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Giving Patient Educators a Consequential Role in Pharmacy Education Requires Influence over Curriculum Decisions, Recognition of Lived Expertise, and Accountability for Institutional Responses

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Abstract

Patient involvement in health-professions education has expanded from participation in teaching encounters toward curriculum development, assessment, and institutional engagement, yet the presence of patients in educational activity does not establish that their expertise influences what institutions decide. This conceptual article develops a Consequential Patient-Educator Partnership Framework for pharmacy education. It distinguishes patient presence, voice, influence, decision authority, recognition, and institutional accountability and asks when involvement becomes consequential rather than merely visible. The framework treats lived expertise as a situated form of educational knowledge whose influence depends on where it enters curricular decision processes, what authority accompanies it, and how institutions respond when recommendations are accepted, modified, or not adopted. It further separates meaningful influence from an assumption that equal decision authority is appropriate in every educational task. Recruitment, preparation, remuneration, accessibility, assessment roles, and organisational implementation are treated as conditions that can enable or constrain consequential participation. The central theoretical contribution is a decision-sensitive account of partnership: patient involvement becomes consequential when it can demonstrably alter a relevant educational option, criterion, process, or decision, or when the institution provides a transparent and accountable response explaining why input was modified or not adopted. This approach offers a basis for designing and evaluating patient-educator involvement without reducing partnership to attendance, storytelling, satisfaction, or a single hierarchy of participation.

Keywords: Patient educators, Pharmacy education, Lived experience, Curriculum co-design, Patient partnership, Institutional accountability

Introduction

Pharmacy education increasingly recognises that patients and carers can contribute knowledge that is difficult to reproduce through faculty explanation, simulated cases, or professional experience alone. Contemporary pharmacy scholarship places patient and carer voices across teaching, feedback, curriculum advice, and educational development and also identifies infrastructure, funding, preparation, and accessibility as conditions for sustained participation [1]. Yet expanding the number of occasions on which patients appear within a curriculum does not by itself establish that patient expertise has changed what is taught, how competence is judged, or how an institution responds to recommendations.

This distinction matters because the wider health-professions literature contains many forms of involvement with different purposes and levels of organisational reach [2, 3]. Patients may tell illness stories, participate in simulated encounters, comment on

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communication, contribute to curriculum discussions, assess aspects of learner performance, or participate in policy and governance. These activities cannot be treated as interchangeable examples of "partnership." Their educational consequences depend on the kind of knowledge being contributed, the decision to which that knowledge is connected, and the extent to which the participant can affect what happens next.

Accountability adds a further dimension. In work developing principles for patient and public engagement in medical-school educational missions, contributors placed substantial emphasis on inclusion, reciprocity, shared decision-making, and evidence that their contributions had made a difference [4]. The relevant question for pharmacy education is therefore not simply whether patients are included. It is whether the organisation can identify where their expertise enters a decision process, what influence it is permitted to exercise, and what obligation follows when institutional actors accept, modify, defer, or reject that contribution.

This article develops a Consequential Patient-Educator Partnership Framework to address that problem. The framework does not presume that every patient educator should hold equal authority over every educational decision. Instead, it asks whether the authority, support, and response arrangements attached to a role are appropriate to the decision at hand and whether the participant's contribution is capable of producing a traceable consequence. That consequence may be a change in curriculum content, assessment reasoning, educational priorities, learner feedback, or implementation choices. Where change is not adopted, consequential participation can still exist if the institution gives a transparent and reasoned response rather than allowing patient input to disappear without acknowledgement.

From patient presence to consequential partnership

Patient involvement is often described through spectra or ladders that appear to place deeper involvement above more limited participation. Such representations are useful when they expose differences in power, but they become misleading when they imply that every educational purpose should culminate in equal decision authority. Multi-perspective qualitative evidence suggests that participants may value different forms of involvement and that "equal partnership" is not invariably the preferred or most appropriate arrangement [5]. A patient who wishes to contribute a bounded narrative to a therapeutics session should not have that role interpreted as deficient merely because the same person does not seek curriculum-governance authority. Conversely, a school cannot describe an activity as partnership simply because a patient is visible and valued.

The more discriminating question is whether the form of involvement is fit for its purpose and whether the promised role is actually exercisable. An umbrella review of patient and public involvement in initial health-professions education found substantial discussion of educational benefits alongside continuing difficulty embedding involvement across curricula and institutions [6]. This coexistence is important. Educational value can arise from an encounter even when organisational influence remains limited. A moving patient narrative may alter learner understanding while leaving decisions about curricular priorities completely unchanged. The activity can therefore be educationally worthwhile without satisfying a stronger claim of consequential partnership at the curriculum level.

Patient involvement also occupies more locations than the teaching encounter itself. Guidance on patient involvement in health-professions education identifies roles that extend into teaching, assessment, curriculum development, and institutional or policy activity [7]. Role names, however, are not reliable measures of influence. A person called a "curriculum partner" may be asked for views after major decisions have already been fixed, while a nominally consultative contributor may cause a substantial curricular revision if their recommendation enters a genuine decision point and is acted upon.

For this article, presence means that a patient or person with lived experience participates in an educational activity. Voice means that the person is given an opportunity to express experience, judgement, preference, or recommendation. Influence exists when that contribution can alter an option, criterion, interpretation, process, or decision. Decision authority concerns who is formally or practically entitled to choose among alternatives. Recognition concerns whether the expertise and labour involved are acknowledged materially and symbolically. Accountability concerns whether the institution can explain what happened to the contribution and why. Consequential partnership depends on the configuration of these elements, not on the use of a partnership label.

Lived expertise as educational knowledge

The knowledge contributed by patient educators requires conceptual precision. Research on lived experience in health-professions education cautions against treating "perspective," "experience," and "lived experience" as interchangeable terms [8]. A learner, clinician, family member, and patient may all have perspectives on the same event, but they do not occupy the same experiential position. Lived expertise is therefore not defined simply by having an opinion about care. In this article, it refers to situated knowledge developed through navigating illness, treatment, medicines, healthcare relationships, and their practical consequences over time.

Such expertise can illuminate aspects of pharmacy practice that formal professional knowledge may only partially represent. A critical reflection written from the combined standpoint of physician and patient illustrates how movement between professional and patient roles can reveal assumptions that remain less visible within a purely professional viewpoint [9]. In pharmacy education, analogous insight may concern treatment burden, the work required to use medicines safely, the social consequences of adverse effects, difficulties negotiating fragmented services, or the gap between technically correct counselling and what a person can realistically implement.

Recognising this epistemic contribution does not require treating lived expertise as intrinsically superior to scientific or professional knowledge. The issue is complementarity and legitimacy. A pharmacologist may be better positioned to judge pharmacokinetic evidence; a patient living with a complex regimen may be better positioned to reveal how treatment instructions interact with fatigue, employment, stigma, cost, family responsibilities, or competing priorities. Curriculum quality can depend on whether these forms of knowledge meet at the right educational decision.

Power determines whether that meeting is genuine. A co-produced critical review of service-user involvement in mental-health professions education showed how questions of power and epistemic justice permeate decisions about whose knowledge is accepted and how participation is structured [10]. The relevance to pharmacy education lies in the mechanism rather than an assumption of direct contextual equivalence: an institution can invite experiential knowledge while retaining practices that prevent it from affecting established professional interpretations.

Patient stories illustrate this boundary. Educational work using patient narratives shows that stories can enrich students' understanding and connect formal knowledge with experiences of illness and care [11]. That contribution may be substantial. Yet storytelling alone does not reveal whether patients influenced the choice of learning objectives, the interpretation of competence, the design of assessment, or institutional decisions about what should change. Consequential partnership therefore requires attention both to the epistemic value of lived experience and to the structures through which that knowledge can act.

Where influence can occur in pharmacy curricula

Influence becomes analytically useful only when attached to identifiable decisions. Research across health-professions education suggests that educator capability, opportunity, motivation, and educational philosophy shape the depth with which consumers and community members participate in curriculum design and delivery [12]. This means that influence should not be treated as a global property of a school. It occurs at specific points where alternatives are still open and where experiential knowledge can alter what is selected, prioritised, interpreted, or implemented.

One set of influence points concerns what enters the curriculum. Consumer engagement across undergraduate health disciplines has included contributions to teaching and learning in multiple forms, although designs and reported outcomes remain heterogeneous [13]. In pharmacy, patient educators might influence which medication-use problems are considered educationally important, which dimensions of treatment burden are represented, how person-centred communication is framed, or which safety problems are treated as consequences of system design rather than patient behaviour.

A second set concerns how curricular content is framed and organised. Pharmacy-specific evidence shows that patients and caregivers can contribute directly to curriculum development. In an undergraduate pharmacy mental-health curriculum, patient and caregiver involvement generated recommendations that were incorporated into curricular development [14]. This is consequential in a limited but important sense: input crossed from expression into identifiable curricular change. It does not establish that the participants held final authority over the curriculum, nor does it need to. The analytically relevant fact is that their contribution entered a decision process while options were still modifiable.

A third set of influence points concerns how learning is judged. Patient participation in assessment may offer information about learner performance that is difficult to derive from conventional assessors alone, particularly around interpersonal behaviour, communication, responsiveness, and the experience of care. A scoping review of patient involvement in postgraduate assessment nevertheless identified practical conditions involving patient willingness, language, literacy, resources, and system readiness [15]. Assessment therefore demonstrates why authority must be decomposed. A patient may be well positioned to judge whether a learner listened or explained clearly while being neither expected nor authorised to determine every dimension of professional competence.

The framework accordingly distinguishes four questions at each influence point: What educational decision is open? What form of lived expertise is relevant to it? What influence is the patient educator actually able to exercise? Who retains or shares final decision authority? These questions prevent institutions from confusing the existence of an involvement activity with the presence of meaningful influence.

The decision-sensitive distinctions developed above are represented in **Table 1**.

Table 1. Decision sites at which patient-educator contributions can become consequential in pharmacy curricula

Educational decision site	Patient-educator knowledge brought to the decision	Decision object that remains genuinely open	What would constitute traceable influence	Authority configuration requiring explicit definition	What would remain participation without demonstrated curricular influence
Curriculum priority setting	Recurring medicine-use problems, treatment burden, unmet informational needs, care-fragmentation experiences	Which problems, experiences, or patient-safety issues deserve curricular attention	Addition, removal, reprioritisation, or reframing of a curriculum priority	Advisory, shared prioritisation, or institution-retained final approval	Patient testimony collected after priorities have already been fixed
Learning-objective formulation	What patients need professionals to notice, explain, negotiate, or respond to	Wording, emphasis, scope, or expected level of learner performance	Revision of objectives or explicit addition of a patient-relevant capability	Joint drafting or patient-informed drafting with documented academic approval	Feedback acknowledged but not connected to objective revision
Learning-activity and case design	How illness, medicines, services, and everyday constraints interact in real contexts	Case content, scenario realism, role expectations, learning sequence	Altered scenarios, prompts, cases, role instructions, or discussion questions	Co-design, bounded consultation, or faculty-led design with traceable adoption	Use of a personal story as illustrative content without influence on design
Teaching interpretation	Lived consequences of communication, medicine use, uncertainty, adverse effects, or service navigation	How learners interpret the significance of professional actions	Change in teaching emphasis, explanation, or expected response to patient situations	Patient-led, co-facilitated, or faculty-led teaching with defined contribution	Presence as a guest speaker with no capacity to challenge or reshape interpretation
Formative feedback	Patient experience of listening, respect, clarity, responsiveness, and relational behaviour	Learner understanding of performance and areas for improvement	Patient feedback incorporated into formative judgement or learner action planning	Independent patient feedback, co-feedback, or faculty-mediated incorporation	Feedback gathered but omitted from the learner's development process
Assessment design and criteria	Aspects of competence visible specifically to people receiving care	Assessment criteria, descriptors,	Addition or revision of criteria or structured	Shared design with professionally governed validity	Patient participation limited to simulation

		evidence sources, or weighting logic	patient-derived evidence	and fairness safeguards	performance without influence on criteria
Curriculum review and renewal	Cumulative experience of what educational priorities miss or misrepresent	Whether existing curriculum elements should be retained, redesigned, expanded, or removed	Documented change, modification, trial, or reasoned non-adoption	Patient representation in review plus explicit institutional decision ownership	Recurrent consultation with no record of decisions or responses

Development of the partnership framework

The preceding analysis suggests that patient partnership should be represented as a configuration rather than a rank. Curriculum co-design research shows that active partnership requires more than being consulted, but it also demonstrates that formal co-design remains unevenly developed and often descriptively reported [16]. The practical challenge is therefore to specify what must be configured without assuming that every educational decision should allocate authority identically.

The first element is epistemic position. Educational paradigms influence what kinds of knowledge are valued, which roles are legitimate, and how teaching and assessment are aligned with underlying assumptions about learning [17]. A curriculum that treats knowledge primarily as expert transmission may welcome patient narratives while reserving interpretation and curricular judgement almost entirely for professionals. A more plural conception can treat lived expertise as a legitimate knowledge source without dissolving disciplinary responsibilities.

The second element is location of contribution. Evidence from simulation-based health-professions education shows that people with lived experience can contribute at multiple points in the design and enactment of educational activities [18]. Applied more broadly, this means that patient involvement can occur before, during, or after teaching: in agenda setting, design, delivery, feedback, assessment, review, and institutional learning. A framework that records only whether patients were "involved" loses these distinctions.

The third element is influence and authority. Influence concerns whether patient input can change an educational option; authority concerns who is entitled to make the final decision. They often overlap but should not be collapsed. A patient educator may have substantial influence without formal veto power. Conversely, a committee seat may confer nominal authority while institutional routines prevent the member from affecting the agenda. The distinction protects the framework from equating formal representation with actual control.

The fourth element is conditions of participation. Recruitment, preparation, accessibility, recognition, and remuneration shape who can participate and whether involvement is sustainable. These conditions are not peripheral to influence. They affect which experiences become available to the institution, whether contributors can understand and contest educational processes, and whether participation is distributed beyond people who can afford to contribute unpaid time.

The fifth element is institutional response. Engagement principles emphasising accountability and evidence that contributions make a difference provide a basis for treating response as part of partnership rather than an optional courtesy [4]. At the same time, qualitative evidence cautions against assuming that the highest formal level of partnership is inherently optimal for every person and task [5]. Organisational conditions also influence whether educators can enact more substantial forms of involvement [12]. Taken together, these findings support a decision-sensitive account rather than a universal hierarchy.

The framework therefore proposes that a patient-educator relationship becomes consequential when two conditions are jointly satisfied. First, the contribution enters a decision process while a meaningful educational option remains open. Second, the contribution either changes an option, criterion, interpretation, process, or decision, **or** generates a transparent institutional response explaining how and why it was accepted, modified, deferred, or not adopted. This second route is important because partnership cannot reasonably mean that every recommendation must be implemented. Institutions retain obligations to educational standards, resources, regulatory requirements, feasibility, fairness, and other stakeholders. What distinguishes accountable non-adoption from symbolic consultation is whether the contribution disappears without explanation.

Figure 1 represents this multilevel configuration without treating partnership as a one-directional ladder.

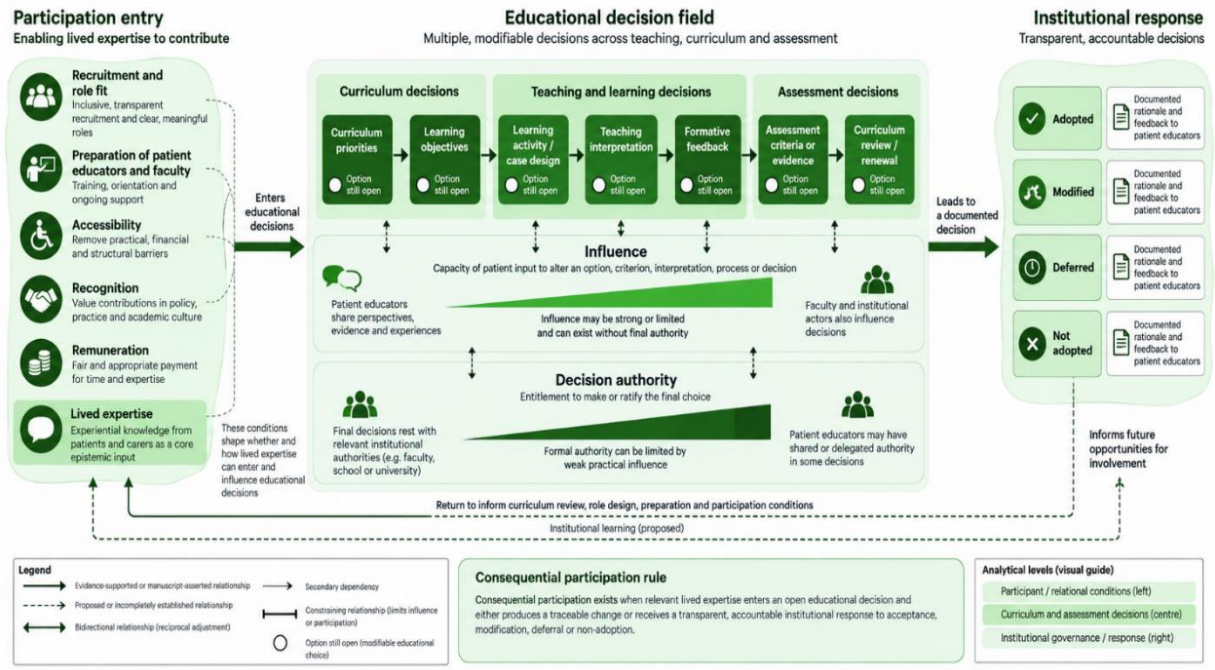


Figure 1. Consequential patient-educator partnership as a multilevel field of expertise, influence, authority, support, and institutional response

Recruitment and preparation

Consequential influence begins before a patient educator enters a classroom or committee. Recruitment determines whose experiences are made available to the institution and what those individuals are being asked to contribute. A pharmacy pilot involving patient partners demonstrates that active patient participation in undergraduate pharmacy teaching is feasible and can be received positively by students [19]. The deeper design question, however, is not simply whether willing patients can be recruited. It is whether recruitment matches the educational decision with the expertise required.

A school seeking to revise medication-safety teaching may need different experiential knowledge from a school redesigning mental-health communication, chronic-disease self-management, or assessment of person-centred care. Recruitment should therefore begin with the decision or educational problem rather than an undifferentiated category of "patient representative." This does not imply that individuals must be treated as representatives of entire patient populations. Their contribution is situated expertise, not statistical representativeness.

Preparation is equally reciprocal. Patient educators may require information about curriculum structures, assessment terminology, decision processes, confidentiality, and the scope of their role. Educators may require preparation to work with experiential expertise without appropriating, sanitising, or defensively resisting it. Ethical issues become particularly visible in settings where personal experiences may be sensitive. A recent review of patient involvement in obstetrics and gynaecology education identified inconsistent reporting of consent, compensation, training, debriefing, and related participant safeguards [20]. The specialty context differs from pharmacy, but the underlying principle is transferable: educational benefit does not remove the institution's obligation to protect dignity and participation conditions.

Active roles also depend on being explicitly enabled. Qualitative work on real-time patient involvement in medical education found that patients could desire more active contributions while contextual and relational conditions affected whether those roles were realised [21]. Preparation must therefore include clear invitation

and role negotiation. A patient should not have to infer whether they are permitted to challenge a teaching interpretation, question an assessment criterion, or ask what happened to a previous recommendation.

Faculty capability is part of the same arrangement. Educational initiatives designed specifically to teach health-professions educators how to involve patients demonstrate that patient partnership is itself a capability that may require development [22]. Reciprocal preparation therefore protects against two common failures: placing patient educators in unfamiliar institutional settings without usable support, and assuming that experienced academics automatically know how to share interpretive or decision space.

Curriculum co-design and decision authority

Curriculum co-design is often invoked as a marker of advanced partnership, but the term becomes analytically weak unless the decision rights inside "co-design" are specified. Contemporary analysis argues for extending patient involvement upstream into curriculum development rather than restricting it to delivery [23]. The relevant question is what participants can actually do once they enter that upstream space.

At least four decision activities should be separated. Patient educators may help set an agenda by identifying problems the existing curriculum neglects. They may generate options for content, cases, learning activities, or assessment approaches. They may participate in deliberation, contesting professional assumptions and comparing alternatives. They may also share some form of decision authority, although final approval may remain with programme committees or regulatory-accountable academic structures. Treating these activities as one undifferentiated category of co-design obscures where power lies.

Institutional feasibility complicates this picture. Curriculum-change research shows that adoption is shaped by compatibility with existing systems, local champions, social relationships, and organisational conditions [24]. Patient educators may therefore make a compelling recommendation that cannot immediately be adopted because of regulatory requirements, resource limitations, sequencing constraints, accreditation expectations, or conflict with other educational priorities. Such constraints do not make patient participation inconsequential by definition. They make the institutional response more important.

The pharmacy mental-health curriculum example provides a useful distinction. Patient and caregiver contributions resulted in identifiable curricular recommendations and subsequent changes [14]. That case demonstrates that consultation can have real educational consequences even when participants do not possess final governance authority. It would therefore be misleading to define consequential partnership as synonymous with maximal shared control.

At the same time, curriculum co-design literature warns against calling limited consultation "partnership" merely because stakeholders are present in a design process [16]. The framework resolves this tension by separating authority level from consequence. Shared final authority is one possible configuration, but it is not the only route through which lived expertise can matter. A bounded advisory role can be consequential when the advice genuinely enters an open decision and alters what is chosen. Conversely, formal committee membership can remain symbolic when agendas, options, and final interpretations are effectively closed before the patient educator can influence them.

Decision authority should therefore be made explicit for each curricular activity. Contributors should know whether they are offering advice, jointly generating options, participating in deliberation, sharing a decision, or contributing evidence to a body that retains final approval. Institutions, in turn, should be able to explain how those roles connect to actual decision processes. This clarity prevents two opposite errors: overstating symbolic participation as shared governance and dismissing meaningful influence merely because patients do not hold final authority over every curricular choice.

Assessment and feedback influence

Patient involvement in assessment requires a different authority logic from participation in curriculum design. Patients may observe dimensions of performance that conventional assessors cannot fully reproduce, particularly whether learners listen, communicate clearly, respond respectfully, and adapt explanations to the person receiving care. The assessment literature nevertheless indicates that patient participation depends on willingness, language, resources, preparation, and assessment-system readiness [15]. Patient-generated evidence should therefore be treated as a distinct information source rather than automatically converted into independent high-stakes authority.

The strongest evidence is currently more persuasive for formative influence. A systematic review of patient feedback found generally favourable effects on healthcare students' clinical and communication learning, while also identifying a small and methodologically heterogeneous evidence base [25]. In pharmacy education, patient feedback can consequently contribute to developmental judgement, learner reflection, and the revision of communication practices without implying that patient ratings alone should determine progression or competence.

The consequential-partnership test remains the same: patient observations should enter assessment processes where they can affect feedback, criteria, interpretation, or subsequent educational action. If such information is routinely collected but excluded from consequential judgement, the institution should not infer substantive assessment partnership merely from patient participation.

Recognition, remuneration and accessibility

Recognition concerns both the status accorded to lived expertise and the conditions under which people are asked to provide it. Patient educators may derive personal value from educational participation. Qualitative research has described benefits including reflection, purpose, contribution, and learning associated with involvement in health-professions education [26]. These benefits are important, but they cannot substitute for fair consideration of payment, preparation, access, or burden. The framework therefore separates reciprocity from remuneration. Reciprocity concerns whether participation offers respect, information, support, meaningful involvement, and appropriate benefit to contributors. Remuneration concerns material recognition for expertise and labour. Some patient educators may prefer unpaid participation, but institutions should not treat willingness to volunteer as evidence that payment is unnecessary. A role becomes inequitable if sustained participation depends on having sufficient income, time, health, mobility, digital access, or confidence to contribute without institutional support.

Accessibility has similar theoretical importance. If inaccessible meeting formats, uncompensated travel, rigid scheduling, unfamiliar terminology, or digital exclusion prevent some people from participating, the resulting partnership field is already selective before any formal decision occurs. Contemporary pharmacy scholarship consequently places funding and accessibility alongside the infrastructures required for sustained patient and carer involvement [1]. Recognition is thus not ceremonial. It affects which forms of lived expertise can reach educational decisions and remain present long enough to influence them.

Institutional response and accountability

Consequential partnership ultimately depends on what the institution does after patient input has been offered. Health-professions education scholarship on knowledge translation and implementation emphasises that evidence does not move automatically into practice; adoption depends on contextual processes, stakeholders, and systems capable of translating knowledge into action [27]. Patient contributions face an analogous problem. Listening is not the same as institutional uptake.

Organisational evidence from patient engagement in healthcare quality improvement similarly indicates that leadership, engagement strategy, and a receptive organisational context condition whether participation reaches meaningful organisational change [28]. That evidence comes from healthcare delivery rather than pharmacy education and therefore supports the present argument analogically rather than proving an educational mechanism. It nevertheless reinforces the importance of institutional receptivity.

The framework proposes four legitimate response states when patient input enters an open educational decision: adoption, modification, deferral, and non-adoption. None is inherently evidence of good or poor partnership. Accountability depends on whether the institution records what was considered, identifies who held decision authority, explains the rationale, and communicates the outcome to contributors. Curriculum change can reasonably be constrained by accreditation, resources, evidence standards, competing stakeholder needs, or implementation feasibility [24]. Those constraints justify neither automatic adoption nor silent dismissal.

A consequential relationship therefore remains possible when a recommendation is not implemented, provided that the non-adoption is reasoned and traceable. This distinguishes accountability from compliance. Patient educators are given consequential standing because their contribution requires an institutional answer, not because they are guaranteed a preferred outcome.

Figure 2 represents this response logic and its feedback into future educational decisions.

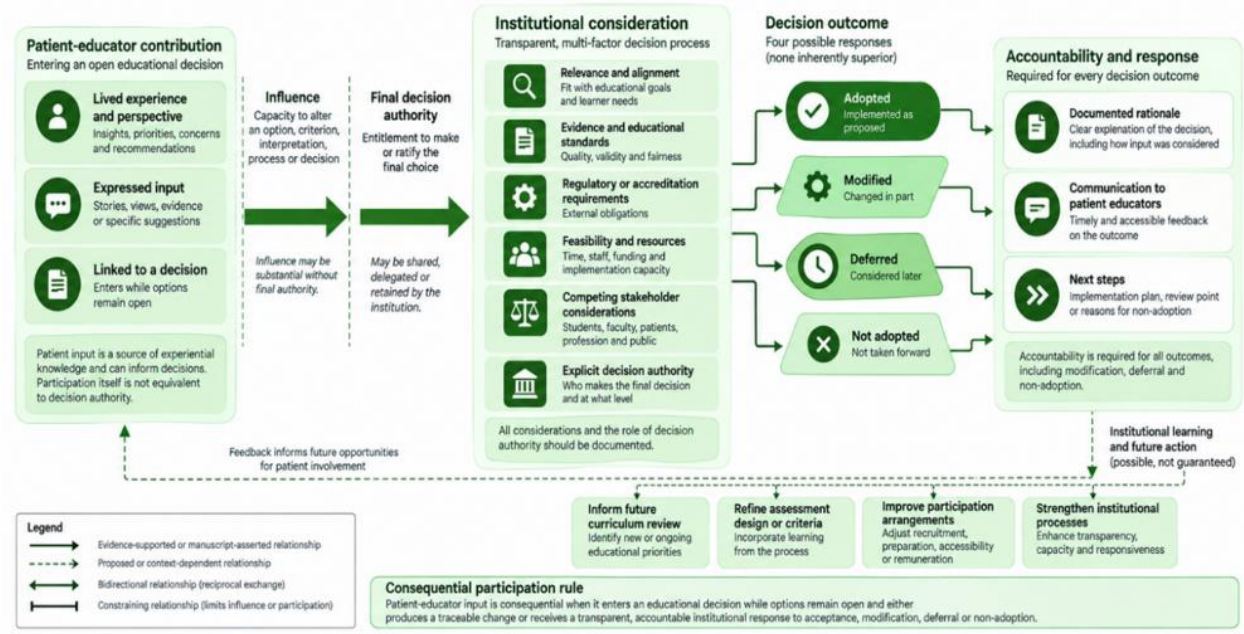


Figure 2. Institutional accountability after patient-educator input: from decision entry to response, feedback, and renewed educational action

Indicators of consequential rather than symbolic participation

Observable indicators are necessary if "partnership" is to mean more than institutional self-description. Attendance, positive satisfaction scores, repeated invitations, and compelling stories can demonstrate participation and educational value, but they do not alone establish influence. This does not diminish storytelling or bounded participation. Qualitative evidence shows that participants may reasonably prefer different roles [5]. The question is whether the claims made about a role correspond to what it actually permits.

The proposed indicators therefore focus on traceability rather than a numerical partnership score. Consequential participation is more plausible when patient educators enter decisions before options close; understand what authority they hold; can identify where their contribution went; can point to an altered option, criterion, interpretation, or process; or receive a reasoned institutional response when change does not occur. Accountability is strengthened when contributors can see that their participation made a discernible difference to institutional consideration [4].

Interpretation must remain contextual. Partnership varies across health-professions settings [2], and persistent institutional marginality can coexist with apparently active involvement [6]. No single indicator should therefore become a universal threshold. **Table 2** provides qualitative discriminators rather than a validated measurement scale.

Table 2. Observable discriminators between visible participation and consequential patient-educator involvement

Observed condition	What can legitimately be concluded	What remains unproven	Accountability test
Patient educator attends or contributes a story	Patient presence occurred and experiential knowledge entered the activity	Influence over curriculum, assessment, or institutional decisions	Was any decision actually open to this contribution?
Patient educator is asked for views	Voice was invited	That the contribution could alter an option or criterion	Was the input connected to a named decision process?
Recommendation is documented	Contribution became traceable	That it affected deliberation or outcome	Who considered it and under what authority arrangement?

Curriculum or assessment element changes after input	A plausible pathway of influence exists	That patient input was the sole cause	Can the institution identify what changed and how the contribution informed it?
Recommendation is modified	Patient input entered deliberation	That modification preserved the contributor's central concern	Was the modification explained and returned to the contributor?
Recommendation is deferred	Decision remains unresolved	That delay is legitimate rather than avoidance	Is the reason, review point, and responsible decision body documented?
Recommendation is not adopted	The institution retained final authority	That participation was therefore symbolic	Was non-adoption reasoned, traceable, and communicated?
Patient educator receives payment, preparation, and accessible participation options	Material and procedural support were provided	Consequential influence by itself	Could the supported role actually reach an open educational decision?
Institution repeatedly invites patient educators	Participation infrastructure may be established	That organisational learning or shared power occurs	Is previous input traceable to subsequent decisions or responses?

Results and Discussion

The central contribution of this framework is to relocate the analysis of patient partnership from labels and participation levels to the relationship among lived expertise, an identifiable educational decision, usable influence, decision authority, and institutional response. Wider health-professions evidence supports the importance of relational and structural conditions, while the direct pharmacy literature demonstrates that patient and caregiver contributions can influence educational content [2, 14]. The framework makes those relationships explicit without claiming that every component is newly discovered.

Its strongest rival explanation is that elaborate partnership structures may be unnecessary for many educational purposes. Patients may value bounded roles, and institutions face practical barriers to deeply embedded involvement [5, 6]. That objection is persuasive against a universal demand for shared authority. It is less persuasive against accountability. A school can legitimately retain professional or institutional authority while still making the patient educator's role explicit, locating their influence, and providing a reasoned response.

The evidence base also imposes limits. Direct pharmacy studies remain fewer than the broader medical and health-professions literature, and evidence supporting patient participation in assessment is stronger for feedback and formative learning than for autonomous high-stakes judgement [15, 25]. Some organisational reasoning in this article is transferred from implementation scholarship and patient-engagement research outside pharmacy education [27, 28]. These transfers identify plausible mechanisms and conditions rather than validated pharmacy-specific causal pathways.

Several empirical tests follow. Future pharmacy-education research could examine whether patient recommendations are more likely to affect decisions when contributors enter before curricular options close; whether remuneration and accessibility broaden the range of lived expertise represented; whether explicit authority statements reduce misunderstanding about partnership roles; and whether documented institutional responses alter willingness to continue participating. Comparative studies could also determine whether consultation with traceable influence produces outcomes different from formal co-design in which decision authority is shared.

The framework also raises an institutional design question. A response system could strengthen accountability but become bureaucratic if every contribution generated excessive documentation. Proportionality therefore matters. The objective is not to create an administrative ledger for every educational encounter. It is to ensure that when an institution represents patients as partners in curriculum or assessment decisions, their contribution does not disappear at the boundary between consultation and authority.

Conclusion

Patient educators can make distinctive contributions to pharmacy education because lived expertise reveals consequences of medicines, communication, services,

and professional action that conventional educational knowledge may incompletely represent. Consequential partnership, however, cannot be inferred from patient presence alone.

The strongest evidence-bounded position is conditional. Patient involvement becomes consequential when relevant lived expertise enters an educational decision while meaningful options remain open and can either alter that decision or generate a transparent institutional response explaining acceptance, modification, deferral, or non-adoption. Equal decision authority is not required in every educational task, but clarity about authority, fair recognition, accessibility, and accountability is required if institutions wish to claim partnership rather than participation alone.

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