113,116); instructing learners (97); ensuring that educational content or format is relevant to the experiences of patients (56–58,76,79,80,84,85,93,95,96,101,103,109,110); ensuring that professional competencies and educational framework align (102,107); increasing understanding of patient preferences for bedside teaching (90,92,94,106); meeting curricular expectations (87,88,111); and creating a realistic environment for skill transfer (82,98,104,105,108,111). Thompson et al. (104) also justified their use of standardized patients by contrasting it with the use of non-human alternatives: "Patient simulators or manikins would not have been as effective for the nonverbal feedback needed" (p.30). Thus, they indirectly emphasized the unique value of human patient involvement as teaching material.

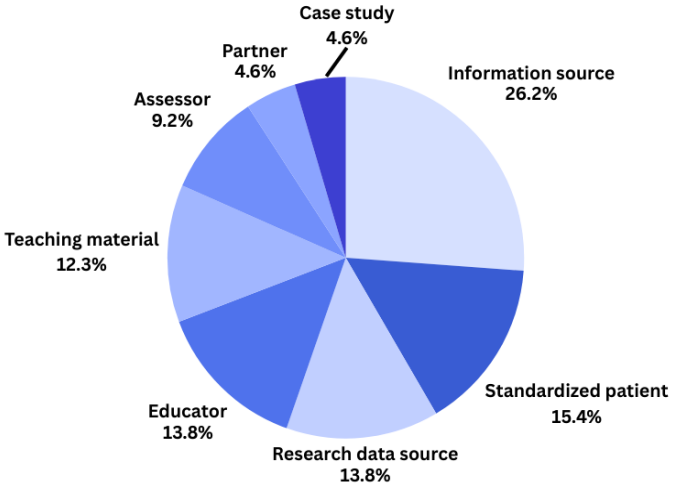
State of Research on Patient Involvement. Most of these publications were peer-reviewed articles (n = 42); however, three were abstracts from poster or oral presentations. The types of publications were empirical research (n = 16), reports (n = 14), evaluations (n = 13), and commentaries (n = 2). Teams who conducted empirical research and evaluation studies mostly used non-experimental study designs (e.g., surveys; n=24), while five used a quasi-experimental design (e.g., pre-post comparison groups), and one used an experimental randomized controlled trial design. The remaining publications used a case study approach (n=4) or a process approach (i.e., discussing practices or the development process for frameworks, curricula, learning activities, and assessment tools; n=11). Publications often focused on a singular profession, with midwifery being the most common (n=16), followed by medicine (n=11) and nursing (n=6). However, some took an interprofessional approach by focusing on more than one profession (n=12). Considering the overlap of professions in some studies, the most common profession discussed was midwifery (n=27), followed by medicine (n=19), and nursing (n=15). Figure 2 depicts the distribution of professions in the included studies. Some studies discussed the central professions for this review (medicine, nursing, and midwifery), in addition to other occupations. These are included in the small circles at the centre of the image, as well as in the overlap between nursing and midwifery.

Figure 2. Distribution and overlap of professions represented across included studies



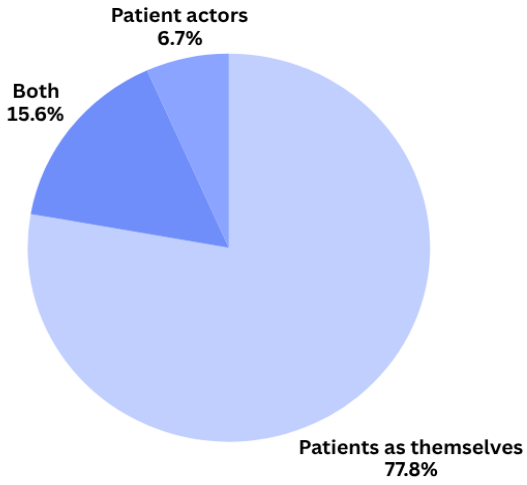
The most common level of learning was undergraduate education (n = 29), followed by postgraduate education (n = 17), continuing professional development (n = 6), and graduate education (n = 3). The most common perspective studied in the publications was the patient perspective (n = 31), followed by the learner perspective (n = 27), the educator perspective (n = 12), and two publications did not seek to study any perspectives. Obstetrical care was the focus of 26 publications, while OB/GYN together were the focus of 13 publications, and Gynecological care was the focus of six publications. Patients' roles included information source (n = 17), standardized patient (n = 10), educator (n = 9), research data source (n = 9), teaching material (n = 8), assessor (n = 6), partner (n = 3), and case study (n = 3). The ratios of roles are depicted in Figure 3, and their descriptions are listed in Appendix L.

Figure 3. Ratios of Functional Patient Roles



Patient Actors vs. People. Within these roles, the common form of patient portrayal was patients portraying themselves only (n=36), followed by patients acting in both scripted roles and portraying themselves at different moments during the activities (n=6), and finally, patients acting only in scripted roles (n=3). Figure 4 illustrates this ratio.

Figure 4. Ratio of Patient Portrayal



Skills Developed with Patient Involvement. The reporting of skills to be developed by learners through patient involvement was often unclear in these publications. Skills to be developed were usually reported as outcomes of the initiative, program or research in general and not specifically developed as a result of the patient involvement component. The skills were often quite general, and complete tasks tended to be presented as a set of skills. Technical skills included following the patient care flow or caring for patients overall

(59,76,80,82,95,101,102,104,108,109); obstetric examination (111) or gynecological pelvic examination (87,97,116); IUD insertion (87); postnatal visits (88); foreseeing long-term outcomes of care (79); patient and carer education (91,98,100); continuity of care (89,93,96); performing surgery (106); and patient discharge (115). Non-technical skills included affirmation and support (82,103); respect (83); compassion (83); sensitivity (97); empathy (99); woman-centred care (58); community engagement (91); understanding the patient perspective (57,78,81,92); interprofessional collaboration (86,100,105); communication (104,113,117); therapeutic listening (77); shared decision-making (112); enquiring about domestic violence (85); patient advocacy (114); and cultural competency (99).

Research Question 3: What are the priority areas for future research on patient involvement in obstetrics and gynecology education and training?

Consistency in Reporting Standards. An overwhelming gap in the included sample was the lack of detailed reporting. For example, many studies did not report the details of patient involvement in their context, simply acknowledging that patients were involved (86, 90, 102, 108, 117). A large number of publications also provided little to no practical basis or purpose for the involvement of patients in their context (76,78,80,83,85–87,94,97,98,105–108,111,112, 116). Theoretical bases for patient involvement were not reported in the majority of the included publications (56,76,79–83,85–90,94–102,104–108,110–117), nor were explicit definitions of patient involvement (76–78,80,82,84–91,93,95–100,102–108,111–117).

Effectiveness of Politicizing Patient Involvement. Davis and McIntosh (58), Warren et al. (57), and Jay (56) noted that governing bodies of HPE have instated requirements for patient involvement in program development and implementation. These publications also reflected a strong institutional valuing of patient involvement, demonstrated through multiple integrated roles. Davis and McIntosh (58) described a long-standing tradition of involving patients in shaping midwifery education and practice. Currently, patients participate in admissions committees, allow learners to follow their pregnancy journeys throughout their studies, and provide feedback on learner performance to educators. They also participate in role-play scenarios near the end of learners' studies and provide performance-based input as part of the final assessments. Similarly, Warren et al. (57) described patient involvement not only on the admissions committee of a midwifery program but also in curriculum development and the establishment of professional standards. Patients in this context contribute by delivering lectures

and seminars, as well as sharing personal stories and images that form part of the curriculum content. Jay (56) also highlighted a strong commitment to patient involvement, particularly through the compensation and training provided to patients who participate in admissions interviews. Notably, patient input is given equal weight to that of staff interviewers.

Discussion

Publication Characteristics

Language. Despite developing search strategies to capture both French and English literature, the entire sample included was published in English. It is widely known that English is the dominant language of academic publishing (118), so it is not surprising that English-language publications constitute the entire sample for this review. However, the absence of French literature has implications. It may limit our understanding of HPE practices in regions where French is widely used, such as parts of Europe (e.g., France, Belgium, Switzerland) and many countries in West and Central Africa. This gap raises concerns about the underrepresentation of context-specific practices and innovations in patient involvement from these regions (119). As such, the findings of this review may not fully reflect global practices and may overlook valuable insights from non-English-speaking settings.

Publication Year. Interestingly, the uptick in publications during the 2010s coincides with the period following several key developments in policy and research around patient involvement in HPE. These include Towle et al.'s publication of the patient involvement continuum in 2009 (1), the UK Nursing and Midwifery Council's introduction of standards recommending patient involvement in all aspects of midwifery education in 2009 (120), and the release of the Vancouver Statement by the University of British Columbia in 2016 (121), which outlines guiding principles for meaningful patient and public involvement in HPE. These milestones may have catalyzed increased academic interest and institutional commitment to involving patients in the design, delivery, and evaluation of HPE, as reflected in the growing body of literature throughout the 2010s and the sustained volume of publications into the 2020s.

Location. Given that Canada is one of the most prolific publishers of HPE-related literature (122), the absence of Canadian publications in the final sample was unexpected. One possible explanation is that, while Canada has demonstrated broad support for patient involvement in HPE, the care focus of OB/GYN may not be a priority area for research in this context. The historical trajectory of women's health research in Canada has been shaped by

patriarchal and inequitable practices, with meaningful progress only beginning to emerge in recent years (123). Despite policy statements like the Government of Canada's *Women's Health Strategy* (124), changes in research funding and publication output in this area remain limited (106).

Another contributing factor may be the relatively recent integration of midwives into frontline OB/GYN care teams in Canada, which began in the mid-1990s (60). Compared to countries where midwifery has been long-established within mainstream maternal care, Canada may have had less time to develop, evaluate, and report on formal educational programming that involves patients in meaningful ways. Additionally, midwifery in Canada has historically existed outside of institutional healthcare structures (33,34), which may have limited its inclusion in academic HPE research. As midwifery education becomes increasingly professionalized and embedded within formal education, opportunities for research on patient involvement in OB/GYN-focused education and training are likely to expand. Similarly, with the growing number of nurse practitioners (125), their role in managing patients within OB/GYN care will likely increase, bringing this profession to the attention of researchers. Still, these professions may not yet be widely represented in the literature.

Study Design. Only one publication in the review employed an experimental randomized-controlled design. This finding aligns with the observations made by Towle et al. in their review of the literature on active patient involvement in HPE, where they noted a lack of experimental designs among published studies (1). The predominance of non-experimental study designs, including descriptive reports, case studies, and evaluations, may help explain the ongoing lack of practical, strong evidence-based guidance for implementing patient involvement in OB/GYN education and training. This is not to imply that non-experimental methods are inferior, as they are often the most practical and sometimes the only feasible approach in real-world or emerging educational contexts (126,127). Non-experimental designs can provide valuable insights into context, feasibility, and learner experience. However, because these designs lack the manipulation of independent variables or random assignment, they are less conclusive in establishing causality (127), generating more potential questions than consensus. Given the relative novelty of patient involvement in this field, researchers may understandably prioritize exploratory approaches over tightly focused experimental designs. A limitation of this reliance on non-experimental designs is that the field continues to rely heavily on anecdotal or

exploratory findings rather than on proven evidence. Increasing the use of experimental or quasi-experimental designs could strengthen the empirical foundation for patient involvement practices and support their broader integration into OB/GYN education and training. This being said, it is not easy to do so in a field such as education. Variables such as learner motivation can confound results (128). For example, students who opt into non-mandatory learning experiences may be more motivated or engaged than those participating in mandatory sessions, potentially exaggerating the perceived effectiveness of the intervention. Testing effects also pose a risk; exposure to pre-tests may cue learners to what is important to gain from the intervention, thereby influencing their performance on post-tests in ways unrelated to the intervention itself. Additionally, instructor and assessor variability can introduce bias. When interventions involve live instructors, differences in teaching style, responsiveness, or emphasis, even from the same instructor across different learner groups, can create inconsistent learning environments. Similarly, if assessment involves subjective judgment (e.g., through live assessors), results may be influenced by inconsistencies in scoring or assessor bias. These and other confounding variables are difficult to fully control in educational research, highlighting the importance of careful study design and transparent reporting.

Building Understanding and Consensus on Theory and Concepts

Levels of Patient Involvement. While many of the included publications described the roles that patients played in their initiatives, they did not assess how those roles compared in terms of meaningfulness to other forms of involvement. Although frameworks by Towle et al. (1), Tew et al. (74), and Forrest et al. (75) categorize patient involvement based on its level of meaningfulness and activity, their application in practice is often complicated by the nuanced and context-specific nature of patient involvement. This raises an important question: what criteria should be used to evaluate the meaningfulness of patient involvement in practice? Though Towle et al. (1) outline specific criteria for active involvement, their framework focuses exclusively on patients participating as themselves and does not account for more nuanced or varied forms of involvement. For example, Rowland et al. (4) discuss how the use of real patients as standardized patients or as objects of learning through care may be interpreted by some as active or meaningful involvement. Their analysis highlights the subjectivity surrounding the concept of meaningfulness in the current literature. Notably, many publications in this review did not assess the meaningfulness of involvement at all, nor did they attempt to situate their

approach within a broader spectrum of involvement. A key exception is Warren et al. (57), who describe their patient involvement efforts as "Growing Involvement" according to Tew et al.'s (74) ladder of involvement. This reference offers valuable context by outlining both the current level of involvement and the progress made from more passive forms of involvement. It also highlights steps towards building authentic partnerships with patients, where responsibilities and authority are shared. To ensure that patient involvement is thoughtfully integrated within OB/GYN education and training, in a way that empowers patients' lived experience, program developers and researchers should consider positioning their approach within an established or evolving continuum of involvement. Doing so can promote clarity, intentionality, and opportunities for reflection and improvement. This is especially important in OB/GYN, where patients involved in HPE may face an increased risk of vulnerability due to the intimate and sensitive nature of the specialty. By situating their approach within a broader framework, stakeholders are more likely to critically assess the roles patients play, be attentive to their needs and well-being, and adopt practices that are both ethical and sustainable over time.

Definition of Patient Involvement. Among the included publications, those that offered a definition of patient involvement often did so in a way that reflected the type of involvement featured in their activities. In other words, the conceptualization of patient involvement appeared to be shaped by how patients were engaged in practice. For example, Coleman et al. (79) involved carers at multiple stages of the educational activity, including the design phase and through direct storytelling with learners. Consistent with this approach, the authors defined patient involvement as "people with lived experiences engaging in teaching as partners to share their views" (p. 104). This definition emphasizes partnership and acknowledges expertise by experience.

This pattern suggests that definitions of patient involvement are not always rooted in established theoretical frameworks but are also retrofitted to reflect the scope of involvement within a given project. While this may help contextualize the concept within given activities, it can also contribute to researchers and faculty making assumptions about the impact of their patient involvement approach (129). Without theoretical grounding, these initiatives risk being inconsistently understood, reported, and evaluated across the literature. These inconsistencies contribute to several challenges, including a lack of institutional buy-in due to the absence of clear frameworks and implementation strategies for patient involvement (130), terminological

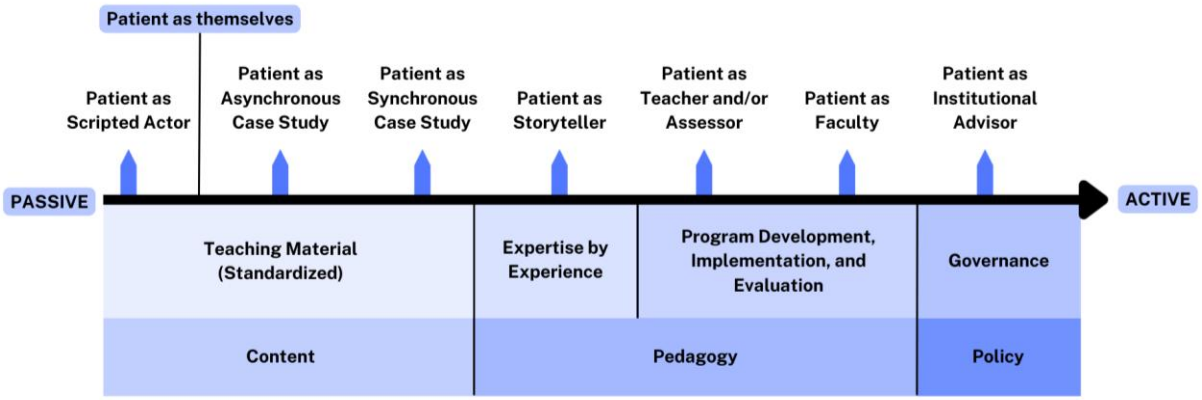
confusion that hinders theoretical consensus, and the persistence of tokenistic involvement, which perpetuates power imbalances (131). Developing shared definitions that accommodate a range of involvement types, while still promoting meaningful engagement, may help improve clarity and comparability across future studies.

Should Patient Actors be Part of the Spectrum of Involvement? Though Towle et al. (1) have discounted patient actors as part of the continuum of active involvement, Thompson et al. (104) state that an "added benefit of SPs [standardized patients] is the ability of students to ask questions and receive feedback, both verbal and non-verbal, from a live patient" (p.30). In their simulation, patients portrayed people who had recently become pregnant. Yet, the non-verbal feedback they offered, such as body language and emotional cues, is presumed to be authentic and drawn from their own lived experiences. This blurs the line between acting and being. Even when patients portray someone else, aspects of their genuine responses may surface, offering valuable learning opportunities. As such, there is a grey area between patients portraying roles and patients being involved as themselves, especially when non-verbal cues reflect their real reactions and lived experience. This challenges the strict distinction between passive and active involvement in patient-actor contexts. Future research could benefit from exploring the perspectives of patient actors in OB/GYN education and training to see how they perceive their role along this spectrum. Incorporating their insights would ensure that patient input is meaningfully integrated into the development of patient involvement frameworks, helping to create models that accurately reflect the lived experience and the educational contribution of patients.

Refining the Spectrum. Research grounded in meaningful patient involvement remains limited, as few studies in this review offered a detailed foundation for involving patients in their activities. Failing to identify clear problems that will be addressed by involving patients is a common issue across the patient involvement literature, which can perpetuate surface-level or tokenistic engagement (129). As a result, passive forms of involvement, such as using patients as teaching materials, tended to dominate the literature. Though these forms of involvement can still be beneficial to the HPE process (4), the lack of clarity and consistency in reporting the reasoning for patient involvement highlights the need for more structured ways to conceptualize and assess patient involvement. To address this, I adapted a spectrum of patient involvement that builds on Towle et al.'s original framework (1), incorporating additional insights from Tew et al.

(74) and Forrest et al. (75; Figure 5). I also considered the layers of nuanced involvement underscored by Rowland et al. (4). This adapted spectrum captures the variety of patient roles found in the literature and introduces concepts that distinguish between levels of involvement. It also extends the framework to account for involvement types that are often overlooked, such as patients acting in scripted roles that do not accurately reflect their own identities, which is common in OB/GYN simulations. These roles are critical for providing standardized, controlled learning environments that ensure equitable opportunities for skill development while maintaining patient safety. As obstetric care becomes increasingly medicalized (12,13) and complex, competency-based education demands that learners demonstrate adequate knowledge and behaviours required for safe and effective practice. Expanding the spectrum of patient involvement to include these scripted roles acknowledges their pedagogical value in training skillful practitioners. This is especially essential in OB/GYN, where patient vulnerability is heightened and care outcomes depend heavily on both skill and sensitivity. The roles positioned along this spectrum leave room for adding new roles between them and for adapting the concepts that differentiate them. The purpose is to make it evident that patient involvement is nuanced and can be implemented in various forms with various goals in mind. Rather than treating involvement as a binary of presence versus absence within HPE, this framing emphasizes the spectrum as a dynamic, evolving tool that can be tailored to the needs of programs, learners, and patients themselves. By situating roles within this spectrum, program administrators and researchers can better justify their choices, identify opportunities for deeper engagement, and avoid tokenistic practices by aligning the form of involvement with clear pedagogical, institutional, or policy objectives.

Figure 5. Adapted Spectrum of Patient Involvement



Education vs. Training. As outlined earlier in the definitions of education and training, a notable pattern emerged in how patient roles were positioned across the adapted spectrum of involvement. In training-focused activities, such as simulation exercises, standardized patient encounters, or live-mannequin-style role plays (roles 1-3 in Figure 5), patients were often positioned as passive participants. Their involvement primarily served as a tool for learners to practice clinical or communication skills, aligning with the "teaching material" category in the adapted spectrum. Roles within this category provide opportunities to demonstrate and apply various skills, behaviors, and attitudes, making them particularly suited to training objectives.

In contrast, within education-focused activities, where the aim is broader development of professional identity, values, and critical thinking, patients took on more active roles. These included sharing lived experience, participating in curriculum development, serving on admissions committees, and engaging in dialogue with learners (roles 4-6 in Figure 5). Such roles fall within the "expertise by experience" and "program development, implementation, and evaluation" sections of the spectrum. These forms of involvement reflect a meaningful integration of patients' perspectives and demonstrate a shift toward authentic partnerships. In this approach, patients are recognized as co-educators who share responsibility for shaping the learning environment.

This contrast suggests that while patient involvement in OB/GYN training may often be procedural and skill-focused, aimed at developing expertise in surgical techniques, diagnostic procedures, examinations, and patient management, there is greater potential for transformative, partnership-based involvement in educational contexts. Positioning patient roles along this spectrum could help researchers and HPE program administrators ground and justify their involvement of patients by linking the roles to the underlying concepts that explain their purpose. By presenting concrete examples of roles across the spectrum, these interest-holders are more likely to recognize the diversity of patient contributions, encouraging them to move beyond tokenistic engagement and toward meaningful, authentic partnerships.

Focusing on Patient Involvement. Few publications provided detailed descriptions or justifications for their patient involvement, focusing instead on the design and delivery of their OB/GYN education and training activities. This suggests that patient involvement was not a primary focus, either in the development of the initiatives or in their reporting. This pattern is consistent with previous research, which has noted that the rationale or "why" behind patient

involvement is often underreported or absent altogether (29,31,132). Future research and publications may benefit from a greater emphasis on the details of patient involvement, including the rationale for their involvement, the nature of their contributions, and the extent of their influence on outcomes. Improved transparency in these areas could enhance the reproducibility of initiatives, support critical evaluation of patient involvement practices, and contribute to building a more consistent and meaningful evidence base for patient involvement in OB/GYN education and training.

Outcomes of Involvement

A significant lack of clarity persists regarding the specific outcomes of patient involvement in OB/GYN education and training. In many of the included publications, reported outcomes tended to focus on the broader intervention, such as improvements in learner skills, development of knowledge, or evaluation of program effectiveness, rather than explicitly examining or attributing outcomes to the involvement of patients. This may be because patient involvement is a relatively new concept in OB/GYN education, and there is not yet methodological consensus on how to appropriately measure its specific outcomes. Moreover, numerous confounding variables, such as the quality of teaching, faculty expertise, institutional resources, learner motivation, or curricular design, could make it difficult to isolate the unique impact of patient involvement. As a result, the role of patient involvement is often overshadowed by the general success of the intervention and not meaningfully evaluated as a distinct contributing factor. This lack of targeted outcome reporting can diminish the perceived value of patient involvement, positioning it as secondary or supplementary to the main educational or training activity rather than as an integral component. Without clear evidence of its unique contributions, patient involvement risks being seen as optional or tokenistic rather than essential to high-quality HPE. Moving forward, research should aim to identify and report outcomes specifically tied to patient involvement, to better establish its relevance and effectiveness in OB/GYN education and training. Thus, it would be highly beneficial for the field to develop methodologies that explicitly measure and evaluate the contributions of patient involvement, enabling a rigorous assessment of its impact.

Diversity in Health Professional Scopes and Philosophies

In nursing, there is no standardized or mandatory educational pathway for specialization in OB/GYN, which may contribute to the more generalized nature of nursing education and

practice. As a result, nursing literature may address patient involvement in broader terms, without a specific focus on obstetric or gynecological contexts. Generalist training can foster comprehensive, holistic care that focuses on the whole patient rather than specific illnesses or anatomy (43). It may also cause nurses to receive less focused instruction on the unique sexual and reproductive health needs of pregnant people, potentially limiting the depth of OB/GYN-specific patient involvement in nursing-related educational programs.

In contrast, midwifery is a profession entirely specialized in reproductive, pregnancy, and postpartum care. Because its scope is inherently focused on obstetrical health, midwifery education and training are more likely to be structured around patients' specific reproductive needs, values, and lived experiences. For example, many of the publications involving midwifery in the included sample explicitly reflected feminist perspectives. The phrase *"being with woman"* appeared as a defining feature of both their care and educational philosophies. Carolan and Hodnett (133) trace the roots of this concept to a commitment to empowering women throughout the birthing process, with an emphasis on minimizing unnecessary medical intervention. With patient-centredness embedded at the core of midwifery philosophy, the profession aligns with the values underpinning meaningful patient involvement. This foundational alignment may help explain why midwifery accounts for the majority of patient involvement examples identified in this review.

Physicians, on the other hand, begin as generalists upon completing their undergraduate medical education and then specialize in OB/GYN during residency. As such, patient involvement in OB/GYN contexts may appear more frequently in postgraduate medical education literature than at the undergraduate level. The transition from generalist to specialist may also affect how and when patient involvement is introduced in medical training, with opportunities for deeper engagement arising later in a physician's educational journey.

Politicizing Patient Involvement

While the regulatory basis for patient involvement was beyond the scope of this review, it emerged as a noteworthy theme. Some of the included publications referenced regulatory requirements as a driving force behind their patient involvement initiatives or as justification for reporting practices (56-58). Together, these examples illustrate multi-layered patient involvement and demonstrate meaningful institutional support for the concept. This suggests that policy and accreditation standards may play a significant role in shaping how, when, and why

patients are involved in OB/GYN education and training. A dedicated review of existing regulations across countries and professional bodies could offer valuable insight into the global landscape of patient involvement. Mapping these regulatory frameworks and comparing their similarities and differences could help inform the development of consistent guidelines in regions where such standards are lacking or underdeveloped.

Honourable Mentions from the Study Selection Process

Stage 3 of this review revealed various notable trends identified by my supervisor and me. As discussed in the Database Search section of the Methodology, the terms "patient instructor," "patient educator," and "patient teacher" can be assigned to both, patients who are involved in HPE, and health professionals who provide education to patients. This ambiguity became especially clear given the abundance of publications on nurse educators in our results. These are nurses who provide education to patients in clinical settings. Although these were excluded from our analysis, the overlap highlights a persistent issue of terminology in reviews of this nature.

In addition, our search strategy retrieved many publications focused on patient involvement in their own care decision-making. These were also excluded; however, it is worth noting that even in retrospect, it remains challenging to design a search strategy that filters out such publications without inadvertently omitting relevant ones.

Among the findings of this review, only three publications address patients' acceptance of learners in bedside teaching (90,92,105). However, a substantial number of publications on this topic, particularly at the undergraduate level, were excluded from the review, highlighting its ongoing prominence in the literature. This raises several potential research questions: Is there a consensus on how patients perceive the presence of HPE learners in their care? If so, what is that consensus? Why does this topic continue to dominate the discourse, and what challenges prevent the field from moving beyond it? Finally, how does patient acceptance of learners in bedside teaching relate to broader forms of patient involvement in HPE?

Some excluded findings, such as virtual reality simulations and digital patients, were intriguing. While these do not involve actual patients, their influence and potential in HPE, especially when compared to real patient involvement, merit further discussion and exploration.

Lastly, although this review did not include doulas, we encountered a significant number of publications related to this profession. In light of midwifery being the most common

profession to involve patients in this review, an interesting possibility arises: community-based professions may be particularly inclined to involve patients in their education and training processes.

Study Limitations

Search Strategy Constraints. Despite the development and pilot testing of search strategies in collaboration with a Research Librarian, there remains a possibility that relevant articles were missed. Terminology, as discussed in most of the scoping and systematic reviews consulted during this study (68,69,71,73), remains an issue. While the *Healthcare Simulation Dictionary* (134) exists for simulation terminology, it does not address other types of involvement or cover all expressions used in simulation.

Language and Inclusion Boundaries. Limiting this review to English and French publications inevitably excludes valuable insights available in other languages. Relatedly, traditional birthing attendants were excluded from this study due to a lack of documentation in English and French. Their absence represents a missed opportunity to enrich this discussion with culturally embedded practices.

Potential for Reviewer Bias. Having a singular interpretation of publications and data categorization creates a high potential for reviewer bias, particularly given inconsistent reporting standards across the included literature. To mitigate this bias, I outlined my positionality, clearly defined data extraction criteria with my supervisor, and reported on the research process transparently.

Limited Analytical Tools. Due to the absence of an established framework to measure levels of patient involvement, I was unable to categorize publications based on the level of participation. Such analysis could have provided a stronger evidence-based understanding of the nature of patient involvement in OB/GYN education and training.

Study Strengths

Expert Collaboration. Throughout this review, I worked closely with my supervisor, thesis committee members, and a Research Librarian. Their expertise greatly informed the development of research questions, methodology, and reporting practices, serving as a foundational strength of this work.

Comprehensive Data Collection. By systematically searching across eight distinct databases, I achieved broad coverage of the literature. This was further supported by hand-

searching reference lists and relevant websites, thereby enhancing the depth and reliability of the dataset.

Conclusion

This scoping review revealed that while patient involvement in OB/GYN education and training is acknowledged across various global contexts, its conceptualization, implementation, and reporting remain inconsistent and underdeveloped. The included publications reflected a broad spectrum of patient involvement, ranging from passive roles, such as standardized patients and case studies, to more active contributions, including roles like co-educator and institutional advisor. Despite these diverse roles, meaningful involvement of patients remains unevenly applied and rarely evaluated through rigorous research designs.

The lack of theory-based rationales for involving patients may have contributed to this uneven distribution. Across the literature, there was no clear or consistent reason as to why patients were involved, even within a given patient role, making it difficult to assess the alignment between purpose and practice. As Rowland et al. note, solutions in this space are often proposed without thorough evidence to demonstrate their relevance to a problem or aim (109). A strong theoretical understanding of the aim of patient involvement in OB/GYN is desperately needed before any meaningful advancement can be made in this field.

Terminology also varied widely across studies, further contributing to ambiguity in definitions and roles. Only a few studies provided theoretical grounding or formal definitions of patient involvement, and when they did, these often aligned with the specific practices they featured rather than broader frameworks. This points to an ongoing need for shared conceptual clarity and consistent definitions. The adapted spectrum of involvement in Figure 5 offers a valuable lens for assessing patient roles by situating them along concepts that distinguish levels of activeness, while also providing a basis for evaluating, designing, and reporting on patient involvement initiatives.

Geographic and disciplinary disparities were also apparent. Midwifery education, grounded in patient-centred and feminist care philosophies, accounted for most examples. In contrast, the absence of Canadian publications, despite the country's strong support for HPE, suggests gaps in OB/GYN research that may stem from historical and structural factors.

While many publications noted regulatory drivers for involvement, few critically evaluated the outcomes or offered evidence-based guidance for practice. Furthermore, the field

relies heavily on non-experimental designs, limiting the ability to draw causal conclusions about the impact of patient involvement on learner development. Where involvement was assessed, outcomes such as empathy, communication, and clinical competency were often attributed to the overall program effects rather than patient contributions specifically.

In response to these gaps, I propose greater transparency in reporting practices, intentional use of involvement frameworks, and the pursuit of more rigorous, outcome-focused research. These priorities are especially urgent in the field of OB/GYN, where patients, both those receiving care and those involved in HPE, may face increased vulnerability due to the intimate and sensitive nature of sexual and reproductive health care. In this context, ensuring that health professionals receive patient-centred education and training through meaningful and ethical patient involvement is not only pedagogically necessary, but also a matter of equity and quality of care. Advancing the conceptual and empirical landscape surrounding patient involvement, OB/GYN education and training can move beyond tokenistic involvement toward true collaboration and transformative learning for health professionals, ultimately improving health outcomes and empowering communities.

Acknowledgements

- The Centre for Research on Educational and Community Services (CRECS) for supporting the dissemination of the project at the Meredith Marks Medical Education Days conference in May 2025.
- Dr. Kaylee Eady and Research Librarian, Patrick Labelle, for their continued support and guidance.
- Dr. Julie Chartrand and Dr. Katherine Moreau for their guidance at important milestones of the project.

Funding

No funding to be declared for this thesis project.

Declaration of Interests

No conflicts of interest to be declared.

Ethics Approval

No human participants were consulted during this study.

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Appendices

Appendix A: Spectrum of Involvement

Table 1 Spectrum of involvement: this taxonomy describes a continuum of patient involvement. In all instances we assume that patients represent their true selves (not a simulation). The taxonomy is grounded in six attributes (A–F) and six levels (1–6)

A	B	C	D	E	F
Degree to which the patient is actively involved in the learning encounter	**Duration of contact with learner**	**Patient autonomy during the encounter**	**Training for the patient**	**Patient involvement in planning the encounter and curriculum**	**Institutional commitment to patient involvement in education**
1 *Paper-based or electronic case or scenario*					
Patient is focus of a paper-based, electronic or web-based case or scenario	None	N/A	N/A	None	Low
2 *Standardised or volunteer patient in a clinical setting*					
Patient encounter with student is scripted and serves as an example to illustrate or reinforce learning (e.g. teacher asks patient to provide student with history or student practises a clinical examination)	Encounter-based	None	None	None	Low
3 *Patient shares his or her experience with students within a faculty-directed curriculum*					
Patient is invited to share experience; faculty members plan the encounter but patient determines personal comfort and level of participation	Encounter-based	None–low	Brief, simple	None	Low
4 *Patient-teacher(s) are involved in teaching or evaluating students*					
Patient is given preparation for specific teaching role, may actively question students, may be involved in giving feedback and evaluating students' performance	Variable	Moderate	Structured, extensive	Low–moderate	Low–moderate
5 *Patient-teacher(s) as equal partners in student education, evaluation and curriculum development*					
Patients are involved in many aspects of educational delivery, development and evaluation, beyond specific courses to the curriculum as a whole; this is a true partnership in which patients make meaningful and valued contributions to decision making	Moderate–extensive	High	Extensive	Moderate–extensive	Moderate
6 *Patient(s) involved at the institutional level in addition to sustained involvement as patient-teacher(s) in education, evaluation and curriculum development for students*					
As (5) above but with additional institutional policies that ensure involvement in decision-making bodies within undergraduate, graduate and continuing health professional education	Extensive	High	Extensive	High	High

N/A = not applicable

From *Active patient involvement in the education of health professionals* (Towle et al., 2009)

Appendix B: Search Management Table

Database	Platform	Date searched	Results in database
MEDLINE	Ovid	12/19/2024	1403
ERIC	Ovid	12/19/2024	70
CINAHL	EBSCOhost	12/19/2024	246
PsychINFO	Ovid	12/19/2024	250
Web of Science	-	12/19/2024	939
EMBASE	Ovid	12/19/2024	2112
Academic Search Complete	EBSCOhost	12/19/2024	423
Education Source	EBSCOhost	12/23/2024	53
		Total	**5496**
	After Covidence removed duplicates		**3120**
	After removing duplicates manually during TI/AB review		**3095**
	After removing duplicates manually		**3087**

Appendix C: MEDLINE Search Strategy

MEDLINE	Search	Results
1	Patient Participation/	30628
2	((patient* or "service user*" or consumer* or community or public or person* or client* or family) adj3 (direct* or activation or navigat* or particip* or involv* or engag* or collaborat* or partner* or educator* or instruct* or teach* or advis* or advoca* or mentor* or consult*)).ti,ab,kf,kw.	438331
3	or/1-2	458331
4	Education, Medical/	62641
5	Education, Medical, Graduate/	34881
6	Education, Nursing/	35392
7	Internship and Residency/	64147
8	Preceptorship/	5805
9	((medic* or nurs* or midwi*) adj5 (curricul* or pedagog* or school* or educat* or train* or instruct* or program* or fellow* or preceptor* or residen* or postgrad* or "post grad*" or student* or intern*)).ti,ab,kf,kw.	432733
10	or/4-9	531854
11	Midwifery/	22143
12	Gynecology/	21386
13	Obstetrics/	25354
14	Women's Health/	30322
15	Reproductive Health/	5843
16	(gyn?ecolog* or obstetric* or OB GY* or OBGY*).ti,ab,kf,kw.	215766
17	(midwif* or ((women* or reproduct* or matern*) adj3 (health*))).ti,ab,kf,kw.	168724
18	or/11-17	406032
19	3 and 10 and 18	1403

Appendix D: EMBASE Search Strategy

EMBASE	Search	Results
1	patient participation/	38816
2	((patient* or "service user*" or consumer* or community or public or person* or client* or family) adj3 (direct* or activation or navigat* or particip* or involv* or engag* or collaborat* or partner* or educator* or instruct* or teach* or advis* or advoca* or mentor* or consult*)).ti,ab,kf,kw.	649436
3	or/1-2	674393
4	medical education/	268573
5	education, medical, graduate/	249567
6	nursing education/	92241
7	residency education/	34783
8	((medic* or nurs* or midwi*) adj5 (curricul* or pedagog* or school* or educat* or train* or instruct* or program* or fellow* or preceptor* or residen* or postgrad* or "post grad*" or student* or intern*)).ti,ab,kf,kw.	564027
9	or/4-8	789201
10	midwife/	31777
11	gynecology/	45995
12	obstetrics/	41395
13	women's health/	35916
14	reproductive health/	27128
15	(gyn?ecolog* or obstetric* or OB GY* or OBGY*).ti,ab,kf,kw.	313589
16	(midwif* or ((women* or reproduct* or matern*) adj3 (health*))).ti,ab,kf,kw.	207854
17	or/10-16	557742
18	3 and 9 and 17	2112

Appendix E: Web of Science Search Strategy

WOS	Search	Results
1	TS=((patient* or "service user*" or consumer* or community or public or person* or client* or family) NEAR/2 (direct* or activation or navigat* or particip* or involv* or engag* or collaborat* or partner* or educator* or instruct* or teach* or advis* or advoca* or mentor* or consult*))	605046
2	TS=((medic* or nurs* or midwi*) NEAR/4 (curricul* or pedagog* or school* or educat* or train* or instruct* or program* or fellow* or preceptor* or residen* or postgrad* or "post grad*" or student* or intern*))	422170
3	TS=(gyn?ecolog* OR obstetric* OR "OB GY*" or OBGY*)	144053
4	TS=(midwif* or ((women* or reproduct* or matern*) NEAR/2 (health*)))	176303
5	#3 OR #4	307063
6	#1 AND #2 AND #5	939

Appendix F: ERIC Search Strategy

ERIC	Search	Results
1	((patient* or "service user*" or consumer* or community or public or person* or client* or family) adj3 (direct* or activation or navigat* or particip* or involv* or engag* or collaborat* or partner* or educator* or instruct* or teach* or advis* or advoca* or mentor* or consult*)).ti,ab.	80964
2	Medical Education/	10604
3	Graduate Medical Education/	1356
4	Continuing Education/	5443
5	Nursing Education/	6004
6	"Clinical Teaching (Health Professions)"/	801
7	((medic* or nurs* or midwi*) adj5 (curricul* or pedagog* or school* or educat* or train* or instruct* or program* or fellow* or preceptor* or residen* or postgrad* or "post grad*" or student* or intern*)).ti,ab.	27988
8	or/2-7	382338
9	Allied Health Personnel/	3807
10	Gynecology/	182
11	Obstetrics/	378
12	(gyn?ecolog* or obstetric* or OB GY* or OBGY*).ti,ab.	483
13	(midwif* or ((women* or reproduct* or matern*) adj3 (health*))).ti,ab.	2351
14	or/9-13	6672
15	1 and 8 and 14	70

Appendix G: APA PsycINFO Search Strategy

PsycINFO	Search	Results
1	Client Participation/	3550
2	((patient* or "service user*" or consumer* or community or public or person* or client* or family) adj3 (direct* or activation or navigat* or particip* or involv* or engag* or collaborat* or partner* or educator* or instruct* or teach* or advis* or advoca* or mentor* or consult*)).ti,ab.	168814
3	or/1-2	170210
4	Medical Education/	21190
5	Continuing Education/	2050
6	Medical Residency/ or Medical Internship/	5759
7	Nursing Education/	8280
8	((medic* or nurs* or midwi*) adj5 (curricul* or pedagog* or school* or educat* or train* or instruct* or program* or fellow* or preceptor* or residen* or postgrad* or "post grad*" or student* or intern*)).ti,ab.	93866
9	or/4-8	104647
10	Midwifery/	1964
11	Gynecology/	1105
12	Obstetrics/	1712
13	Reproductive Health/	4810
14	(gyn?ecolog* or obstetric* or OB GY* or OBGY*).ti,ab.	11260
15	(midwif* or ((women* or reproduct* or matern*) adj3 (health*))).ti,ab.	32025
16	or/10-15	44170
17	3 and 9 and 16	250

Appendix H: CINAHL Search Strategy

CINAHL	Search
1	MH "Consumer Participation"
2	TI((patient* or "service user*" or consumer* or community or public or person* or client* or family) N2 (direct* or activation or navigat* or particip* or involv* or engag* or collaborat* or partner* or educator* or instruct* or teach* or advis* or advoca* or mentor* or consult*)) OR AB ((patient* or "service user*" or consumer* or community or public or person* or client* or family) N2 (direct* or activation or navigat* or particip* or involv* or engag* or collaborat* or partner* or educator* or instruct* or teach* or advis* or advoca* or mentor* or consult*))
3	S1 OR S2
4	MH "Education, Medical"
5	MH "Education, Graduate"
6	MH " Education, Nursing"
7	MH "Education, Continuing"
8	MH "Internship and Residency"
9	MH "Preceptorship"
10	TI((medic* or nurs* or midwi*) N4 (curricul* or pedagog* or school* or educat* or train* or instruct* or program* or fellow* or preceptor* or residen* or postgrad* or "post grad*" or student* or intern*)) OR AB ((medic* or nurs* or midwi*) N4 (curricul* or pedagog* or school* or educat* or train* or instruct* or program* or fellow* or preceptor* or residen* or postgrad* or "post grad*" or student* or intern*))
11	S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10
12	MH "Obstetrics"
13	MH "Gynecology"
14	MH "Midwifery"
15	MH "Women's Health"
16	MH "Reproductive Health"
17	TI(gyn?ecolog* OR obstetric* OR OB GY* OR OBGY*) OR AB (gyn?ecolog* OR obstetric* OR OB GY* OR OBGY*)
18	TI(midwif* or ((women* or reproduct* or matern*) N2 (health*))) OR AB (midwif* or ((women* or reproduct* or matern*) N2 (health*)))
19	S12 OR S13 OR S14 OR S15 OR S16 OR S17 S18
20	S3 AND S11 AND S19

Appendix I: Education Source Search Strategy

ED Source	
1	TI((patient* or "service user*" or consumer* or community or public or person* or client* or family) N2 (direct* or activation or navigat* or particip* or involv* or engag* or collaborat* or partner* or educator* or instruct* or teach* or advis* or advoca* or mentor* or consult*)) OR AB ((patient* or "service user*" or consumer* or community or public or person* or client* or family) N2 (direct* or activation or navigat* or particip* or involv* or engag* or collaborat* or partner* or educator* or instruct* or teach* or advis* or advoca* or mentor* or consult*))
2	DE "Medical education"
3	DE "Graduate medical education"
4	DE "Nursing education"
5	DE "Continuing education"
6	DE "Internship programs"
7	DE "Medical preceptorship"
8	TI((medic* or nurs* or midwi*) N4 (curricul* or pedagog* or school* or educat* or train* or instruct* or program* or fellow* or preceptor* or residen* or postgrad* or "post grad*" or student* or intern*)) OR AB ((medic* or nurs* or midwi*) N4 (curricul* or pedagog* or school* or educat* or train* or instruct* or program* or fellow* or preceptor* or residen* or postgrad* or "post grad*" or student* or intern*))
9	S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8
10	DE "Obstetrics education"
11	DE "Gynecology education"
12	DE "Midwifery education"
13	TI(gyn?ecolog* OR obstetric* OR OB GY* OR OBGY*) OR AB (gyn?ecolog* OR obstetric* OR OB GY* OR OBGY*)
14	TI(midwif* or ((women* or reproduct* or matern*) N2 (health*))) OR AB (midwif* or ((women* or reproduct* or matern*) N2 (health*)))
15	S10 OR S11 OR S12 OR S13 OR S14 S15 OR S16
16	S1 AND S9 AND S15

Appendix J: Academic Search Complete Search Strategy

ASC		Results
1	DE "PATIENT participation"	12218
2	DE "CONSUMER-driven health care"	118
3	TI((patient* or "service user*" or consumer* or community or public or person* or client* or family) N2 (direct* or activation or navigat* or particip* or involv* or engag* or collaborat* or partner* or educator* or instruct* or teach* or advis* or advoca* or mentor* or consult*)) OR AB ((patient* or "service user*" or consumer* or community or public or person* or client* or family) N2 (direct* or activation or navigat* or particip* or involv* or engag* or collaborat* or partner* or educator* or instruct* or teach* or advis* or advoca* or mentor* or consult*))	375493
4	S1 OR S2 OR S3	381654
5	DE "MEDICAL education"	38441
6	DE "GRADUATE education"	9420
7	DE "NURSING education"	15105
8	DE "CONTINUING education"	17374
9	DE "INTERNSHIP programs"	11343
10	DE "MEDICAL preceptorship"	1019
11	TI((medic* or nurs* or midwi*) N4 (curricul* or pedagog* or school* or educat* or train* or instruct* or program* or fellow* or preceptor* or residen* or postgrad* or "post grad*" or student* or intern*)) OR AB ((medic* or nurs* or midwi*) N4 (curricul* or pedagog* or school* or educat* or train* or instruct* or program* or fellow* or preceptor* or residen* or postgrad* or "post grad*" or student* or intern*))	270710
12	S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11	318832
13	DE "OBSTETRICS"	16286
14	DE "GYNECOLOGY"	10529
15	DE "MIDWIFERY"	4405
16	DE "WOMEN'S health"	49880
17	DE "REPRODUCTIVE health"	15818
18	TI(gyn?ecolog* OR obstetric* OR OB GY* OR OBGY*) OR AB (gyn?ecolog* OR obstetric* OR OB GY* OR OBGY*)	72755
19	TI(midwif* or ((women* or reproduct* or matern*) N2 (health*))) OR AB (midwif* or ((women* or reproduct* or matern*) N2 (health*)))	109031
20	S13 OR S14 OR S15 OR S16 OR S17 S18 OR S19	166650
21	S4 AND S12 AND S20	423

Appendix K: Data Extraction Sheet

https://docs.google.com/spreadsheets/d/1QhFFFo7KJQ5z68Ge6518MQkHjZX1TdxThHgqQiwPUiA/edit?usp=sharing

Appendix L: Description of Extracted Data

- **Publication Characteristics:**
    - **Title**
    - **Authors**
    - **Publication year**
    - **Country/Region: location of the study or activity**
    - **Publication type:**
        - **Report:** Describes a specific case, program, or initiative and outlines its outcomes; not based on empirical research.
        - **Commentary:** Synthesizes existing information or perspectives to interpret, critique, or clarify a concept or issue.
        - **Evaluation:** Assesses whether an initiative, program, or intervention is achieving its intended goals or outcomes.
        - **Empirical Research:** Involves the collection and analysis of data to support, challenge, or refine a theory or hypothesis.
    - **Study design (or nature of reporting):** the overall methodological approach used in the publication to collect and analyze data, such as whether the study was experimental, descriptive, reflective, based on case analysis, etc.
- **Conceptual Data:**
    - **Profession(s):** professions discussed in the context of the patient involvement
    - **Learner population(s):** learners discussed in the context of the patient involvement
    - **Level(s) of learning:**
        - **Undergraduate:** The stage of education prior to becoming a licensed health professional.
        - **Graduate:** Education pursued after initial professional qualification, often to develop additional or advanced skills.
        - **Postgraduate:** Specialized training or education undertaken after becoming a licensed practitioner, typically in a specific field or discipline.

        - **Continuing Professional Development (CPD):** Ongoing education completed after formal training to maintain, update, or enhance professional competencies.
    - **Perspective(s) studied:** Identifies whose viewpoint is explored or reported in the publication such as that of the involved patient, the learner, the educator (or administrator), if a specific perspective is sought or emphasized.
    - **Care focus:**
        - **Obstetrical care:** Focuses on pregnancy, childbirth, and postpartum care, including prenatal monitoring and labor and delivery support.
        - **Gynecological care:** Involves the diagnosis, treatment, and prevention of conditions related to the female reproductive system, outside of pregnancy.
        - **OB/GYN:** Refers to care that combines both obstetrics and gynecology, addressing the full spectrum of reproductive and sexual health across the lifespan.
    - **Learner skill(s):** The specific skills that the patient involvement activity is designed to develop in learners.
    - **Theoretical basis for patient involvement:** The underlying theory or conceptual framework that informs or justifies the involvement of patients in the activity.
    - **Practical basis for patient involvement:** The applicable reasons for involving patients in the activity.
    - **Formal definition of patient involvement:** The definition the authors chose to describe the concept of patient involvement.
    - **Terminology used to describe the involvement (if applicable):** Descriptors used by the authors to refer to the involvement activities.
    - **Terminology used to describe patients:** Descriptors used by the authors to refer to persons with lived experience in care.
    - **Patient role(s):**
        - **Information source:** The patient provides input into program development, governance, or decision-making based on their lived experience.

        - **Standardized patient:** The patient performs a scripted scenario to simulate a clinical case for teaching or assessment purposes.
        - **Educator:** The patient plays an active role in teaching by sharing personal experiences, engaging in dialogue, or helping learners develop knowledge and skills.
        - **Research data source:** The patient contributes to the study solely as a participant from whom data is collected.
        - **Teaching Material:** The patient is used by learners to practice clinical or communication skills, often without interactive engagement or feedback.
        - **Partner:** The patient is involved as an equal contributor to the health professions education process, alongside faculty and learners.
        - **Assessor:** The patient is responsible for evaluating learners and providing structured feedback on their performance.
        - **Case study:** The patient's story is used as educational content without them being present.
    - **Acting or portraying themselves?:** Indicates whether the patient was portraying someone else in a scripted role or involved as themselves in the activity.
    - **Summary of patient involvement:** A brief description of how patients were involved in the educational activity, including their responsibilities and their specific contributions.
    - **Purpose of patient involvement:** The specific intended outcome or objective of involving patients in the educational activity.
- **Other pertinent data points (with potential for discussion):**
    - **Recommendations for future research:** Priority areas for research or recommendations for the future of the patient involvement activity.
    - **Summary of pertinent results/discussion points:** Pertinent points from the publications that could add to the discussion of this review.

Part 3: Conclusion of My Thesis by Article

Lessons Learned

My experiences as a student in this Master's program have reinforced my person-centred and collaborative HPE philosophy. I have intentionally sought to engage with peers from diverse backgrounds, challenge my own thinking through collaborative work and course assignments that allowed for creative freedom, and embrace learning opportunities both inside and outside the classroom. Notably, some of my most transformative insights have come from experiences beyond formal instruction, no offense intended to my professors... This has shaped my belief that facilitators should not only deliver content but also inspire learners to explore, question, and connect ideas independently beyond the classroom. In doing so, education becomes a dynamic, lifelong process of shared growth and discovery.

In preparation for my thesis, I felt overwhelmed by coming up with a task schedule for my project as the workload seemed endless. Even after setting myself deadlines, I had difficulty meeting them as I knew they were my own goals. I found that sharing the schedule with my supervisor helped greatly in keeping me accountable for the timeline I'd set, even though my supervisor never applied any pressure.

As I conducted my review, I developed an understanding of the balance between being independent and searching for my own answers, and asking for help. I found it quite difficult in the early stages, to reach out when I did not understand something, but gradually learned that this process is supposed to be new and confusing for someone who hasn't conducted empirical research before. Upon reaching this balance, I felt a sense of relief and was able to get through the steps of my methodology. There were also many moments of feeling "imposter syndrome" as I looked at my data and realized there were inconsistencies in definitions for the terms I was using to describe the data. There were moments where I wasn't completely sure I understood the definition of empirical research and how it differed from evaluation. The same goes for the distinction between the practical basis of and the purpose of patient involvement. If I were to do it all again, I would ensure the definitions for each term used in the extraction sheet are documented in my own words so I could return to them in my moments of doubt. I began to do this about halfway through the extraction process and felt the need to revise the first rows to ensure consistency.

As I completed my data extraction, I had the opportunity to attend the Meredith Marks Medical Education Days 2025 conference and present a research poster for this project. I was able to discuss my methods and preliminary findings with graduate students, academic faculty, and practicing health professionals. I mainly received encouragement to continue this important work, though I also received some feedback surrounding the cultural inclusivity of my review. As I focus on a biomedical model of care with institutionally-educated and trained practitioners, I am missing a subsection of community-based practitioners providing birthing care. The concept of cultural inclusivity was echoed by keynote speaker Dr. Thirusha Naidu, who explained that the nature of scoping reviews can be discriminatory to non-Western contexts due to their exclusion of non-indexed literature. With only a few months remaining to complete my review and report the findings, I felt I did not have the time to re-frame my study, though I carry this recognition on with me for my future research.

When drafting this report, I found it helpful to work in small sections without thinking too much about the requirements of the end product. Having a general outline of ideas and flow allowed me the freedom to organize the pieces in a way that is conducive to understanding the story of the review.

Next Steps

Ultimately, I would like to publish this review in a OB/GYN or HPE journal to promote informed patient involvement within OB/GYN education and training. This experience has allowed me to get familiar with the granular details in the literature and has laid a good base for potential doctoral research, should I choose to do so. As I discovered a lot about non-biomedical models of birthing support throughout the completion of my study, I would be interested in exploring how patient perspectives differ between community-based obstetric providers and biomedical obstetric providers. This could potentially inform the orientation of HPE toward community-based learning and service learning. I am also interested in contributing to Canadian scholarship on patient involvement in OB/GYN, especially through bilingual (French and English) dissemination, given the clear gap in French-language literature identified in my study. Additionally, I would be excited to support the development of a patient involvement dictionary to help standardize terminology and improve clarity in reporting practices. Alongside this, I see value in contributing to the development of a widely accepted spectrum or continuum of patient involvement that could respond to the diverse needs of faculty and researchers working in this

space. In terms of immediate applicability, I am interested in building on my program evaluation and teaching skills in the workplace, as doing so will allow me to engage with HPE on practical, instructional, and scholarly levels. This holistic perspective of HPE could strengthen the quality and relevance of my future research. Through the process of conducting this review, I have developed greater cultural awareness, which I can now apply not only in research, but also in the design and facilitation of programs. I have gained confidence in my research abilities and believe I can approach future scholarly work with greater clarity and conviction. Importantly, I have learned the value of seeking support and drawing on the expertise of others, an insight that will enhance my ability to work collaboratively in research and professional settings.

Conclusion

This thesis marks the culmination of a profoundly enriching journey. One shaped not only by formal instruction but also by the collaborative and exploratory spirit of HPE. Through intentional engagement with peers, academic challenges, and personal reflection, I have deepened my commitment to a person-centred and collaborative approach to education and training. The belief that learning extends beyond the classroom, fueled by curiosity, anchors my educational philosophy.

The research process itself was transformative, navigating uncertainty, deadlines, and moments of self-doubt. Finding the balance between independence and seeking guidance became a lesson in humility and growth. With each methodological hurdle, I gained technical skill and understanding of what it means to be both, a learner and researcher.

Presenting this work at the Meredith Marks Medical Education Days 2025 reinforced the value of open academic dialogue, while also highlighting the importance of cultural inclusivity in scholarship. Feedback around the biomedical framing of my review underscored the need for broader representation of community-based perspectives in OB/GYN education and training, an insight I carry forward for future research.

The experience of conducting this study and writing my thesis has prepared me not just for academic contribution, but for continued inquiry into meaningful, inclusive, and community-rooted HPE practices.