Family physician preceptors' conceptualizations of health advocacy: implications for medical education

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Family Physician Preceptors' Conceptualizations of Health Advocacy: Implications for Medical Education

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Abstract

Purpose
Despite its official acceptance as an important physician responsibility, health advocacy remains difficult to define, teach, role model, and assess. The aim of the current study was to explore physicians' conceptions of health advocacy based on their experience with health-advocacy-related activities.

Method
In 2012, the authors conducted 11 semistructured interviews with family physician clinical preceptors and analyzed the interviews in the tradition of phenomenography.

Results
The authors identified three distinct but related ways of understanding health advocacy: (1) *Clinical*: Health advocacy as support of individual patients in addressing health care needs related to the immediate clinical problem within the health care system, (2) *Paraclinical*: Health advocacy as support of individual patients in addressing needs that the physician preceptors viewed as peripheral yet parallel to both the health care system and the immediate clinical problem, and (3) *Supraclinical*: Health advocacy as population-based activities aimed at practice- and system-level changes that address the social determinants of health.

Conclusions
The qualitatively different understandings of health advocacy shed light on why current approaches to defining, teaching, role modeling, and assessing health advocacy competencies in medical education appear idiosyncratic. The authors suggest the development of an inclusive and extensive conceptual framework that may allow the medical education community to imagine novel ways of understanding and engaging in health advocacy.

Health advocacy—widely recognized as an important responsibility of physicians—is, along with other related concepts (e.g., health promotion), a core outcome in many official medical education frameworks internationally.[1–4] For example, the Royal College of Physicians and Surgeons of Canada names "Health Advocate" as one of seven key physician roles in its CanMEDS framework.[1] Likewise, in the United States, the Accreditation Council for Graduate Medical Education (ACGME) includes health advocacy activities within one of its New Accreditation System milestones, "System-Based Practice."[2] Although the language and semantics are slightly different, both Tomorrow's Doctors,[3] produced by the General Medical Council in the United Kingdom, and the Tuning Project in Europe[4] include capabilities and activities related to health advocacy.

However, despite the inclusion of health advocacy and related concepts in official medical education documents, health advocacy appears to be one of the more difficult of the competencies to define, to teach explicitly, to role model, and to assess.[5,6] Perhaps one reason for this difficulty is the lack of a common understanding of health advocacy, even amongst those who are tasked with teaching and modeling it for the next generation of physicians. An appreciation of the different ways that clinical preceptors conceptualize and frame health advocacy—and of how these viewpoints are similar and different not only from one another but also from the roles ascribed to health advocacy in the literature and in existing educational frameworks—will be useful. Such an appreciation will allow medical educators to better articulate the concept of health advocacy in education and, subsequently, to enhance its actualization in practice.

The aim of our study, therefore, is to explore family physician preceptors' conceptions of health advocacy and of the practical activities they identify as exemplifying the physician's role as health advocate. Our premise is that practicing physicians who are also clinical teachers are well placed to inform the thinking around and practical applications of health advocacy and to help delineate the possible scope of physician responsibilities around this role. An examination of the concept of health advocacy—based on constructs described by, and seen as meaningful to, clinical preceptors—can help medical educators more clearly delineate the range of ways in which to define, teach, role model, and assess health advocacy.

The literature exploring the challenges of health advocacy falls into two domains: (1) debate about its definition and (2) exploration of differences in perspectives regarding the scope of physicians' role in health advocacy and social responsibilities. Both of these issues (definition and scope of responsibility) are of consequence in medical education. With respect to definition and scope, there is little clarity of what the role entails in practice, particularly given the wide range of potential activities and applications.[5] In

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her 2005 study, Oandasan[7] categorizes health advocates as, from the viewpoint of physicians, either "indirect change agents" or "direct change agents." As *in*direct change agents, physicians provide evidence-based health-related information by, for example, writing letters, completing health information forms, or making phone calls to other care providers and agencies involved in decision making that affects the patient. An example of an *in*direct change agent activity is filling out forms to help a patient obtain coverage for medication that is not normally paid for by the government. As direct change agents, physicians may be involved in uncovering, disseminating information about, reacting to, and proposing or planning a response to a concern within the community. They may, for instance, work to help organize a community to campaign for changes to legislation regarding bicycle helmet use.

Dobson and colleagues[8] have also suggested that the function of the physician as a health advocate entails two distinct but related roles ("agent" and "activist"), each entailing different goals and requiring unique skill sets. A physician acting as "agent," for example, assists an individual patient in navigating or "working the system"[8] (e.g., making a phone call to get an MRI done more urgently for a patient). This role is familiar to most physicians because it invokes a conventional element of the physician–patient relationship and ethical practice.[9] A physician acting as "activist," on the other hand, might address issues influenced by the social determinants of health, with the goal of creating system-level changes that go beyond the individual doctor–patient relationship. Dobson and colleagues,[8] however, note that "activism" is not merely "agency on a grander scale" in that each requires unique competencies.

Within the context of activism, the notion of political advocacy is particularly contentious as illustrated by the ongoing debate around whether it is a role that all physicians ought to undertake or whether it is in fact beyond the scope of the physician's social contract.[10–12]

Additionally, some have suggested that health advocacy belongs in further specialist education, such as in public health training.[10–13] Despite the growing literature on physician advocacy, including at least one proposed health advocacy curriculum,[14] it remains unclear who ought to take responsibility for governing and organizing health advocacy activities, particularly in relation to systems-level changes: Is it the responsibility of individual physicians, subgroups within the medical profession, the medical profession as an entity, the health care system, policy makers, community organizations, some level of government, or a combination of these stakeholders? What *is* certain is the growing interest around the physician's role as health advocate and the emerging realization that removing barriers to good health cannot exclude the physician. Physicians must have a role in shaping the broader factors that influence health outcomes.[5]

Method

We employed phenomenography[15,16] to explore the qualitatively different ways in which family physician preceptors conceptualize health advocacy. This emerged as the ideal methodology for two main reasons: (1) An empirical approach providing perspectives on the physician's role in health advocacy is absent in the literature; and (2) it focuses on the variations among different ways of conceptualizing health advocacy that are inductively derived from the data, and thus results in a range of related understandings of health advocacy. Phenomenography, as a methodology, is also particularly helpful for research in health care and medical education for illuminating how a particular phenomenon is conceptualized on the basis of the lived experience of various actors, which can differ significantly both among and within groups of patients, trainees, physicians, and other health care professionals.[17]

Following ethical approval from the Behavioural Research Ethics Review Board of the University of British Columbia (UBC), in 2011, we identified potential study participants from a group of family physicians based at the UBC Department of Family Practice. All had roles as postgraduate preceptors. We invited the preceptors to participate through a letter. We employed purposeful sampling, inviting both men and women and physician preceptors whose length of time since graduation and patient populations varied. We did not offer any incentives to participate, and all participants provided consent. We both audio recorded and transcribed the interviewers, removing all identifiers. We decided to interview family physicians because of their role in primary care and their longitudinal relationships with patients, and we thought the first author's position as a family physician would provide a unique insider perspective. Finally, we chose physicians working as clinical preceptors because of their basic familiarity with education frameworks and terminology. Although, as mentioned, the participants included men and women, physicians whose length of time in practice varied, and physicians who worked with a variety of patient populations, we limited the participants to a relatively homogenous group to enable in-depth investigation.

Data collection

The first author (M.M.H.) conducted all of the individual, face-to-face, semistructured interviews. Each interview opened with a discussion about the research goals, followed by a set of open-ended questions about the meaning of health advocacy and the physician's corresponding experience and activities. M.M.H. explained to the participants that we were not seeking one truth and that answers would not be judged as right or wrong. She explained that, instead, we were searching for a range of perspectives, each based on the unique experiences of physicians. That is, we wanted to know what individual practicing physicians considered contextually relevant, meaningful, and practical.[17]

Examples of some of the open-ended questions and prompts used in the interview include the following: "I would like to explore what the notion of family physician as health advocate means to you," "Describe a colleague who is a health advocate," "What best practices can family physicians aspire to with respect to health advocacy?" and "Would you describe yourself as a health advocate? Why/why not?"

After discussing their views on physician advocacy, the participants were presented with the CanMEDS[1] Health Advocate role definition and competency list, and to stimulate further discussion about health advocacy, M.M.H. asked them to identify phrases that were striking or challenging for them.

Data analysis

Analysis of transcripts followed a seven-step approach as proposed by Dahlgren and Fallsberg.[18] First, we read

Table 1

Characteristics of Family Medicine Preceptors Who Participated in a Qualitative Study Examining Their Perceptions of and Experiences With "Physician Advocacy," University of British Columbia, 2012

Characteristic	No. (% of 11)
Gender	
Women	4 (36)
Men	7 (64)
Practice location[a]	
Urban	10 (91)
Suburban	1 (9)
No. of years since graduation from medical school	
≥ 41	1 (9)
31–40	5 (45)
21–30	1 (9)
11–20	2 (18)
≤ 10	2 (18)

[a]The authors defined "urban" and "suburban." The latter refers to the suburb of a large city.

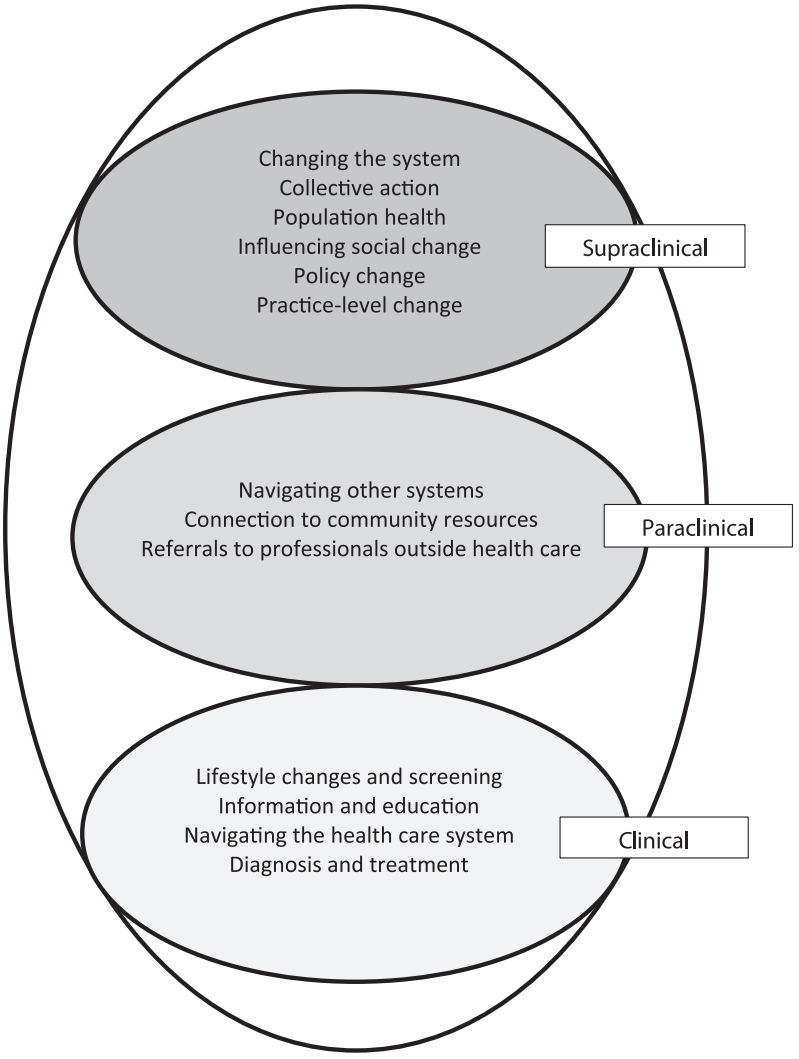

Figure 1 Conceptualizations of health advocacy of family physician preceptors (n = 11), 2012: (1) clinical, (2) paraclinical, and (3) supraclinical.

all transcripts several times, considering all of them equally. Next, the first author (M.M.H.) extracted categories of meaning (e.g., lifestyle changes) from the transcripts and identified similarities and differences between these categories. After comparing the categories, she grouped similar categories together. Next, the full research team negotiated the basic meaning and content of each group. Then, the team discussed the final groups and the relationships among them, resulting in minor changes in the description of the groups and rewording of categories within these groups. These steps were then repeated iteratively to ensure that similarities within (and differences among) the groups were clear. The three investigators also engaged in peer debriefing for testing the findings and asking questions.[17]

The research team consisted of a family physician preceptor and qualitative researcher who conducted the interviews and did the preliminary analysis (M.M.H.), an experienced qualitative researcher who confirmed the methodologic integrity and rigor of analysis (R.A.), and a content expert and scholar in the field of health advocacy research who verified the analytic process and made links to and identified connections with the wider literature (S.D.).

Results

Participants and interviews

We interviewed 11 family physician preceptors (see Table 1 for demographic information). No new ideas were emerging in the last interview, suggesting that we had reached thematic saturation and had gained an adequate depth of data and range of experiences.[19] The interviews were, on average, 48 minutes in length (range 28–76 minutes).

Understandings of health advocacy

Three distinct but related ways of understanding health advocacy emerged from our analysis: clinical advocacy, paraclinical advocacy, and supraclinical advocacy (Figure 1).

Clinical advocacy. One way of understanding health advocacy that emerged from the physicians' descriptions of their experiences related to their clinical work—that is, health advocacy as support of individual

Table 2
Themes and Supporting Quotations Within the Conception of Health Advocacy, as "Clinical Advocacy"[a]

Theme	Supporting quotation (Participant identifier, gender)
Diagnostic and therapeutic care	[T]o help people through the system in terms of making a diagnosis, dealing with their concerns … then helping them with the process of actually getting treatment, whatever it is. (FP8, male)
Referral to other health care professionals	[Y]ou've got a patient who you would like to see a back surgeon … so that might mean making sure the referral goes to the right place, or maybe making a phone call or whatever that involves. (FP1, male)
Navigation of the health care system	It would involve helping the patient navigate the system and getting them to where they need to be. (FP4, male)
Provision of information and patient education	[P]eople ask me questions, talk about flu shots, you know, basic things. I don't do a health talk for everybody, but if they ask questions—we make sure that we help to promote things that are important. (FP2, female)
Recommendation of lifestyle modifications and healthy behaviors	[P]romoting an active lifestyle and specifics on exercise, diet, preventative screening, preventive tests, what else. I guess, yeah, maintaining a healthy body weight and how to get around to that. If they're on the brink of any sort of chronic disease, yeah, well, basically healthy lifestyle is, I guess, the big one. Alcohol and smoking screening, and then counseling on quitting and—or cutting back. And I guess safe sex education. (FP11, female)
Recommendation of screening tests	While you're doing a physical you can point out … the age that they're at and the appropriate screening tests that should be done. (FP11, female)

[a]The authors interviewed 11 family medicine preceptors from the University of British Columbia in 2012 regarding their perceptions of and experiences with "physician advocacy." One conception (of three) was "clinical advocacy" or "support of individual patients in addressing health care needs related to the immediate clinical problem within the health care system."

patients in addressing health care needs related to the immediate clinical problem within the health care system.

Physicians with this perspective understood health advocacy as any activity related to the clinical encounter with an individual patient. It involved addressing factors that affect individual patients' health and well-being within the context of clinical care. Activities representative of this conception, as named by our participants, were ensuring access to appropriate diagnostic and therapeutic care (including referrals to other health care professionals as needed), providing information and patient education, and making recommendations for lifestyle changes and for screening tests (e.g., mammography). Physicians understood their areas of expertise and obligations as health advocates to be confined to the clinical care of individual patients, and health advocacy included promoting healthy behaviors and reducing barriers to medical care (Table 2).

Paraclinical advocacy. Another distinct category of understanding related to health advocacy included supporting individual patients in addressing needs viewed as peripheral but parallel to the health care system and the immediate clinical problem. For our participants, paraclinical advocacy entailed attending to broader issues that may affect health outcomes by, for example, navigating systems such as social services, filling out forms for special services, and connecting patients with community resources (Table 3).

Supraclinical advocacy. Finally, some of our participants conceptualized advocacy as engagement in population-based activities aimed at practice-level and systems-level changes. Health advocacy within this context was focused on addressing the broader social determinants of health. Experience with health advocacy, according to this category of understanding, required active engagement with various groups and organizations dedicated to population-level initiatives. Representative activities included considering one's practice from a population health perspective (e.g., performing reviews of health indicators such as percentage of women patients obtaining Pap smears), joining existing organizations with an advocacy mandate, influencing public policy, and creating change at a system level, such as developing policies regarding health care benefits for refugees (Table 4).

Interactions among understandings of health advocacy

Having an understanding of health advocacy as engaging in primarily supraclinical activities was incompatible with an understanding of health advocacy as engaging in exclusively clinical activities. Although all of the physicians interviewed agreed that the activities described in the clinical category were critical and important components of good medical care and essential to "being a good doctor," some preceptors described activities related to clinical health advocacy but did not enact or mention supraclinical health advocacy. Some of those who saw health advocacy in the supraclinical domain did not recognize any of the purely clinical pursuits as bona fide health advocacy activities. To illustrate, one female participant noted, "Responding to individual patient needs, to me it's almost like this [shouldn't be] considered advocacy because to me this seems like good … medicine."

Upon being presented with the CanMEDS description of health advocacy, preceptors recalled additional experiences that supported the conception of health advocacy they had already described; none of the preceptors reported a significant change in their understanding of health advocacy, and none recalled experiences that were related to a different conception of health advocacy. The participants' conceptions of health advocacy did not appear to be correlated with their gender, their length of time in practice, or their patient population.

Table 3

Themes and Supporting Quotations Within the Conception of Health Advocacy, as "Paraclinical Advocacy"[a]

Theme	Supporting quotation (Participant identifier, gender)
Navigating systems outside the health care system	[F]inding out … the relevant health needs which are often beyond sort of the science and more the … social model … helping patients navigate the social system … in terms of patients who require EI[b] or welfare or health and housing and disability forms. (FP3, female)
Being aware of and using community resources, agencies, and assistance	You got to maximize the access to groups and resources that are in the community. You have to have an awareness of them. So that you know which patients of yours might seek them out or might benefit from them or might continue with these various programs. (FP4, male)
Filling in special forms (e.g., special authority, disability)	[H]ow to fill out a disability form and what other services are available. And help build a … list of contacts within the social services that are useful … to be aware of. (FP3, female)

[a]The authors interviewed 11 family medicine preceptors from the University of British Columbia in 2012 regarding their perceptions of and experiences with "physician advocacy." One conception (of three) was "paraclinical advocacy" or "support of individual patients in addressing needs that are peripheral, but parallel to the health care system and the immediate clinical problem, addressing broader issues that may impact health."
[b]EI indicates Employment Insurance: temporary financial assistance for individuals who are unemployed.

Discussion

Our empirical study explored family physicians' conceptions of health advocacy, which various licensing and accrediting bodies around the world recognize as fundamental for medical practice[1–4] but do not consistently define. Our empirical findings provide insight into the range of ways in which family medicine preceptors conceptualize health advocacy; they uncover critical differences in conception, and they suggest a broader conceptual framework for thinking about health advocacy activities—all novel contributions to the current literature.

Three different conceptualizations of health advocacy emerged: clinical, paraclinical, and supraclinical. Although each approach conveys components of good patient care (and thus, none is better or more important than another), one of our key findings is that the different understandings of health advocacy among clinicians do not overlap. This lack of consensus possibly explains why defining, teaching, role modeling, and assessing health advocacy in medical education appears to be idiosyncratic[7,13,20]—that is, training in physician advocacy is likely conditional, dependent on the qualitatively different understandings held by the preceptors who are doing the training. More important, health advocacy is not consistently defined either across or even within competency frameworks. For example, the ACGME states that graduates should "advocate for quality patient care and optimal patient care systems."[2(p10)] It is unclear whether this guideline means that residents should ensure that an individual patient in a clinic setting gets appropriate health care, or if they should lobby for an overhaul to public health care systems. Oandasan[7] similarly alludes to a problematic dichotomy by which health advocacy is either assumed to take place simply because physicians work in a helping field *or* it is deemed beyond the call of duty and thereby the responsibility of just a few outstanding physicians.

Unpacking how health advocacy is understood and enacted by practicing physicians in the community is critical to the development of educational frameworks. Practitioners require guidelines not only to be clinically relevant, doable, and meaningful but also to lead to improved patient and population health outcomes. Given that residents spend the majority of their graduate training with practicing physicians—that is, with clinical preceptors who act as role models, coaches, and teachers—medical education frameworks need to be more explicit about the intended meanings and actions of health advocacy. Medical educators can use these preceptor conceptualizations that we have uncovered to elaborate on what they mean by advocacy, and to integrate these various constructs in a way that is consistent and compatible with clinical practice. Further, medical educators can use the understandings and language reported here, the working conceptualizations of preceptors who successfully combine advocacy with clinical practice, to avoid the unhelpful duality highlighted by Oandasan.[7] Specifically delineating what we physicians mean when we say "to advocate" will be helpful; do we mean to help, to support, to lobby for, to speak on behalf of, to enact practice improvements, or something else? Once we have agreed on operational definitions, we can begin to understand the related activities that are associated with day-to-day clinical work, and we can begin to teach the next generation of physician advocates.

Connections to previous literature

Toward the goal of a common understanding, we have reviewed our findings in light of earlier literature. Specifically, the notion of health advocacy as a *clinical* activity, as described by our family physician preceptors, reflects or echoes Dobson and colleagues'[8] conceptualization of the physician as "agent," and the types of activities described within this role (e.g., helping an individual patient obtain needed services). The corresponding "activist" role appears to be parallel to the *supraclinical* understanding of health advocate (e.g., working toward system-level change, influencing the social determinants of health). Where *paraclinical* activities fit within this binary division is not entirely clear and warrants further study. One might suggest that paraclinical activities are "agent" activities that also work as a bridge toward "activist" activities.

In comparison, the "indirect change agent" described by Oandasan[7] performs what we have described as *paraclinical* and/or *supraclinical* activities, whereas her "direct change agent" is likely to be directly involved in *supraclinical* activities either alone or as part of a group. Per Gruen and colleagues,[10] "physician obligations" include caring for individual patients, addressing access

Table 4

Themes and Supporting Quotations Within the Conception of Health Advocacy, as "Supraclinical Advocacy"[a]

Theme	Supporting quotation (Participant identifier, gender)
Consideration of practice needs from a population perspective	Often [advocacy] is in response to common issues that a family doc might be seeing in a practice. So perhaps an occupational injury that's popping up frequently.… There's more of an ability to begin to look at care for marginalized populations, hard-to-serve populations … there's better opportunity now to advocate for even people within your own practice that you're not seeing very often [who] for a variety of reasons, just can't make it in. For economic reasons. For work pressures. For all those sorts of things. (FP7, male)
Collective action/joining organizations with advocacy mandate	Not only do people do their clinical work, but outside of that, they [are] engaged in advocacy … some physicians put on their coats and stethoscopes and all went and occupied a local MP's office.[b] And then that movement has gone across Canada and there's been this e-mail network of 40 to 50 health care practitioners who are really advocating at the political level for changes to the system … they were getting residents and medical students involved … creating awareness about this issue and showing that it's okay for health care practitioners to devote their time in this area. (FP3, female)
Population health strategies	It's a multilayered concept … we actually have a responsibility at the level of the collective of our patients, and beyond that, at the level of the community in which that collective of patients is embedded and the influences on the health of that community, then we get into more of the realm … what you would generally call population health. (FP10, male)
Impact on public policy	Well, you know, I think the notion that it's patients and communities and populations, is really important. And then I think the notion of influencing population health and public policy, is important. (FP7, male)
Public education	In the theoretical roles of family doctors we have the … public educator role and that kind of thing. I think that is worn comfortably by some and not by others. (FP8, male)
Action to improve the social determinants of health of populations	So social responsibility and … social determinants is … part of an overlapping kind of Venn diagram in a sense that through us—our social responsibility is dependent on social determinants in a broader way than simply through medicine. (FP9, male)
Use of influence for social change	Medicine has a privileged position and in that sense there's a social responsibility to not simply take advantage of that, but to use its position, its knowledge, energies that people have in the field, connectiveness … to try to advance the well-being of society in a broader sense. (FP9, male)
Improvement of the delivery of health care services	So I've never really been interested in research necessarily for research's sake, but … how it may improve patient care, improve health service delivery. So for my own purposes that's how I see my role as an advocate. (FP3, female)

[a]The authors interviewed 11 family medicine preceptors from the University of British Columbia in 2012 regarding their perceptions of and experiences with "physician advocacy." One conception (of three) was "paraclinical advocacy" or "engagement in population-based activities aimed at practice-level and systems-level changes."
[b]MP indicates a Member of Parliament: a local, elected representative to the Canadian government's House of Commons.

to care, and influencing socioeconomic factors directly linked to health (e.g., public policy related to smoking); thus, the *clinical* and *paraclinical* activities described in our study fit better within Gruen and colleagues' articulation of "physician obligations." Even some of the *supraclinical* activities described by our study participants (e.g., becoming involved in creating a public policy around bicycle helmet use) would be considered "physician obligations" in Gruen and colleagues' model. Other *supraclinical* activities (e.g., action to reduce exposure to environmental pollutants), that fall within Gruen and colleagues' domains of "broad socioeconomic" or "global health influences," would be considered "physician aspirations."[10] These broad domains and levels of activity suggest that individual physicians may be responsible for some, but not all, supraclinical activities.

Theoretical connections

Carlisle's theoretical model on health promotion, advocacy, and health disparities[21] can work as a lens through which to view the various understandings of health advocacy described by family physician preceptors in our study. Carlisle suggests that health advocacy can be located on two axes: The horizontal axis has the goals of empowerment and facilitation at one end, and the goals of protection and prevention at the other; the vertical axis has individuals and groups at one end, and policy and structure at the other (see Figure 2).

The model divides health advocacy into four sectors: (1) Representation, (2) Community Development, (3) Community Activism, and (4) Social Policy Reform.[21] The *clinical* and *paraclinical* perspectives of health advocacy map largely onto the Representation quadrant but can also overlap with the Community Development and Social Policy Reform quadrants. The focus of the physician health advocate is on individuals or groups of patients with the goal of protection and prevention by prescribing behavior and lifestyle changes and providing health education information; it also includes speaking *for* others to obtain health needs they are unable to attain on their own. In contrast to maintaining an exclusive focus on individuals, the goals of Community Development are empowerment

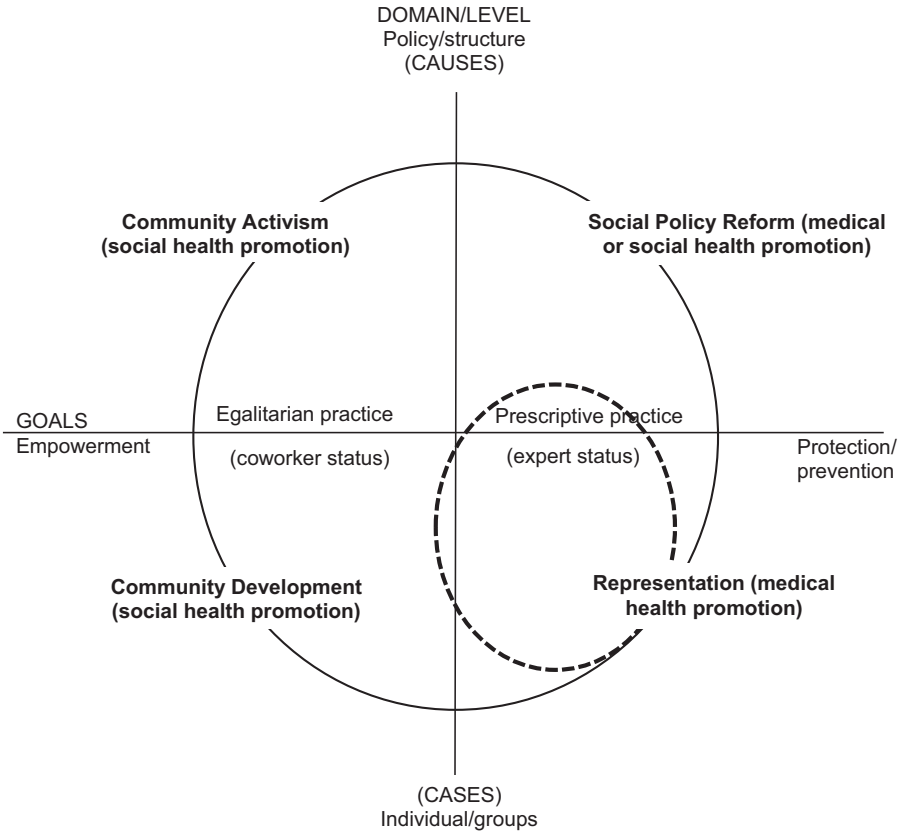

Figure 2 Conceptualization of health advocacy mapped to Carlisle's framework. Conceptualizations of health advocacy of family physician preceptors (n = 11) fall mainly within the area represented by the dotted circle. Carlisle's original figure does not include *facilitation*, although she does describe this in the text of the article. *CAUSES* refers to movements or policies or fields, whereas *CASES* refers to individual patients or groups. The framework is adapted from Carlisle S. Health promotion, advocacy and health inequalities: A conceptual framework. Health Promot Int. 2000;15:369–376. Printed with permission from Oxford University Press.

and community contribution. The Community Development approach has been criticized for having a paternalistic orientation—hence the current emphasis on ensuring that the community itself is involved both in defining its health needs and in designing solutions. Practitioners act more as peers, guiding and working alongside community members, than as experts, directing the health needs of the community. The *supraclinical* conception of health advocacy maps more closely toward the Community Activism and Social Policy Reform quadrants. Community Activism aims to address sources of health inequities by empowering the community to advocate for policy and organizational or structural changes. Partnerships between communities and organizations and coordination between health and other sectors are fostered. Social Policy Reform–oriented advocacy includes the goals of minimizing health inequalities through social organization and policy-level changes, and it involves the medical practitioner health advocate as the expert who has the knowledge and authority to lead reform efforts.

Carlisle's model[21] allows us to situate the health advocacy conceptions, experiences, and activities of the family physician preceptors we interviewed in a more comprehensive framework of activities occurring within medicine, across the health care sector, and in other domains (e.g., community organizations). The model challenges physicians and medical educators alike to think past the limited biomedical definition of health and the relatively narrow classification of health advocacy that is traditionally considered within medicine. It also makes explicit where the health advocacy activities of physicians fit within the road map of health advocacy, such that these activities are considered both part of other medical activities and integral to the world beyond medicine and medical education. It may also reduce any perception among physicians that each must be an effectual *singular* voice for change—that each is exclusively and individually responsible for health advocacy. Further, the Carlisle model[21] may illuminate for the medical community where partnerships and collaborations may be developed with other groups enacting health advocacy. It does not imply that individual physicians must be responsible for activities in all quadrants, nor that physicians should be constrained to a certain type of activity. Having a better understanding of how/where our work as physicians is situated in a broader world of activism and advocacy helps define what role we should, as well as *can*, play in effecting change. A more thorough understanding may give us more specificity and precision with respect to what health advocacy means and how physicians and trainees might enact it. Further development of an inclusive and extensive framework may also allow us physicians to imagine novel ways in which the profession might understand and engage in health advocacy.

Strengths and limitations

This study has provided novel insights into how family physician preceptors understand health advocacy. Competency frameworks outline what abilities a learner needs to have by the end of training, but not how these abilities should be taught or assessed. Exploring constructs described by and seen as meaningful to clinical preceptors will help medical educators more clearly delineate the range of ways in which health advocacy can be defined, taught, role modeled in practice, and assessed.

We note some limitations to this study. We cannot exclude that the first author's familiarity with the work of some of the preceptors could have affected data collection; however, we framed the questions such that there was no right or wrong answer, and we emphasized that the purpose was to explore the range of experiences and activities of the preceptors. It was conducted at only one institution in order to enable in-depth exploration of health advocacy. Further, 10 of the 11 family physician preceptors who participated were based in an urban setting (one was in a suburban setting); thus, although the group was diverse with respect to patient population, length of time in practice, and gender, our results may not be generalizable to other physician

specialties or practice settings. Further, to keep our sample size manageable for our in-depth study, we did not consider other demographic variables such as ethnicity, country of medical education, or religion that may have increased the diversity of the sample and, in turn, the generalizability of our findings.

Conclusions and future research directions

This study analyzed the qualitatively different ways that a small group of family physician preceptors in one family medicine postgraduate program conceptualized health advocacy. It illuminates why current approaches to defining, teaching, role modeling, and assessing health advocacy competencies in medical education appear idiosyncratic.[7,13,20] The implications of our study suggest the need to be explicit about the set of activities that are considered within the health advocacy competency framework. Although the literature does describe barriers and challenges to health advocacy activities, an important next step will be to examine why and how the advocacy experiences of physicians affect their understanding and their ability to overcome challenges related to health advocacy. Further research in this area can be designed to elicit the understandings and activities of other physicians (those in rural settings, specialists, etc.), of other health professionals, and of community organizations with an advocacy mandate so as to identify areas of potential knowledge translation and collaboration across groups. The further development of an inclusive and extensive conceptual framework may allow the medical profession to imagine novel ways for understanding and engaging in health advocacy.

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References

1 Frank JR, ed. The CanMEDS 2005 Physician Competency Framework. Ottawa, Ontario, Canada: Royal College of Physicians and Surgeons of Canada; 2005.
2 Accreditation Council for Graduate Medical Education. ACGME Common Program Requirements. Effective July 1, 2013. http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/CPRs2013.pdf. Accessed July 30, 2014.
3 General Medical Council. Tomorrow's Doctors: Outcomes and Standards for Undergraduate Medical Education. United Kingdom: General Medical Council; 2009. http://www.gmc-uk.org/static/documents/content/Tomorrow_s_Doctors_0414.pdf. Accessed August 18, 2014.
4 Cumming A, Ross M. Learning Outcomes/Competences for Undergraduate Medical Education in Europe. The Tuning Project (Medicine). 2007. http://www.tuning-medicine.com/pdf/booklet.pdf. Accessed August 18, 2014 .
5 Dharamsi S, Ho A, Spadafora SM, Woollard R. The physician as health advocate: Translating the quest for social responsibility into medical education and practice. Acad Med. 2011;86:1108–1113.
6 Stafford S, Sedlak T, Fok MC, Wong RY. Evaluation of resident attitudes and self-reported competencies in health advocacy. BMC Med Educ. 2010;10:82.
7 Oandasan IF. Health advocacy: Bringing clarity to educators through the voices of physician health advocates. Acad Med. 2005;80(10 suppl):S38–S41.
8 Dobson S, Voyer S, Regehr G. Perspective: Agency and activism: Rethinking health advocacy in the medical profession. Acad Med. 2012;87:1161–1164.
9 Earnest MA, Wong SL, Federico SG. Perspective: Physician advocacy: What is it and how do we do it? Acad Med. 2010;85:63–67.
10 Gruen RL, Pearson SD, Brennan TA. Physician–citizens—public roles and professional obligations. JAMA. 2004;291:94–98.
11 Kanter SL. On physician advocacy. Acad Med. 2011;86:1059–1060.
12 Huddle TS. Perspective: Medical professionalism and medical education should not involve commitments to political advocacy. Acad Med. 2011;86:378–383.
13 Verma S, Flynn L, Seguin R. Faculty's and residents' perceptions of teaching and evaluating the role of health advocate: A study at one Canadian university. Acad Med. 2005;80:103–108.
14 Flynn L, Verma S. Fundamental components of a curriculum for residents in health advocacy. Med Teach. 2008;30:e178–e183.
15 Marton F, Booth S. Learning and Awareness. Hillsdale, NJ: Lawrence Erlbaum; 1997.
16 Sjöström B, Dahlgren LO. Applying phenomenography in nursing research. J Adv Nurs. 2002;40:339–345.
17 Stenfors-Hayes T, Hult H, Dahlgren MA. A phenomenographic approach to research in medical education. Med Educ. 2013;47:261–270.
18 Dahlgren LO, Fallsberg M. Phenomenography as a qualitative approach in social pharmacy research. J Soc Adm Pharm. 1991;8:150–156.
19 O'Reilly M, Parker N. "Unsatisfactory saturation": A critical exploration of the notion of saturated sample sizes in qualitative research. Qual Res. 2012;13:190–197.
20 Leveridge M, Beiko D, Wilson JW, Siemens DR. Health advocacy training in urology: A Canadian survey on attitudes and experience in residency. Can Urol Assoc J. 2007;1:363–369.
21 Carlisle S. Health promotion, advocacy and health inequalities: A conceptual framework. Health Promot Int. 2000;15:369–376.