Perspective: **Agency and Activism: Rethinking Health Advocacy in the Medical Profession**

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Abstract

Health advocacy is being formalized as a professional activity for physicians across North America, but the accommodation of this activity into conceptions of daily practice has been controversial and confusing. There appears to be a lack of clarity around what a physician should do as a health advocate and how this should manifest in daily practice. In this article, the authors explore how the medical community has characterized the health advocate role and the roots of the debates regarding its place within training and practice, using the example of the CanMEDS Health Advocate Role. They argue that the confusion might be a result of subsuming two distinct activities, agency and activism, under the rubric of health advocacy. They propose that these activities and their associated skills are sufficiently distinct as to merit separate discussions. Agency involves advancing the health of individual patients ("working the system"), and activism involves advancing the health of communities and populations ("changing the system"). The authors suggest that distinguishing between agency and activism within health advocacy provides opportunities to explore their distinct goals and skill sets in a manner that will advance the debate about health advocacy, a conversation that remains critically important to the medical profession.

The question of whether health advocacy should be a compulsory element of medical education and practice continues to inspire vigorous debate.[1–4] Health advocacy appears in various forms in professional charters and standards,[5–7] highlighting that within the profession advocacy is recognized as an essential domain of competent and responsible practice. Still, the practical implementation of health advocacy remains a source of puzzlement and contention,[8,9] and, as a recent issue of this journal demonstrates, the impassioned argument about advocacy's place in medicine shows no signs of abating.[10–17]

Why has health advocacy caused such turmoil? One answer may be that the term "advocacy" describes a vast array of activities, and it is not always clear in discussions which activities are being referenced. The goal of this article is to characterize how the medical community has envisioned the health advocate role and to explore roots of the debates regarding its place within training and practice. We will seek to restructure the conversation around this issue in a way that allows us both to move forward in areas where we agree, and to discuss more effectively the areas that are causing the current difficulties.

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The CanMEDS Health Advocate Role

To explore the characterization of health advocacy in the medical profession, we turn to the CanMEDS Health Advocate role as a specific example. The CanMEDS framework[7] is a competency-based framework developed by the Royal College of Physicians and Surgeons of Canada that describes the core knowledge, skills, and abilities of specialist physicians. Intended as an educational framework, it identifies and elaborates seven core roles (Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar, and Professional) that serve as a set of organizing principles around which training can be constructed.[7] We have chosen to use the CanMEDS construction of the Health Advocate role for two reasons. First, CanMEDS explicitly defines the expectations and competencies of the role and therefore offers a clear language around which to articulate the issues. Second, the CanMEDS roles have grown increasingly important outside of their initial Canadian postgraduate medical education context, having been broadly adopted and integrated into undergraduate curricula and continuing professional development standards by a variety of health professional organizations around the globe.[18]

In the CanMEDS framework, the Health Advocate role asks physicians to "responsibly use their expertise and influence to advance the health and well-being of individual patients, communities, and populations."[7] Consistent with larger debates about advocacy, the Health Advocate role has been identified by researchers as one of the most difficult to teach and evaluate.[8,9,19] Further, trainees perceive it to be less important than other CanMEDS roles; they have variously described it as charity or as going above and beyond regular duties.[9,19] The repercussions of this perception are considerable. Although residents also identify a desire to participate in advocacy activities, they note a large number of barriers—among them a lack of time, insufficient sleep, and persistent stress—to advocacy activities in residency.[19] Perhaps more worrisome, on leaving residency trainees demonstrate a lack of interest in pursuing advocacy activities once established in practice.[19] Consistent with this finding, several

studies have concluded that although physicians generally endorse the idea of advocacy, they rarely engage in it.[2,20,21]

Disambiguating the Language of Health Advocacy

The tensions uncovered by how physicians engage with the CanMEDS Health Advocate role thus point toward a larger issue. That is, the main barrier to productive conversations about the place of health advocacy appears to be a lack of clarity around what a physician should do as a health advocate and how this should manifest in daily practice. Given the breadth of activity described in the Health Advocate role, perhaps it is not surprising that there is confusion amongst residents and faculty alike about the activities and expectations related to health advocacy. In a 2005 study, for example, Verma and colleagues[9] discovered that residents were disinclined to take on the responsibility of addressing societal issues within the community and observed that many felt that it was beyond their capacity. Interestingly, the same authors also noted that the residents described having difficulty distinguishing between the expectations of physicians in their Health Advocate role and the expectations of physicians in their daily practice.[9]

These apparently conflicting beliefs—that the role of Health Advocate is beyond the capacity of most physicians but also indistinguishable from daily practice—suggest that the scope and function of the role remain fundamentally misunderstood. Indeed, this puzzlement surrounding the activities and expectations of advocacy in medicine also manifests in the theoretical debate around advocacy.[1,2] The numerous attempts to define health advocacy and to delineate its scope suggest that a satisfactory description has not yet been reached.[1,2,9,22]

We would like to suggest that dissecting the set of activities described within the broad rubric of health advocacy offers an opportunity to illuminate some of the uncertainty around what it means to be a physician health advocate. Untangling this issue may be as straightforward as clarifying the language of advocacy. It appears that the language of the Health Advocate role may encompass, and consequently conflate, two activities that are complementary but importantly dissimilar. We suggest that these two activities have sufficiently different goals and require sufficiently different skill sets that they might be more accurately characterized as two subroles of the Health Advocate. The first activity is advancing the health and well-being of *individual patients*. As outlined in one section of the CanMEDS description of the Health Advocate role, "individual patients need physicians to assist them in navigating the healthcare system and accessing the appropriate health resources in a timely manner."[7] The second activity is advancing the health of *communities and populations*. This is in turn outlined in another section of the CanMEDS description of the health advocate: "communities and societies need physicians' special expertise to identify and collaboratively address broad health issues and the determinants of health."[7]

We believe that these subroles are sufficiently distinct as to benefit from distinguishing labels, and in this spirit, we suggest labeling the first subrole the "agent" and the second the "activist." More than being simply a convenient alliterative tool, these terms describe, and act as shorthand for, the specific sets of activities associated with each subrole. To elaborate, an agent acts on behalf of another.[23] As such, a physician agent acts on a patient's behalf to secure access to social services, facilities, and support. This is the role of navigating a patient through the health care system when that patient would encounter challenges or barriers if he or she acted independently. In this sense, the agent is *working the system* on behalf of a patient. By contrast, an activist campaigns to bring about institutional, social, economic, or political change.[23] Thus, the physician activist addresses the socioeconomic determinants of health in collaboration with his or her community. In a sense, activism has a quality of legacy; it extends beyond the improved health of an individual patient and, in fact, 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*.

Subroles of Advocacy: Agency and Activism

There are several advantages and consequences to creating a distinction between agency and activism within the Health Advocate role. First, such a distinction provides some clarity around the perceptions of and arguments about advocacy within the profession. For example, in Verma and colleagues' study, residents appeared to take for granted the responsibility for patient advocacy (agency) but felt unprepared to take on the responsibility for going beyond the care of an individual patient and into their communities (activism).[9] Similarly, clinical faculty members appeared to feel that they were satisfying the mandate of the Health Advocate simply by behaving as agents in their daily practice[9] and, in so doing, may have undermined the promotion and teaching of the activities associated with the activist subrole. As a further example, Huddle[3] argues that agency ("advocacy for individual patients") is unproblematic because it is a "natural extension of their obligation to help and heal patients," whereas activism ("political advocacy") is detached from the doctor–patient relationship and involves physicians arguing for a redistribution of societal resources toward health care. This, he argues, is outside both the scope of a physician's knowledge and authority and also outside a physician's professional duty.

As a corollary to the first, a second advantage of separating agent and activist is that it allows us to ask questions of each of these subroles individually. In distinguishing between these subroles by representing them as divergent professional competencies, we can discuss them as unique activities deserving equal attention but requiring separate treatment. For instance, the agent subrole, which maintains the familiar and conventional physician–patient relationship, appears uncontroversially understood to be a core professional activity.[1–3,9] The questions we must ask about this subrole, then, are how best to enable it and evaluate it in order to ensure that the associated activities truly do become an integral part of every physician's practice. We can, for example, identify excellent agent role models without having to demand that they also role model activist behavior. In short, we can ensure that the controversies of the activist subrole do not interfere with our efforts to enhance and promote the activities of agency.

Third, and perhaps most important, it allows us to more effectively address the larger and vital question that the advocate role seems to evoke regarding the responsibility of the medical profession as a whole versus the responsibility of the individual practitioner to engage in activism.[4,10–17] Formalizing an advocacy role in medicine seems to take for granted the authority available to physicians to shed light on matters influencing the health of their patients and communities. Physicians and other health professionals witness the effects of the socioeconomic determinants of health every day, made visible to various degrees in every patient encounter. Whether this authority translates into an obligation, and how best this might be done, is a conversation worth continuing. Indeed, this is the question at the core of both Huddle's[3] argument and the vociferous responses to it.[10–17] Huddle asks whether a physician is obliged to take on a public, political stance as part of his or her professional duties. Yet, the question of whether the profession has this responsibility need not be equated with the question of whether each physician has this responsibility. Rather, how the medical profession chooses to enact this responsibility may take a number of different forms. Indeed, as just one possibility, all physicians *might* be trained to engage in some form of activism in their daily clinical practice, and we might explore how to envision this "everyday activism." As another possibility, the activist role might become its own medical specialty, whereby a subset of individuals would be entrusted, empowered, and educated to perform activist activities on the profession's behalf. We are not suggesting that one or the other of these possibilities represents the right solution to this ongoing debate, or even that they are the only options. We are suggesting, however, that as long as the role of the activist is entangled with the role of the agent (a role that appears uncontroversially to be the job of every physician), many potential solutions cannot even be considered.

Of course, it is not hard to understand why the agent and activist subroles have been placed under the single umbrella of the Health Advocate. They share a common conceptual understanding of issues related to the socioeconomic determinants of health, and they involve a set of professional activities that extend beyond direct interaction with a specific patient to address a specific clinical complaint. However, their approach to addressing these issues represents an important divergence that deserves explicit recognition—a divergence that we are suggesting might be well captured by the distinction between working the system on behalf of a patient and changing the system on behalf of a population of patients. Although the agent and activist subroles are complementary, therefore, we believe that it may not be helpful to conceptualize activism simply as agency on a grander scale.[1,9] Thus, a continuing failure to effectively distinguish between them will risk perpetuating the general sense that the Health Advocate role is, at the same time, both trivial and overwhelming in its mandate.

Concluding Remarks

Advocacy is being formalized as a professional activity for physicians across North America and around the globe, but the accommodation of this activity into conceptions of daily practice has been far from smooth. Although we have used the CanMEDS language as a specific example, we believe that the confusion, anxiety, and vigorous debate[1–3,24] inspired by discussions of health advocacy are not problems of any one framework. Rather, at the core of all these difficulties is a general uncertainty about what is expected of a physician as a health advocate. As a first step in addressing this uncertainty, we have suggested drawing a conceptual distinction between the agent and activist subroles that have been conflated in the discussion about advocacy and the role of the Health Advocate. It is important to note that we do not see drawing this distinction as the end of the debate but, rather, as a contribution to an ongoing conversation that is critically important to the profession. Our current description of the two subroles, for example, has associated agency activities (working the system) with a focus on individual patients in the setting of the everyday clinical context and has associated activism activities (changing the system) with a focus on communities and populations occurring outside the typical physician–patient clinical interaction. Our clustering of these properties is likely an oversimplification and almost certainly does not yet capture all the potential activities that could be imagined within the larger rubric of health advocacy. However, it is our hope that the reframing of health advocacy language as agent and activist may add nuance to the wider discussion about advocacy in the medical profession by acting as a first approximation to represent these distinct sets of activities.

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