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**Perspectives of Patient Educators about their Participation in an Interprofessional
Program for Healthcare Students and Postgraduate Medical Students**

Laure Fiquet ^{1,2}, Marie Dupard ¹, H el ene Fortier ¹, Marie Pancher ¹, Fran oise Annezo ³,
Pierric Renaut ¹, and Emmanuel Allory ^{1,2}

¹University of Rennes, Department of general practice, F-35000 Rennes, France

²CHU Rennes, Inserm, CIC 1414 (Centre d'Investigation Clinique de Rennes), F-35000
Rennes, France

³AFDET (Association Fran aise pour le d veloppement de l' ducation th rapeutique), F-
75003 Paris, France

Author Note

Corresponding author : Dr Laure Fiquet, University of Rennes, Department of general
practice, 2 Av. du Professeur L on Bernard, F-35000 Rennes, France, E-mail :
laure.fiquet@univ-rennes1.fr

Abstract

Including patients in Interprofessional Education (IPE) programs improves healthcare students' education. However, little is known about the perspective and experience of the involved Patient Educators (PEs). An IPE program (Interprofessional Seminars, IPS) that includes PEs was developed in France in 2009. The aim of this study was to describe the PEs' perspectives about their involvement in IPS. Data were collected using semi-structured interviews with 32 experienced PEs, and analysed using a reflexive thematic analysis in the framework of an inductive approach. PEs had an identifiable profile. They were motivated by a sense of civic service, had well-developed communication skills, and were prepared to share their experiential knowledge with students. They were concerned about their capacity to express themselves in front of students and the need to consolidate their involvement through a structured partnership that involves briefing, collaboration, remuneration, and feedback. They proposed to establish compulsory interprofessional training for all students and to strengthen the collaboration between an interprofessional group of students and a PE. Our results highlight the PEs' desire to be involved in IPE and to develop a genuine patient-student partnership. These insights should support the systematic integration of PEs in IPE.

Keywords: Interprofessional education, medical education, qualitative research.

Perspectives of Patient Educators about their Participation in an Interprofessional Program for Healthcare Students and Postgraduate Medical Students

Including patients in health professional education provides benefits to students, teachers and patients (Towle et al., 2010). Students gain interpersonal skills and empathy from understanding the patient perspective (Lauckner et al., 2012). This is important because strong patient engagement in their care experience improves their satisfaction and health outcomes (De La Rosa et al., 2020; Mickan, 2005). However, an agreed, uniform nomenclature to describe patient involvement in health education is lacking (Morgan & Jones, 2009), and different terms are used, such as patient educator, patient instructor, and patient moderator (Gordon et al., 2020). We chose to use the term patient educator (PE) to describe patients who are actively engaged in a teaching role because of their health experiences and expertise (Solomon et al., 2003).

Actively involving patients in interprofessional education (IPE) programs is strongly encouraged and recommended (The Health Foundation, 2011). Interprofessional education (IPE) defines any method that allows two or more professions to learn with, from, and about each other and to improve their collaboration and care quality within an interprofessional healthcare team (Centre for the Advancement of Interprofessional Education [CAIPE], 2017).

Various IPE programs involving PEs have been conducted. At Thomas Jefferson University (USA), the health mentors program was developed in 2007. In this program, each interprofessional team (four-five students from different disciplines: first and second year couple and family therapy, medicine, nursing, occupational therapy, pharmacy and physical therapy) complete four modules over 2 years where patients with chronic conditions participate as mentors (Collins et al., 2011). Authors reported that the involved students felt that they gained a deeper understanding about coping with chronic conditions. Moreover,

collaboration between healthcare students within teams was strengthened and students learned about their colleagues' roles and the patients' perspectives (Arenson et al., 2015).

Since 2010, Montreal University (Canada) has developed a patient-as-partner approach recognizing that the patient's experiential knowledge and integration in healthcare teams are essential (Karazivan et al., 2015; Pomey et al., 2015). In this approach, patient-trainers provide training in interprofessional collaboration to 13 healthcare and social services programs (~1,200 students per cohort). Students learn how to increase the patients' engagement in the management of their health by better understanding their needs (Vanier et al., 2013).

Towle and Godolphin (2013) investigated the feasibility and impact of interprofessional workshops with community educators in British Columbia (Canada): 142 students from 15 different disciplines attended workshops that included 24 community educators who had a chronic disease or a mental health problem. They found that a patient-centred educational intervention in which the patient is the teacher was feasible. Students who participated said that they would recommend the workshop to others.

However, little is known about perspectives of PEs involved in IPE programs. In the United Kingdom, Cooper and Spencer-Dawe (2006) carried out a multi-stakeholder evaluation of 500 students (studying medicine, nursing, occupational therapy, physiotherapy, and social work) who participated in workshops facilitated by trained practitioners or co-facilitated by trainers and patients. According to their evaluation, students thought that patient co-facilitation bridged the gap between theory and practice. The 10 involved PEs found that contributing to IPE in the early stage of student training was important. They thought that through their intervention, they could improve communication between patients and professionals, and between professionals from different disciplines. They shared their experiences and provided a "real life" perspective. Similarly, Romme et al. (2020) in the

Netherlands explored the experiences of students and of 16 PEs who provided personal testimonies to undergraduate students on their own experiences in professional-patient communication. This interprofessional perspective helped students to understand that care delivered in a fragmented way is not patient-centred, and that they must learn about their colleagues' role and competences. The meeting with PEs made students adopt a more comprehensive care approach. Little is known about the motivations that drive PEs to engage in IPE and their experiences.

Background

In line with recent international recommendations, current healthcare reform guidelines in France recommend incorporating IPE and patient participation into medical training (Ministry of Solidarity and Health, 2019). However, in 2018, among the 35 general medicine teaching schools in France, only 13 offered IPE programs that included students from at least another healthcare profession, mostly pharmacists (Tyrant et al., 2021). Furthermore, PEs have been recently integrated in medical education and only in few French universities (Gross et al., 2017).

The Inter-Professional Seminar (IPS) was the first French IPE program that implicated PEs. The IPS was proposed at Rennes University in 2009, at Besançon University in 2012, and at Lille University in 2014. This program was created by an academic, interprofessional team (AIT) of healthcare professionals. Each year, approximately 100 students from nine healthcare and social professions (e.g., dietitians, family medicine practitioners, midwives, nurses, occupational therapists, pharmacists, physiotherapists, podiatrists, social workers) take part, on a voluntary basis, in this program (three 2-day sessions over 9 months). Non-medical students are in their final year of study when attending the seminar. Medical students are family medicine residents who already have primary care experience through internships. The IPS main objective is to develop participants' interprofessional collaborative competencies,

based on the French competency frameworks for each healthcare profession (Ministry of Health, 2010). The program is developed from an interprofessional pedagogic perspective, in organization and student mentoring. There are three IPS sessions, and each focuses on a specific theme (Fiquet et al., 2015): (a) the different healthcare professionals and how they can collaborate, (b) the healthcare provider-patient relationship, and (c) how to build an interprofessional healthcare project. PEs participate in the second session. Their main objective is to provide a testimony to students about their disease-related experiences and their expectations about health professionals and healthcare teams. A 90-minute interactive discussion with 10 students is organized. The AIT recruits PEs from community-based health organizations (e.g., diabetes associations), healthcare practices (e.g., family medicine practices, physiotherapist practices), or by snowball effect. PEs are adult volunteers who have at least one chronic disease or disability or who care for a patient with a chronic condition. PEs do not receive any training before their participation to ensure that their contribution is based only on their real-life experience. Before session two initiation, the AIT welcomes each PE. Patients are not paid for their intervention. One AIT member is present in each group and their role is to facilitate exchanges. After the session, students give their feedback on the discussion content and format.

The PEs' perspectives about their participation and integration in the IPS have never been studied. Yet, knowing their experiences, motivations, difficulties, and ideas for improvement seems to be a key element for developing IPE programs with PEs. Therefore, the aim of this study was to explore the PEs' perspectives concerning their intervention in the IPS.

Methods

Study Design

In this qualitative study we explored the PEs' perspectives about their involvement in an IPE program (IPS) using semi-structured interviews and a reflexive thematic analysis in the framework of an inductive approach.

Recruitment

All PEs ($n=52$) who participated in at least one IPS session at Rennes ($n=24$), Besançon, ($n=20$), and Lille ($n=8$) Universities since 2009 were contacted. Each PE was contacted by telephone and/or e-mail to be introduced to the researchers and to receive information on the study purpose. As 20 PEs chose not participate, only 32 PEs ($n=19$ in Rennes, $n=10$ in Besançon, $n=3$ in Lille) were interviewed. Their characteristics are reported in Table 1. Twenty-nine PEs had a chronic disease (diabetes, rheumatic disorder, ear nose and throat pathology), one a disability (paraplegia). Two PEs were caregivers (their husbands had a neurodegenerative disease). Eighteen of these PEs were still participating in the IPE program after this study.

Data Collection

Data were collected using face-to face interviews (one interviewer and one PE), based on a pre-defined interview guide Table 2, between April and December 2018. The three interviewers (MD, MP, and HF) had been trained to conduct interviews by a senior researcher (LF). Interviews took place in a quiet place chosen by the PE (their home or at their patient association premises). Throughout the research, the interviewers took field notes. After the interviewers gained more experience in conducting interviews, they interviewed by telephone several PEs who lived far away. Written informed consent was obtained before each interview.

The interview guide was developed following a rigorous process (Kallio et al., 2016). It was based on a literature review and was validated by all co-authors. The final version reported in Table 2 was pilot-tested by an IPS organizer and a PE (leader of a community-

based health organization who did not participated in the IPS). The first question invited PEs to talk about themselves (e.g., family composition, job). The second question explored how they were invited to participate in the IPS. Then, PEs were questioned about their expectations, concerns, and fears about participating in the IPS. They were asked to describe how they became involved and to talk about their difficulties. Next, they were invited to suggest some improvements for the IPS. The last question concerned their opinion on patient involvement in IPE and healthcare education. At the end, basic demographic information was collected. PEs could stop the interview at any time and could choose not to answer one or more questions. Interviews lasted between 38 and 92 minutes (mean length: 62 minutes). The interviews were digitally recorded with the participants' permission.

Data Analysis

The audio recordings were transcribed verbatim using Microsoft Word, taking into account the PEs' silences, nuances, and non-verbal communication, which were reported in the field notes. Transcripts were not handed out to the PEs. All collected data were treated as confidential. Any information that could identify participants was removed during the transcription to ensure anonymity.

Three researchers (MD, MP, HF) read the transcripts several times and familiarized themselves with the field notes. Following Braun and Clarke's inductive approach (2006), qualitative data were analysed using reflexive thematic analysis. Data familiarization is key to thematic analysis, and in this study, the researchers personally collected and transcribed the data. Each researcher manually and individually coded the interviews, line by line, together with a senior researcher (LF). Then themes were identified. Following an iterative process and discussion, a coding framework was constructed. After 30 interviews, sufficient and rich information was obtained to identify robust themes and analyse the research question. The last

two interviews reinforced the thematic analysis process (Sandelowski, 1995). The analysis results were read by four PEs who participated in this study.

Ethical Considerations

The study was approved by the Rennes University Hospital Ethics Committee (Number 18.22).

Results

The reflexive thematic analysis of the interviews revealed four major themes that included sub-themes concerning PEs' participation in the IPS, reported in Table 3 : (a) PEs' profiles and skills, (b) PEs' motivations and fears, (c) PEs' perspectives about the event sequence during the seminar, and (d) PEs' future prospects and suggestions for improvement.

PEs' Profiles and Skills

PEs were dynamic, determined, and involved in many projects, particularly PEs from associations. Most of them were healthcare professionals or teachers, retired or unable to work. Many had had professional careers marked by retraining. "I have a fairly wide background, I ended up as the training director in a public healthcare school" (p. 3). Many PEs had held positions of responsibility or requiring good verbal skills, in patient associations and professional environments. According to the PEs, having diverse profiles, from "all spheres," was very important for their activities. Some also suggested to invite their wives and their families to enrich their testimonials. Among the PEs involved in patient associations, some led discussion groups, and many talked to other patients, often after having received training on listening skills, delivered by their own association. Others had organized conferences with invited speakers from medical, paramedical, and sports associations. Some reported previous experience in speaking in front of healthcare providers, particularly in nursing schools. Two PEs had talked about their disease experiences in primary schools.

Others had organized seminars, presentations in conferences, or other presentations on their disease to educate, raise awareness, and promote screening or illness prevention.

I have done a lot of presentations about the disease. For example, before a play. I have also done some presentations on the radio, and I have been to several schools to talk about my journey, the association, and the disease. (p. 25)

Some PEs did not have any speaking experiences, but this was not a selection criterion to participate in the IPS. Their commitments varied, but highly developed communication skills were required, including listening, speaking, and communicating clearly.

PEs' Motivations and Fears

From the interview onset, PEs expressed a strong motivation to participate in IPE. They presented themselves as citizens, talked about altruistic values and their high level of interest. They showed a desire to attend the IPS and interact with students, and also to provide a citizen contribution to improve the healthcare system. "My expectations were to add a small stone to the edifice" (p. 9). The vast majority emphasized their interest in participating in IPE, meeting students, and understanding the trainees' profile.

Would I meet, excuse the term, "cowards" who brag because they graduated and think they are better than the others, or people who listen to patients and who take them into account as persons [...] I was curious to see what the future of the hospital world would be (p. 28).

PEs believed that this meeting was essential for future healthcare professionals. "It's like when you learn about World War I or World War II from someone who went through it. Then, you understand things differently [...], we feel sentimental, [...], human beings are really connected!" (p. 17). According to them, their experiential knowledge was complementary to the teaching the students had received. They thought that the IPS allowed healthcare students to consolidate their theoretical knowledge with the patients' practical knowledge, giving

meaning to their learning and practice. Regarding the students participating in the IPS, PEs stressed the importance of having a variety of students from various healthcare professions. The inter-professional nature of the program was an essential element. They underlined its enriching and innovative character. “You are multidisciplinary. I don’t think we would have obtained this result if we had only doctors, only nurses, only physiotherapists...” (p. 8).

PEs believed that all healthcare professionals should be able to recognize their limitations and overcome them by drawing on the skills of other healthcare professionals. They wanted to share with students the need of interprofessional communication and cohesion. “What I wanted to share was the importance of working together, of transversal work, and of exchanging knowledge” (p. 29). PEs thought that interprofessional work was essential for better quality of care and for a more efficient and cheaper healthcare system. “If there were coordination among all professionals, among all specialties, and with patients, then I think we could really take full advantage of our healthcare system. We would save a lot, there would be so much well-being.” (p. 17). They considered that integrating PEs into IPE programs fosters and increases the impact of interprofessional healthcare.

Several patients expressed concerns about their capacity to express themselves in front of a group of students. They thought that lack of self-confidence could be a barrier. “My fears were that I might not be good enough, might get off the topic, and not meet their expectations. [...], not to be understood, to be irrelevant” (p. 7). They were worried about poor interaction with the students, not knowing how to deal with their own emotions, and being judged by students.

Faced with these fears, some PEs expressed that being trained to work with students would allow them to better understand their disease, and therefore, to have a more structured and relevant speech. “If we train people about how to construct a speech, it would be more effective for the patient and for the listeners” (p. 3). This training also could protect the

patient. “I found myself in situations where I couldn’t cope, it hit me in the face. So you must be trained.” (p. 7). Training would allow them to have greater legitimacy with the students and to acquire the qualities needed for teaching. “If there is training, leading to a diploma, it is a recognition. For the caregivers, I think it’s a guarantee that this person already has some knowledge” (p. 30).

PEs valued the opportunity to be challenged, to be questioned, to take a step back from their condition, to speak for themselves, and not to make statements. One PE suggested that the university should organize a training course for PEs. “The university may propose a specific training course, a day with some kind of exam, so that the patients would have an official title to take part, to work with them.” (p. 7). However, some pointed out that being trained might diminish their real-life contribution through a more formatted language. “The risk is having a talk that is a little too theoretical, that slightly distorts our experience. I prefer people to be more spontaneous, with less staging, preparation.” (p. 3).

PEs Perspectives about the Sequence of Events During the Seminar

Reception

The convivial atmosphere of the seminar, the simplicity, and spontaneous connections among seminar speakers were emphasized: “The contact with F. [main organizer] and her team is really very direct, open, warm; there was no barrier, no hierarchy ”(p. 2). The welcome they received when they arrived at the seminar location was essential. “It’s nicer when someone is waiting for you. I had the opposite experience, and you don’t feel welcome. It’s nice to be welcomed!” (p. 11). The students’ curiosity, motivation, dynamism, and involvement during the IPS were highlighted. Particularly, the convivial atmosphere and the students’ very active listening strengthened their overall positive feeling. The students’ benevolence and attentiveness were emphasized and appreciated by many PEs: “No one

rubbed salt in the wound too badly. I could see that these were questions to help them to understand, they were respectful” (p. 25).

Participation Sequence

PEs thought that participating in the IPS was relevant. This part of the program deals with concepts about chronic conditions, the patients, and their autonomy. Also, at this stage (second seminar in the series), students had already had time to know each other.

A briefing with the PEs was organized before the seminar to reassure them about their contribution. They believed that structuring their talk in the form of a testimony seemed appropriate. “The students meet someone in the flesh, [...] there is no screen, [...] the spoken word heard live is more powerful than through another intermediary.” (p. 3). They thought that their testimony, based on their experience, expressed in a spontaneous, authentic, and thoughtful manner, would influence the students’ future professional activity.

During their talk, the presence of an AIT member to facilitate the session was important. “I think that there has to be a person [teaching professional] [...] We start talking, without preparation, and afterwards a person can put things in order. [...]. I think that person has to be very competent” (p. 7).

PEs thought that the expectations regarding their testimony were sometimes vague. Some appreciated the freedom they were given to organize their presentation. They generally came without special preparation and spoke spontaneously. Some brought written notes that ranged from a simple list of important subjects to be tackled, to a more elaborate document: “It’s not a thesis, but it’s still 5/6 page-long, discussing the disease from different angles” (p. 4). Some PEs were unsettled by not knowing exactly what was expected from their talk.

We’re heading into the unknown, ‘what am I going to say? Do I have to tell them about my life? My disease? My life before? What is my place?’ It is also difficult as a

patient to wonder about ‘what do I say during these talks?’. So yes, there is an element of stress (p. 17).

PEs also highlighted difficulties. They expressed the importance of talking in a comfortable environment that favours convivial discussions, and not in the university training rooms where the sessions took place. “For these discussions, we must find a new setting, maybe on sofas, more pleasant [...]. Tables and chairs, you still feel like it’s theoretical. And there is a barrier with these tables, a physical barrier” (p. 17).

The silent moments during the discussion with the students, and the fact that some students participate more than others were sometimes difficult. The discussion was occasionally unsettling: “I admit I cried in front of the students [...] you feel kind of exposed ... that’s what was difficult for me” (p. 3). Some PEs explained that witnessing and interacting with students exhausted them. “It’s always quite trying, I manage, but when I come home at night, I’m empty” (p. 15). However, several highlighted the cathartic, even therapeutic nature of this exercise; testimony frees speech.

Remuneration

The question of patient remuneration for the seminars was discussed, first by focusing on the IPS and then by widening the discussion to PE activities in general. Currently, PEs are not paid for their participation in the IPS. For many PEs it is difficult to take time off from their professional and personal lives due to the time-consuming and voluntary aspect of this involvement, thus limiting their diversity and number. “I cannot participate in all the training [i.e., IPS] sessions because it would be too time-consuming. I do it on a voluntary basis and in these occasions, I have to be replaced [at work]. I lose twice [...]. At some point, we will only have retirees in these training sessions!” (p. 5). Remuneration would allow patients to spend more time with the students and for training. “Pay, compensation, would allow us to spend more time on it, to train ourselves, to share more, to take the time to do it.” (p. 5).

Remuneration was seen as a recognition. “I find it essential; it is a recognition of the work that we do and a reward for the interest people have in our sessions.” (p. 11). PEs were generally in favour of transport and meal cost reimbursement.

However, some highlighted the potential drawbacks of remuneration. A possible profit-driven participation, to the detriment of the interest shown in student training was mentioned. The administrative burden generated by this remuneration also was a barrier. Overall, PEs’ “professionalization” may lead to losing the notion of patient. “If PEs were to become “professional”, we would have competing training organizations. It could be unhealthy and detrimental for both healthcare professionals and users” (p. 3). PEs would become professional, fully-fledged trainers, with the risk of losing the link with the reality of being a patient.

PEs’ Future Prospects and Suggestions for Improvement

Overall, PEs expressed a sense of pride and recognition in being able to provide knowledge to students, and also in fulfilling a civic duty. “ We say to ourselves, we are useful for something, we are not doomed! [...] at least our life is worth living!” (p. 18). They thought that they could contribute to improve the healthcare education system: “We are part of the health system, we feel like an actor at that moment, but not just any actor, we feel like a co-creator” (P12). One PE was not sure about the intervention impact and did not share this feeling: “I think that telling my life story doesn’t do anything for them” (p. 26). Overall, they were confident in the future of healthcare and in the students’ capacity to acquire the qualities essential for a good relationship with their patients. “I think that seeing patients who talk about their experience with chronic diseases promotes listening and curiosity in students. And listening and curiosity are two important notions for healthcare professionals.” (p. 14). Most PEs enthusiastically expressed their wish to participate again in the IPS, and even to involve

other people: “I have other friends from the association to whom I say: ‘You also can bear witness, so do it!’” (p. 3).

The students’ voluntary participation in interprofessional training was discussed. “These students are already aware [...], it’s a bit of a bias, in fact. Because the people who are in this course are not really the ones among whom we would want to raise awareness” (p. 24). Some PEs would have appreciated the presence of all students, especially those who are most reluctant to work in interprofessional settings. Moreover, compulsory participation in PEs’ interventions would emphasize the importance of integrating patients in the healthcare system. Others thought that making it compulsory would increase the risk of losing the students’ motivation linked to the voluntary participation, and this could make more difficult the PEs’ intervention. “This is also what I appreciate when I participate, I tell them the door is wide open, you can leave when you want. [...] You cannot impose on students, otherwise they don’t internalize the learning and they don’t build anything” (p. 17) PEs suggested reorganizing the course into two parts: a compulsory first part to arouse the students’ interest and an optional second part to deepen their learning, if they wished.

Many PEs wondered how the students perceived their intervention, in the short and long term. “

[questioning the interviewer] This is what I wanted to give to you, is it pleasant for you? and what are you doing with it [...] And how are you going to integrate this testimony with other experiences that you are going to have? (p. 3).

Some questioned the importance of a post- intervention feedback. “The evaluation is very important in fact [...] it allows us to understand whether our participation is really worthwhile” (p. 17). Thus, they regretted not having the students’ opinion on the value of their testimony. “We give a lot of ourselves [...] it’s a lot of emotion, and in fact we don’t get any feedback, so it’s a shame” (p. 24). Some participants saw this as a lack of reciprocity.

“It’s a great experience, but I’m still hungry [...]. I know I’ve been sowing, but what did I reap? At what point did I enrich myself?” (p. 28). The interviewees suggested that this constructive feedback step could take place immediately after the exchanges, but also through evaluations (e.g., a questionnaire) accessible to the PEs. This feedback would provide both a concluding reflection for the students and a form of recognition for the PEs.

PEs wanted to be included before the intervention to co-create the course and considered it fundamental to the project success. PEs would like to be part of the academic team, like other AIT members, in order to contribute to IPE program development. The objective was to encourage the patients’ involvement by including them from the project start and to enrich the training with their different points of view.

The interventions should be organized in advance with the patients, so that it is a co-construction. [...] What do we, as patients, have to say to these future healthcare professionals and what do the trainers want to do with this seminar? How can we work together to make it an enriching time?(p. 8).

The PE testimony was a catchy way of learning, of understanding the experience of living with a disease, but some PEs found it insufficient. “It’s just a mind opening, I think. However, is it enough? I don’t think so” (p. 3). Interviewees proposed an observation period with patients or patient organizations for students. Another suggestion was to set up a mentorship in addition to the IPS to consolidate what has been learned. “Why not maintaining some kind of interaction, as equals [...], for those who want it?” (p. 12). PEs thought that it would be interesting for interprofessional groups of students to have a patient-referent after the IPS in order to emphasize the importance of the patients’ experiential knowledge.

Discussion

This qualitative study provides pertinent insights into PEs’ integration in an IPE program. PEs who chose to be involved in the IPE program had a specific profile. They were

motivated by a sense of civic service, had well-developed communication skills, and were prepared to share their experiential knowledge with students. Despite their motivation to participate in this IPE program, they expressed some fears about their capacity to express themselves in front of students and the need to consolidate their involvement within a structured partnership that involves briefing, collaboration, remuneration, and feedback. They also proposed to establish compulsory interprofessional training for all students and to strengthen the collaboration between an interprofessional student group and a PE after the IPS session. The enrolled PEs were relatively homogeneous in terms of socio-economic backgrounds or professions. Nevertheless, they insisted on the need to vary the patient profiles involved in IPE. They were all involved in disease awareness training in their patient associations and were highly educated with excellent verbal skills.

The Cambridge framework provides some guidance for involving PEs through four questions: Who will be the PE?, How will the PE be included?, What will be the content of the PE session? Where will it be? (Spencer et al., 2000). The first question helps the AIT to understand that students need to become familiar with a “representative societal sample” during their cursus. In IPE programs, it seems important that different PEs who represent the different components of society should participate to allow students to meet different patient profiles. Romme et al. (2020) stressed the need to diversify the patient profiles in IPE education, to enable students to understand each patient’s unique opinions, needs, and preferences. However, putting together a PE population with diverse characteristics (e.g., age, gender, socioeconomic and education level, sexual orientation, ethnic origin) is complicated (Rowland & Kumagai, 2018).

An additional feature to consider is the type of PE medical conditions. For instance, involving PEs with mental health problems is more difficult because they need to overcome barriers, such as the frequent stereotypes about mental health disorders, medical jargon, a

form of hierarchy between conditions, and their integration difficulties. These elements may limit the participation of some patients (Basset et al., 2006). Also, patients from different geographical and socio-economic locations should be included (Rowland & Kumagai, 2018). This diversity must be considered not only during the IPE program, but throughout the students' curriculum.

As PEs have only recently been integrated in healthcare training in France, there is no organized patient recruitment strategy. Compared with other European countries, such as the United Kingdom where the patients' participation in teaching was already recommended in 2009 (General Medical Council (Great Britain), 2009), in France, there was no official recommendation before the current healthcare reform (Ministry of Solidarity and Health, 2019). However, some local initiatives have been developed before this last reform, such as the IPS and the patient partner program at Paris 13 University (Aires et al., 2019).

Ensuring that PEs feel confident is another key point for the project success (Flora et al., 2016). The PEs involved in this study stressed the importance of feeling valued before their testimonial (being welcomed and given a briefing), during their conversation (clear instructions and collaboration), and after (with feedback and remuneration for their participation). This is in line with a 2020 literature review on the importance of properly informing PEs about the aim and timing of their participation (Romme et al., 2020). PE training is debated both in our study and more generally in the literature (Jha et al., 2009). As currently there is no recommended training framework for PEs, individual training must be considered. The issue of fair remuneration must be addressed. In our study, this point was not consensual. Some PEs considered remuneration as a recognition, whereas others were against and mentioned the administrative burden or profit-driven interventions as reasons for their opposition. Remuneration could be discussed to acknowledge the PEs' contribution and to cover the expenses related to their participation (Tew et al., 2004).

The PEs interviewed in our study highlighted their interest in participating in healthcare student interprofessional training and in actively strengthening their place within the teaching organization. Within the studied IPE program, the PE session was limited to their experience and perception of interprofessional collaboration within healthcare teams. According to the literature on PEs' integration in the healthcare professionals' education, PE involvement in our study was low level (Spencer et al., 2000). However, the interviewed PEs would have liked to have a more important place and proposed to co-construct the program. It has been already suggested that PEs within a training team should be involved from the program start, and their place within the university should be strengthened (Pomey et al., 2015). For instance, Montreal University has given to PEs significant responsibility in constructing a student training course and established a Directorate of Collaboration and Patient Partnership that allowed adapting the health science courses (Karazivan et al., 2015).

In our study, PEs emphasized two important areas for development: (a) continuing and supporting interprofessional collaboration between PEs and students, and (b) developing new forms of partnership, particularly mentoring. As highlighted by Romme et al. (2020), PEs generally support the importance of learning about interprofessional collaboration among healthcare students. The patients' integration in IPE lead students to be aware that integrated care and collaboration between healthcare professionals are essential. Students who participated in the IPS highlighted that meeting PEs was an opportunity to understand how patients live with their disease and what they expect from an interprofessional healthcare team (Fiquet et al., 2015). Faced with the challenge of developing interprofessional collaboration training to improve the healthcare system, the PEs' willingness to be involved in IPE programs is an opportunity for future healthcare providers, particularly in France where interprofessional programs are still rare. Some PEs mentioned mentoring to further advance interprofessional collaboration training. Kline et al. (2020) demonstrated that in

interprofessional student groups, patient mentoring improves their proficiency with patient-centred approaches and interprofessional collaboration. Therefore, this suggestion appears to be a particularly interesting path for IPE programs and more generally in the student curriculum.

Strengths and Limitations

This qualitative study was limited to the PEs who took part in the IPS. All involved PEs were contacted. As PEs were recruited mainly from associations, the generalization of our results to PEs who are involved in other training courses should be done with caution. The involvement of some study investigators in the IPE program (three former students: HF, MD, MP; and one trainer) may have created bias. However, the rigorous analysis and working in a team limited this issue. The researchers were aware of their involvement in the subject, but managed to take a step back in order to be as objective as possible.

Conclusion

This study highlights the PEs' desire to be more involved in IPE and to develop a genuine partnership. This raises questions about the profile of PEs to be recruited, and highlights the importance of PEs' place in interprofessional collaboration training. More studies are needed on the perceptions of PEs involved in co-constructing IPE training courses, and on developing patient mentoring throughout the curriculum. The impact of IPE that integrates patients on each healthcare profession and on interprofessional collaboration should be analysed.

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Declaration of Interest

The authors report no conflicts of interest.

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Table 1

Demographic Characteristics of the Interviewed patient educators (n=32)

Patient educators	All	n=32
Sex	Men	12
	Women	20
Age (years)	30-39	1
	40-49	9
	50-59	7
	60-69	10
	70-79	4
	80-89	1
Socioeconomic group*	Technicians and associated professional employees	1
	Clerks and skill service employees	2
	Small entrepreneurs	3
	Other persons outside the labour force	6
	Professionals	8
	Retired persons	12
PE status	Disability	1
	Caregiver	2
	Chronic diseases (diabetes, rheumatic disorder, ear nose and throat pathology)	29

*based on the European Socio-economic Groups.

Table 2.*Interview Guide*

- 1) To start our discussion, could you please introduce yourself?
- 2) Can you tell me how were you invited to participate in this program?
- 3) What were your expectations or fears before you started your intervention?
- 4) Can you tell me how the meetings with the students were organized?
- 5) How did you feel during the sessions, did they meet your expectations?
- 6) How do you think we can improve these exchanges?
(Before, during, and after the meetings)
- 7) What place do you think patients should have in interprofessional education and in the education of healthcare professionals?

Table 3.*Themes*

Themes	Sub-themes
PEs' profiles and skills	
PEs' motivations and fears	
PEs' perspectives about the sequence	Reception
	Participation sequence
	Remuneration
PEs' future prospects and suggestions for improvement	