

From the Clinic to the Community: The Activities and Abilities of Effective Health Advocates

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Abstract

Purpose

The integration of health advocacy activities into medical training has been controversial and challenging from theoretical and practical standpoints. In part, this may be because it is unclear how such activities could be incorporated into the everyday practices of most physicians. This study explored the breadth of advocacy activities described by physicians engaged in health advocacy in order to articulate a set of activities that might be enacted regularly by all physicians.

Method

From October 2012 to June 2013, 10 physician advocates from British Columbia were interviewed. Using

transcriptions from semistructured interviews, the authors identified all advocacy activities described by participants. Employing an iterative process of individual and group analysis, the authors developed conceptual categories building on previously developed frameworks to represent the types of activities participants articulated.

Results

Physician participants identified five main categories of advocacy activities: clinical agency, paraclinical agency, practice quality improvement, activism, and knowledge exchange. These were enacted at one of three levels: individual patient, practice, and community/

system. They also identified a wide range of abilities and perspectives that they employed across all levels and activities.

Conclusions

Most activities described by health advocates at the patient and practice level (clinical agency, paraclinical agency, practice quality improvement) might reasonably be incorporated into the professional lives of all physicians if training incorporated some reorientation of perspective. Many activities at the system level (activism and knowledge exchange) perhaps require more elaborate skill development and support, which could be provided for those interested in pursuing further advocacy training.

Professional organizations such as the Accreditation Council for Graduate Medical Education¹ in the United States, the Royal College of Physicians and Surgeons of Canada² in Canada, and the General Medical Council³ in the United Kingdom, among others,^{4,5} are increasingly recognizing health advocacy as a key activity in the professional standards for physicians. These organizations are incorporating expectations about health advocacy into their competency frameworks. Advocacy is also being included in the curricular and assessment structures of many medical programs, particularly in North America.⁶ However, the integration of health advocacy in medical professional training, from both a theoretical and practical perspective, continues to be

controversial and challenging.⁷⁻¹² For example, in CanMEDS (one of the most widely adopted frameworks across the world and across professions),⁶ the Health Advocate role sets out the expectation that physicians “responsibly use their expertise and influence to advance the health and well-being of individual patients, communities, and populations.”⁷ Although the expressed intent of the CanMEDS framework is to describe “the principle [sic] generic abilities of physicians oriented to optimal health and health care outcomes,”⁷ in practice the Health Advocate role has been described by trainees as charity work or as going above and beyond regular duties.¹⁰ Further, residents trained in the CanMEDS model have indicated that they are unlikely to pursue advocacy activities once established in independent practice.¹¹ In fact, the controversy with regard to the place of advocacy in physician practice is reflected in an ongoing debate in the literature.¹³⁻²⁵

We have argued previously²⁶ that one potential source of confusion and controversy with regard to health advocacy is that the role conflates two subroles that may have different goals and

skill sets. We preliminarily framed these two subroles as the agent and the activist. To elaborate, a physician agent acts on a patient’s behalf in order to secure access to resources, facilities, and support (such as specialist care, diagnostic testing, and ancillary services). This role, therefore, involves supporting individual patients in their journey through the health care system when these patients would encounter challenges or barriers if acting independently. In this sense, the agent is supporting the patient in *working the system* or doing so on behalf of a patient when necessary. By contrast, physician activists use their “expertise and influence ... [to] change specific practices or policies on behalf of those served.”²² Activism has a quality of legacy, in that the impact extends beyond the improved health of a single patient and would ideally extend and persist beyond the efforts of the individual physician. Thus, whereas agency is about working the system, engaging in activism is about *changing the system*. This suggests that the activist subrole may have a separate set of abilities and goals associated with it that are distinct from those associated with the agent role.²⁶

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This preliminary framing of two separate subroles within advocacy raises the possibility that the main challenge associated with integrating health advocacy activities into training and practice is related to the activist subrole. That is, it may be that the activities and goals of the agent subrole are natural extensions of the clinician–patient interaction and therefore integrate well with daily clinical practice. By contrast, the activities and goals that relate to the activist subrole are less easily reconciled with, and therefore less easily integrated into, the daily activities of patient care. Thus, it is these activist activities that are more likely to be perceived as “above and beyond.”²⁶ If this aspect of health advocacy is to be effectively adopted as a part of the professional practices of every physician, therefore, it is important to understand what “everyday activism” might look like. By “everyday activism,” we mean those activities physicians engage in on a regular basis within the context of their professional role in order to contribute to system change to improve health. To this end, the goal of this study was to explore the everyday activities of physicians who are known to be activists (i.e., advocating for system change) and to better understand the skills and abilities they use, the resources they draw upon, and the ways in which they conceptualize their role. While only a small but prominent subset of physicians might be undertaking activism as the primary focus of their work, we focused our attention on a larger cadre of physicians who incorporate efforts to achieve system change within the context of their routine clinical practices. This was in an effort to better define the scope of “everyday activist” activities, and the factors that enable this type of work.

Method

Recruitment

Following approval from the University of British Columbia’s behavioural research ethics board, we used two approaches to recruit participants from October 2012 to June 2013. First, adapting a protocol conducted by Oandasan and Barker,²⁷ we purposefully sought practicing physicians known in their communities to be activists according to our definition. To this end, we generated a list of primarily urban-health-focused community agencies across British Columbia. We asked the managers of these agencies to name physicians working with them who are involved in changing

policies and practices for the benefit of the population(s) they serve.* We generated a list of potential participants based on the responses of the community organizations. The second recruitment approach was to use a snowball sampling technique asking interview participants to name colleagues who were similarly involved in advocacy activities. Our goal was to interview an even proportion of family physicians and specialists, with representation throughout the province and across years in practice. These were represented in a matrix, and potential participants who fit the requirements of the matrix were prioritized for interviews. Prioritized participants were contacted via e-mail, and each individual we contacted agreed to our request for an interview.

Participants

Of 10 interviewees, 5 were family physicians, 4 were internists, and 1 was a pediatrician. Half of the interviewees had been in practice less than 5 years, another 2 interviewees between 5 and 9 years, and the remaining 3 interviewees for more than 15 years. Nine held salaried positions, while 1 physician was remunerated in a fee-for-service model.

Interviews

Three members of the study team (S.D., S.V., or M.H.) individually conducted one-on-one semistructured interviews either face-to-face or by telephone according to the preference of the participant. The 10 interviews conducted ranged from 50 to 75 minutes in length, with an average interview length of 60 minutes. Following consent from the participant, we audio recorded interviews and transcribed them verbatim with all identifying information removed from the transcripts. After each interview, we met to review transcripts and revise the interview framework to pursue emerging concepts. Examples of the types of questions that we asked of physician participants to elicit their advocacy activities included “What does it mean to advocate for your patients? And what does it entail on a daily basis?” and “What kind of skills do you find yourself using when you’re doing advocacy work? Where did you learn those skills?”

* We recognized that the term “activist” may carry negative connotations, and rather than using the term itself, we instead described the characteristics of the physicians we were seeking (i.e., physicians involved in changing practices or policies on behalf of population[s] they serve).

Analysis

The research team, which consisted of a qualitative researcher with a master’s degree in public health (S.D.), a general internist with qualitative research experience and a master’s degree in adult education (S.V.), a family physician with qualitative research experience and a master’s degree in medical education (M.H.), and a PhD-trained researcher in medical education with experience in qualitative research studies (G.R.), reviewed the transcripts with the intention of identifying all activities listed by the physicians as they described their advocacy role, using a modified directed content analysis approach.²⁸ We then began sorting these activities into categories to identify and delineate the various ways in which the physicians made reference to and described their advocacy activities and practices. All members of the research team engaged in the development of these categories, which we identified both inductively as they emerged during data analysis and deductively from previously developed frameworks.^{26,29} The research team agreed that with the transcripts from 10 interviews there was sufficient depth of data that the likelihood of new activities or categories of activity emerging was small. At that stage we were no longer finding the need to alter the interview framework to elaborate further concepts, suggesting that the sample size was sufficient for the study.^{30,31} This is consistent with qualitative methods literature, which suggests that when exploring a topic within a homogeneous group (in this case, urban physician advocates), a sample size of 10 to 12 is often sufficient.³¹

Results

When we asked physicians about their day-to-day advocacy work, their descriptions addressed not only the advocacy activities in which they engaged but also the abilities they invoked to effectively enact those activities. The first section below, therefore, articulates the activities and the categories of activity that emerged from the analysis. The second section details the various abilities physicians invoked as they were describing these activities.

Activities

Physician participants described a wide variety of advocacy activities. These activities could be broadly classified into

five categories or types of advocacy that occurred either at the patient level, the practice level, or the community/system level: clinical agency, paraclinical agency, practice quality improvement, activism, and knowledge exchange. Each of these types of advocacy is elaborated below and summarized in Table 1. Table 1 also provides an extended list of examples of each type as described by the study participants.

Clinical agency. Physicians described advocacy focused on an individual

patient in a clinical setting addressing a specific medical issue as being an important component of their clinical activities. This included advocating for particular medical services, tests, or treatment. For example, one physician described a situation in which:

I just came off service and we were having a difficult time getting an MRI for a woman who had a spinal abscess who, you know, they—the radiologist felt didn't need it and Infectious Disease did. And so we're advocating on her behalf, trying to make the MRI happen. [P-6]

Interestingly, while most of the physicians we spoke with used the term “advocating” in this context, on further probing they did not characterize this as a health advocacy activity per se, but as basic clinical care that was just part of their job as a clinician.

Paraclinical agency. Physicians also described advocacy activities focused on an individual patient but directed toward addressing a social need that affected the patient's health. They described the importance of incorporating a patient's social context into their patient care

Table 1
Advocacy Activities Identified by 10 Participating Physician Advocates,
From a Study of Activities and Abilities of Effective Health Advocates,
British Columbia, Canada, 2012–2013

Type of advocacy	Description	Examples
Patient level		
Clinical agency	Advocacy activities focused on an individual patient in a clinical setting in order to address an immediate medical need	<ul style="list-style-type: none"> • Arranging treatment or medication not normally covered for a particular condition • Arranging urgent consultation by a specialist • Identifying and ensuring admission to ideal care setting • Arranging urgent investigations • Ensuring that treatment plan is in line with a patient's circumstances (e.g., can she or he afford medication?)
Paraclinical agency	Advocacy activities focused on individual patients in a clinical setting in order to address a social issue impacting health	<ul style="list-style-type: none"> • Arranging housing for a family dispersed through a shelter system • Communicating with/persuading social services • Mobilizing resources and support/connecting patients to services • Contributing opinion as part of health care team regarding best course of action for patient with respect to social services and support
Practice level		
Practice quality improvement	Surveillance at the practice population level and implementing changes to improve the health of a population of patients	<ul style="list-style-type: none"> • Establishing regular meetings with health care team to review patient panel and identify emerging issues (e.g., subset of patients is accessing emergency services with unusual frequency) • Using electronic medical records to monitor practice population, investigating and addressing inequities through changes to practice • Creating specialized services for a subgroup with specific unmet needs within one's practice or team • Providing evidence to support funding for a particular intervention and negotiating with one's practice partners or team to incorporate that intervention systematically within the practice or team • Producing treatment guidelines for one's practice or team
Community and system level		
Activism	Activities aimed at creating lasting change to a system or policy	<ul style="list-style-type: none"> • Raising awareness among colleagues or administrators through presentations, meetings • Writing a letter to a member of government in support of an issue • Having conversations with community members to understand needs in order to address inequities • Having conversations with “people who have their hands on the levers of power” • Championing ideas or issues/supporting the champion • Influencing decisions that are made about resource allocation • Lobbying government agencies for funding or policy changes • Founding/cofounding an association or organization
Knowledge exchange	Activities aimed at creating, disseminating, or sharing knowledge	<ul style="list-style-type: none"> • Teaching trainees about the social determinants of health (“tagging” it for them) • Discussing health issues with community groups • Writing an op/ed piece • Becoming involved in local or national organizations • Giving or moderating talks at schools or community organizations • Giving media interviews about a health topic • Researching and disseminating information (papers, conference presentations, media interviews) related to health inequities

efforts, and they sought resources outside of the health care system to improve a patient's health. For example, one physician worked to reunite a family scattered across several shelters so that a mother could administer medication to her child, who was staying with another family member at the time. The mindset associated with this type of activity was articulated by one physician who stated:

And, you know, they're lying here in the hospital, just one little line, but their life is in the white spaces between these lines, right. And so trying to appreciate what are they going home to, what's going to help them get better, what is it that we can affect. [P-5]

Notably, as with clinical agency, all of the physicians participating in this study engaged in paraclinical agency as part of their everyday professional activities and saw this as an integral part of their role. As such, they considered it an important patient care activity for all practicing physicians.

Practice quality improvement.

Several physicians described quality improvement of their medical practice as a key element of their advocacy activities. These activities were often done in conjunction with the entire practice team, particularly in practices that conducted regular reviews of their patient population. The distinguishing feature of advocacy at this level was that practice quality improvement was done specifically and deliberately to improve the services and outcomes for a particular population of patients, often those who are marginalized or experiencing health inequities. For example, one physician advocate described of their practice group:

One of the things we do at the clinic is ... all kinds of indicators that we review every six months and there's always, you know, we know that our population goes to emerg[ency] a lot and so delving deeper into that. [P-3]

As the participant elaborated, the team reviewed why a subset of their patients had a particularly high incidence of emergency room visits and implemented changes in their system of practice to address that observation. Thus, these quality improvement activities operated at a practice population level: monitoring a panel of patients and addressing health needs identified through this monitoring process.

Activism. Physician participants also described a number of system-level activities they engaged in to address health inequities. These activities included efforts to work with individuals within and outside the health care system to make lasting change to the system, such as system-level policy change, involvement with community groups, or lobbying. These efforts involved a broad set of abilities including negotiation, networking, and mobilizing individuals and groups. For study participants, this level of advocacy seemed to represent the quintessential advocacy activity:

I think it's really a much more political thing, health advocacy, in my mind. It's like how we allocate our resources, right. It's investing in things that are upstream as opposed to all the downstream stuff. [P-5]

Knowledge exchange. Finally, the physicians we interviewed described three types of advocacy activity that could best be characterized collectively as knowledge exchange: research and dissemination, teaching, and outreach.

Several physicians spoke at length about their involvement in research and its relationship to their advocacy activities. The focus of their research related to marginalized and at-risk populations, health inequities, and the social determinants of health. They also spoke about the relationship between research and dissemination, where dissemination played a key role in advocacy by bringing attention and credibility to these topics, particularly in the media:

And you make your argument for advocacy with sound research evidence.... That's probably the most recognized or respected approach. [P-1]

A second key element of knowledge exchange as advocacy was teaching. For example, many physicians spoke about their role in teaching trainees about the social determinants of health and health inequities, by "tagging" learning opportunities in clinical encounters, providing opportunities to work with marginalized populations, and supporting student projects. This sensitizing exercise was described by one participant who explained:

Yeah, so I think as a physician I do talk ... to the students. It's, like, do you see the social determinants of health happening here? I try to tag it for them because I

don't think they're necessarily tagging these observations with the frame. [P-5]

Finally, several physicians described outreach activities within their community as part of ongoing advocacy activities. They described working with community organizations to create workshops or lectures on health topics identified by community members. Importantly, the majority of the processes they described were collaborative and were led by community members rather than by the physician advocates themselves:

So about half a dozen [members] get together every Tuesday, every second Tuesday and they plan the meeting 10 days hence. So they plan the menu. They plan the activities. They plan the speakers, and they just tell me what they want to have done. So it's very much driven by them. [P-1]

Abilities

In describing their activities, physicians also articulated a number of abilities they drew upon to advocate effectively. Our use of the term "abilities" rather than "competencies" or "skills" to describe an advocate's proficiency in a particular area was a deliberate choice on the part of the research team. Many of the abilities described by physician participants are not currently articulated in educational frameworks, which is in part why we felt it was important to distinguish abilities from competencies. Additionally, we felt that the term "competencies" did not adequately reflect what our participants were describing in terms of how they advocate and how they learned to do so. Likewise, the term "skills" did not fully capture the breadth of what our participants told us, and may imply a technical proficiency that is not entirely appropriate in articulating what physician health advocates were describing in this context. Thus, consistent with language used in the CanMEDS² framework but distinct from terms used to describe physician roles, we chose the term "abilities" for our purposes here.

Table 2 lists these abilities and provides examples of their enactment during the physicians' advocacy activities. Some of these are likely relatively familiar and have fairly obvious parallels in various existing competency frameworks (such as communication, using evidence, and working in teams). Others, however, seemed somewhat less obviously

Table 2

Abilities of Physician Health Advocates Identified by 10 Participating Physician Advocates, From a Study of Activities and Abilities of Effective Health Advocates, British Columbia, Canada, 2012–2013

Abilities	Examples of how abilities were put to use
Seeing the “bigger picture”	<ul style="list-style-type: none"> Identifying social determinants of health and their impact on the overall health of patients Recognizing and acting on opportunities to address health inequities Identifying gaps in access, care, support, follow-up
Communication	<ul style="list-style-type: none"> Speaking out against the status quo Creating a safe environment for conversation Actively listening/creating a personal rapport Writing for lay audiences Providing media interviews
Persuasion	<ul style="list-style-type: none"> Seeking out individuals or organizations who can make changes to policies or procedures Using favors/asking for favors Drawing people in/ getting others involved
Leveraging social position	<ul style="list-style-type: none"> Endorsing causes Using one’s name/lending one’s voice
Putting ideas into action	<ul style="list-style-type: none"> Creating momentum Mobilizing and coordinating people and teams Delegating Facilitating and supporting the work of others
Using evidence	<ul style="list-style-type: none"> Reviewing literature and making evidence available to others Linking the social to the biomedical to provide an opinion on next steps in care
Working in teams	<ul style="list-style-type: none"> Amalgamating opinions from all team members to arrive at a considered opinion and plan Brainstorming/problem solving
Working in the community	<ul style="list-style-type: none"> Drawing on community/government resources Building and maintaining links in the community Seeking feedback from community

represented in current frameworks, but were described as being equally if not more important to participants. For example, all of the physicians we spoke to invoked their ability to “see the bigger picture” for their patients in describing their advocacy activities. More specifically, this involved linking a patient’s biological condition to the wider context (social, economic, environmental) of the patient’s life, and seeking solutions with patients that incorporated that wider context. As one physician described:

It’s the attitude of sort of humbly approaching your patient as not just a biological entity but as a conglomeration of factors including their social condition. And appreciating those factors of biology and social conditions together in your approach to that patient. And respecting the interplay of those factors. [P-8]

Other abilities not only seemed absent in formal frameworks but also seemed

to be mentioned with some reticence by physician participants. These seemed to be associated with the acknowledgment of the credibility and social position afforded them as physicians and the extent to which their ability and willingness to leverage this significant social capital appropriately played a role in their efforts to advocate. As one physician described in the context of obtaining community social services for a patient:

In any situation, I’m—if people find out I’m a doctor, it—there is an added deference to my opinion or my contribution. Actually I’m thinking—so when I worked in [city], housing and access to drug and alcohol treatment facilities was a huge issue. And there would be some times when I would call one of the social services and they would kind of go scrambling because a doctor was calling. And I knew that—it was giving the patient the best shot. [P-9]

Although directly relevant to their ability to leverage social position in publicly

advancing causes, the awareness of their position of power and knowing how and when to wield this effectively seemed to be an important component of almost all the advocacy abilities outlined in Table 2 (such as persuasion, putting ideas into action, communicating, and working in teams).

Discussion

One of the main challenges in teaching advocacy is disrupting learners’ perceptions that advocacy activities are “above and beyond” the routine of daily clinical activities. The initial purpose of this study was to better define the scope of everyday activities that advocates engage in to change the system—moving beyond the relatively uncontroversial activities of clinical agency with individual patients to try to understand what sorts of activities each physician might be able to engage in at a systems-change level.

What emerged from the interviews we conducted was a broader construction of the range of advocacy activities, providing a necessary refinement to our initial agency–activism framework.²⁶ While our preliminary construction proved useful in identifying a key challenge in understanding physician advocacy, it was intended only as a starting point towards a richer conceptualization of the role. The categories of clinical agency and activism described by the study participants seem to represent the archetypes of the two subroles we had initially envisioned. However, a number of new categories have emerged to provide nuance to the description of advocacy and a richer understanding of the actual activities undertaken by physician advocates. These findings also build upon work by Hubinette and colleagues,²⁹ which describes the conceptualizations of advocacy among family practice preceptors as falling into three main categories: clinical, paraclinical, and supraclinical advocacy.

While we do not anticipate that this study has identified all possible advocacy activities physicians may engage in or abilities they may invoke to accomplish these activities, our findings do point to a more detailed understanding of advocacy, which can be further developed for all trainees. Specifically, it has identified a set of activities that can be reasonably undertaken on a daily basis within a

clinical setting, even if they are not activities that every physician currently enacts as regularly or as effectively as might be desired. In particular, the domains of clinical agency, paraclinical agency, and practice quality improvement cover both the needs of individual patients and the needs of the wider practice population, while still being tied closely to patient care.

Importantly, both paraclinical agency and practice quality improvement require the development of a broader view of patient care beyond a focus on biomedicine; practice quality improvement additionally requires the application of a population health approach to one's practice. Thus, these activities involve operating beyond individual patient interactions. Whether that involves a critical lens required to observe one's panel of patients and identify areas of improvement, or whether it involves mobilizing a health care team to arrange social supports for a patient, it requires a broader perspective than the one-on-one clinical interaction focusing on a patient's biomedical issue that is the bedrock of traditional medical practice.

However, these activities are not fully reflected in current educational frameworks, leaving educators and trainees with insufficient guidance and role modeling. Thus, a focus on these advocacy activities and a deeper understanding of their associated abilities has the potential to provide the basis of a framework for teaching advocacy to trainees and for ensuring that advocacy is a key component of everyday practice. Additional skill development and support for system-level activism and knowledge exchange could be provided for those interested in pursuing further advocacy training as an important element of their future career. Furthermore, an awareness of the challenges that advocates face in incorporating advocacy activities into their daily work may lead to some strategies and tools to overcome those limitations.

In interpreting these findings it is important to note that our recruitment process created a potential limitation to our study. The participants were primarily urban physicians who, because of our use of snowball sampling, were often known to each other. As a result, we might be inadvertently overrepresenting a subset

of the physician advocate population. Thus, we wish to be cautious about our generalizations about effective everyday activism. However, our difficulty with sampling may itself be an important part of the story here. We would reiterate that our goal with this study was to identify "everyday activism" activities in which every physician might engage. Thus, our intent was to speak with "everyday activist" physicians to better understand what these individuals do on a daily basis. However, we were unable to effectively identify such individuals who were incorporating activism into routine clinical practice. Rather, our participants were, themselves, quite heavily engaged in advocacy at all levels. Furthermore, most advocates we spoke with had made nontraditional arrangements in their professional lives to be able to accommodate system-level work, because the traditional fee-for-service payment model in which most of their colleagues function did not allow them the time or the remuneration to be able to pursue these activities in a meaningful way. It became clear while speaking to study participants that system-level change requires a high level of dedication and persistence. In other words, it appears that system-level advocacy—what we have characterized as activism and knowledge exchange activities (with the exception, perhaps, of health advocacy teaching)—requires extraordinary commitment that is not easily incorporated into traditional practice models. This changed the scope of our study, and it may have limited our ability to fully explore how clinicians in more typical practices might take on an activist role. However, we believe it adds a depth of understanding to some of the underlying issues facing physician advocates. It uncovers some of the ongoing tensions that make this work especially challenging not only to teach trainees but to enact as a practicing physician. Importantly, CanMEDS, like other professional frameworks, is predicated on the idea that for effective practice each physician requires the knowledge, skills, and abilities of each of the roles. The current expectations within the CanMEDS framework for Health Advocacy seem to require that all physicians engage in activism by using their "expertise and influence"² in an effort to "change specific practices or policies on behalf of those served."² We learned from our physician participants that this type of work is not well supported within the health

care system and indeed pushes these individuals to the margins of professional practice. This is an important discussion to continue within the profession in order to clarify expectations and ensure that when this work is taken up more systematically, it is well supported.

The interviews with physician health advocates revealed a set of activities and associated abilities that offer new insight into the daily work of health advocacy. This insight provides a promising start for new ways of thinking about and teaching health advocacy to trainees. It is important to reiterate that most of the advocacy activities described by physician participants take a broader view beyond the one-on-one physician patient interaction and require collaboration, critical analysis, significant amounts of time, and remuneration outside the traditional fee-for-service system. The physician advocates we spoke with were unanimous in their belief that all physicians should be advocating at the individual patient level. However, using one's expertise and influence to advance the health and well-being of communities and populations is not as easy to conceptualize or to enact, which may be one of the central challenges of the meaningful integration of the Health Advocate role within the CanMEDS framework and other professional standards.

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