

Grappling with key questions about assessment of the Health Advocate role

Affronter des enjeux clés liés à l'évaluation du rôle de promoteur de la santé

Kori A LaDonna,¹ Renate Kahlke,² Ian Scott,³ Theresa van der Goes,³ Maria Hubinette³

¹University of Ottawa, Ontario, Canada; ²McMaster University, Ontario, Canada; ³University of British Columbia, British Columbia, Canada;

Correspondence to: Kori LaDonna; email: kladonna@uottawa.ca

Published ahead of issue: Mar 12, 2023; published: Mar 21, 2023. CMEJ 2023, 14(1) Available at <https://doi.org/10.36834/cmej.73878>

© 2023 LaDonna, Kahlke, Scott, van der Goes, Hubinette; licensee Synergies Partners. This is an Open Journal Systems article distributed under the terms of the Creative Commons Attribution License. (<https://creativecommons.org/licenses/by-nc-nd/4.0>) which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is cited.

Abstract

Introduction: Although the CanMEDS framework sets the standard for Canadian training, health advocacy competence does not appear to factor heavily into high stakes assessment decisions. Without forces motivating uptake, there is little movement by educational programs to integrate robust advocacy teaching and assessment practices. However, by adopting CanMEDS, the Canadian medical education community endorses that advocacy is required for competent medical practice. It's time to back up that endorsement with meaningful action. Our purpose was to aid this work by answering the key questions that continue to challenge training for this intrinsic physician role.

Methods: We used a critical review methodology to both examine literature relevant to the complexities impeding robust advocacy assessment, and develop recommendations. Our review moved iteratively through five phases: focusing the question, searching the literature, appraising and selecting sources, and analyzing results.

Results: Improving advocacy training relies, in part, on the medical education community developing a shared vision of the Health Advocate (HA) role, designing, implementing, and integrating developmentally appropriate curricula, and considering ethical implications of assessing a role that may be risky to enact.

Conclusion: Changes to assessment could be a key driver of curricular change for the HA role, provided implementation timelines and resources are sufficient to make necessary changes meaningful. To truly be meaningful, however, advocacy first needs to be perceived as valuable. Our recommendations are intended as a roadmap for transforming advocacy from a theoretical and aspirational value into one viewed as having both practical relevance and consequential implications.

Résumé

Introduction : Bien que le référentiel CanMEDS établisse les normes en matière de formation et de pratique médicale au Canada, la compétence de promotion de la santé (PS) ne semble pas peser lourd aux étapes décisives du continuum de la formation médicale. En l'absence de facteurs incitatifs, les programmes de formation sont peu enclins à intégrer des pratiques solides d'enseignement et d'évaluation en matière de PS. Un système de soins de santé marqué par l'iniquité appelle pourtant des efforts de sensibilisation. En adoptant le référentiel CanMEDS, le milieu canadien de l'éducation médicale a reconnu que la PS est nécessaire à la pratique compétente de la médecine. Il est temps que cet engagement soit traduit en actions concrètes.

Méthodes : Employant une méthode d'analyse critique, nous avons examiné les écrits qui peuvent éclairer les obstacles à l'évaluation sérieuse de la PS et avons formulé des recommandations. L'examen a été effectué de manière itérative en cinq étapes : définition de la question de recherche, recherche documentaire, évaluation et sélection des sources, et analyse des résultats.

Résultats : L'amélioration de la formation en matière de PS suppose, entre autres, que le milieu de l'éducation médicale s'attèle aux enjeux clés suivants : 1) l'élaborer une vision commune de la PS, 2) concevoir, mettre en œuvre et intégrer des programmes d'études évolutifs et 3) considérer les répercussions éthiques de l'évaluation d'un rôle qui comporte une part de risque.

Conclusion : Le manque de visibilité et d'attention accordées à la PS dans la formation amène de nombreux apprenants à se demander si leur compétence en la matière *compte vraiment*. Nous estimons que la promotion de la santé est au cœur des soins centrés sur le patient. Nous lançons donc un appel à redoubler nos efforts collectifs pour faire passer la PS du statut de simple aspiration et de valeur théorique à celui d'une valeur ayant une pertinence et des incidences concrètes.

Introduction

Health inequity is arguably one of the greatest challenges facing both society and our healthcare system.¹ In response, competency frameworks mandate that physicians should be key participants in advocating for solutions.²⁻⁴ However, despite the considerable time and labor devoted to defining health advocacy, designing objectives for the Health Advocate (HA) role, and developing a plan for the sound implementation of advocacy training across medical education, advocacy teaching and assessment lag behind that of the other intrinsic CanMEDS physician roles.⁵⁻⁷ While the importance and value of the Medical Expert, Scholar, Communicator, Collaborator, Leader, and Professional roles are uncontested, there appears to be an unshakeable ambivalence about the HA role which may be rooted in uncertainty not only around what advocacy is but also what it means to be a competent health advocate.⁸⁻¹³ These uncertainties not only make it difficult to design a robust curriculum and assessment strategy for advocacy, but more problematically, they may explain why few physicians either identify as advocates⁹ or agree that engaging in advocacy is an intrinsic physician responsibility.^{9,11,14}

In Canada, obtaining a speciality certification theoretically depends, in part, on demonstrating competence as a health advocate,^{2,3} yet it seems unlikely that an otherwise competent learner will fail solely on the basis of poor advocacy skills.¹⁵ Indeed, although the CanMEDS framework sets the standard for Canadian training and practice, competence for the HA role doesn't appear to factor heavily into high stakes decisions at any point across the medical education continuum, from granting a medical degree to awarding and maintaining licensure.^{16,17} To illustrate, consider not only that the HA competency is poorly represented across undergraduate and postgraduate teaching and assessment,^{15,18-20} but also that few faculty or trainees feel prepared (or in some cases, willing)⁹ to enact this critical aspect of care.^{9,15} If poor, disengaged,⁹ or incompetent advocates can still be deemed safe to practice, it is not surprising that there is little movement by medical education programs toward integrating robust health advocacy teaching and assessment practices.²¹

Inertia is rapidly becoming untenable, however. Honoring the social contract with the Canadian public means that physicians are obliged to look beyond the biomedical to address the inequities that both impair health and impede

access to health systems.¹ Assessments not only drive learning,²²⁻²⁴ they are also a proxy for professional values. By adopting the CanMEDS framework, the Canadian medical education community has endorsed that advocacy is required for competent medical practice. It is time to backup that endorsement with meaningful action that transforms health advocacy from a theoretical and aspirational value into one viewed as having both practical relevance and consequential implications.

Clearly, licencing bodies must revise assessment practices for this fraught intrinsic role—work that both the Medical Council of Canada (MCC) and the Royal College of Physicians and Surgeons of Canada (RCPSC) are currently preparing to do.²⁵ Both re-thinking assessment practices at the undergraduate level and the multi-year project aimed at revising and refining the CanMEDS 2015 framework potentiate a transformative opportunity. To make the most of it, the medical education community urgently needs to both reconceptualize the role and value of health advocacy in 21st century practice and reflect on how best to prepare learners to advocate competently. The purpose of our research was to aid this essential work by asking: What are the key questions about health advocacy that remain unanswered, and how might answering them improve teaching and assessment practices? To do this, we critically examined the literature on health advocacy and related domains, aiming to both unpack the myriad complexities and challenges impeding authentic assessment for the HA role, and to suggest strategies to facilitate more rigorous health advocacy training.

Methods

We used a critical review methodology²⁶ to identify gaps in current approaches to health advocacy assessment, to examine key literatures to inform new approaches, and to develop recommendations.²⁷ To structure this review, we drew on methodological guidance from both Critical Interpretive Synthesis²⁷ (CIS) which is a multi-method approach for inductive critical syntheses often used for healthcare-related inquires, and from our work synthesizing “best practices” for critical reviews.²⁸ Both CIS and critical reviews are qualitative and interpretive, drawing on a wide variety of evidence sources to generate new ways of understanding a topic.^{27,28}

In keeping with both CIS and critical reviews, our review moved iteratively through five phases: focusing the question, searching the literature, appraising sources, sampling the most impactful sources, and analyzing our

results.²⁹ We began by focusing our questions: what are the current gaps in health advocacy assessment? And how can assessment practice be changed to ensure rigorous and ethical assessment of this role? We then met as a team to develop a table of concepts that identified key issues in health advocacy assessment as well as initial sources to consider, connecting with experts (including some who initially conceptualized the HA role for the CanMEDS framework) for feedback and insights. This is a key strategy commonly used in critical reviews.²⁹ Each team member then searched the academic and grey literature relevant to each key area, including with health advocacy generally (such as variable definitions and scope, biomedical orientation to training, and fragmentation of curricular implementation), and issues specific to assessment for the HA role (including integration, limitations with current tools, and ethics).

Searches of the academic literature focused on keywords such as “advocacy” or “social justice” in the context of medical education. We also included searches that paired “advocacy” with “assessment.” We searched common databases such as PubMed, and also capitalized on Google Scholar’s algorithms, ranking sources by the number of citations they receive as well as relevance of the title and full text. Our searches of the grey literature focused on searching websites from licensing bodies (e.g. MCC, RCPSC), and College of Family Physicians of Canada) as well as medical school and residency program websites to understand how health advocacy was being interpreted, and to review publicly available information on how it is assessed.

CIS and critical reviews are less systematic than other review types, privileging careful selection of the most relevant sources over coverage of everything that has been published.³⁰ Researchers leverage their own expertise to identify and appraise the most relevant sources, and to develop new frameworks or recommendations for research and practice.^{26,29} This review was informed by our experiences as a multi-disciplinary team of physicians and PhD scientists with expertise engaging in, teaching, and researching advocacy. Dr. LaDonna and Dr. Kahlke are PhD scientists with training in the social sciences. Specifically, Dr. LaDonna was involved in grassroots patient advocacy, and she focuses much of her research on identifying opportunities to make medical education and practice more patient centered. Dr. Kahlke has a background in instructional design and she studies sociocultural factors influencing learning. Dr. Scott is a practicing family

physician and the Director of the Centre for Health Education Scholarship at the University of British Columbia (UBC). At the time of this writing, he is also the Academic Co-director of the Academic Leadership Development Program at UBC. Dr. van der Goes practiced as a full-service family physician and hospitalist. She is both the Director of Assessment for the postgraduate family medicine residency at UBC, and a long-time member of the Certification Process and Assessment Committee for the College of Family Physicians of Canada (CFPC). Dr. Hubinette is a practicing family physician serving marginalized populations, and she is active in advocacy teaching and learning at the undergraduate level, including as (now past) Chair of the CFPC Undergraduate Education Committee. At the time the research was conducted, Dr. Hubinette held the position of Assistant Dean, Equity Diversity Inclusion at UBC’s Faculty of Medicine. All authors conduct research on defining and training the HA role, and we are all committed to making health care and medical education socially just.

We worked in sub-groups of 1-2 to search and analyze the literature on each sub-topic, drawing on our expertise to engage in an iterative cycle of appraising sources, and identifying and sampling those most relevant and impactful. These discussions within and outside the authorship team were key to developing our thinking around key questions pertaining to the HA role, and, given that the literature pertinent to several questions overlapped considerably, we were able to have rich discussion and offer each other sources for consideration. Any conflict was managed through team discussion until all team members were satisfied with decisions. KL and MH, in consultation with team members, used the initial concept map to develop the final 3 key questions presented here. These questions served as both anchors for scrutinizing the available evidence, and as an organizing framework to ensure that sub-teams tackling portions of the material didn’t duplicate efforts. Based on the literature associated with each of these key questions, our expertise as researchers and advocates, and our sensitization to feminist, critical race, and postcolonial theories, we also developed recommendations for improving health advocacy training. A version of this article was submitted to the MCC as one of a series of invited white papers aimed at improving assessment at the undergraduate level. The present article expands on this work by considering opportunities for improving assessment for the HA role across the medical education continuum.

Results

Improving HA training relies on the medical education community grappling with key questions to develop a shared vision of HA, to design, implement, and integrate developmentally appropriate curricula, and to consider the ethical implications of assessing a role that may be risky to enact. Below, we elaborate on each of these points using our identified key questions, and we propose both philosophical and granular recommendations for stakeholders to consider as they revise and refine assessment for the HA role (Table 1).

Key Question 1. Do stakeholders have a shared understanding about the Health Advocate role?

Health advocacy is an enactment of social responsibility³¹ characterized by actions to promote social, economic, educational, and political changes that ameliorate the threats to human health and well-being that a physician identifies through their professional work.³² As defined by the CanMEDS framework, competent physician advocates “contribute their expertise and influence as they work with communities or patient populations to improve health. They work with those they serve to determine and understand needs, speak on behalf of others when required, and support the mobilisation of resources to effect change.”^{2(p.22)}

According to this definition, health advocacy ought to be a relational activity between health care providers and the people they serve,⁹⁻¹¹ enacted “in partnership with patients and communities.”^{3(p.16)} However, it is unclear whether partnerships between providers, learners, and patients are realized in practice. Indeed, no patients participating in a recent qualitative exploration of health advocacy identified their physician as a health advocate, at least not in the way it is conceptualized in existing curricular frameworks.⁹ Physician participants seemed to agree, with most admitting little understanding of, or interest engaging in, the broad scope of advocacy work.⁹

But what is the scope of advocacy work? At a high level, health advocacy involves a multitude of related and integrated domains and activities including system navigation, health promotion, health equity, health systems literacy, and more. Competency frameworks for the HA role^{2,3,33} divide health advocacy into actions that respond to the needs of individual patients and families, and those that respond to the needs of communities, populations, and systems. Sometimes, this work is classified as either “agentive” or “activist,”³⁴ differentiating

that physicians and learners may engage in advocacy at multiple levels ranging from helping individual patients navigate the system to more political forms of advocacy aimed at disrupting the status quo. To further delineate what it means to be an advocate, actions have been subdivided into micro, meso, and macro activities including examples such as advocating for an individual’s access to existing financial supports (micro), for a healthcare team to seek cultural humility training required to engage effectively with their Indigenous patients (meso), or for national-level changes to laws and policies to support broad access to safe injection sites where they are needed (macro).³⁵

While these frameworks define the theoretical possibilities of health advocacy, in practice, physicians more commonly engage in activities ranging from filling out forms for patients and advocating for emergent consults, to speaking up against policy at departmental meetings and giving educational lectures to patient support groups.⁹ Consequently, much of what existing frameworks classify as health advocacy is viewed as “going above and beyond” usual care,^{9,10,14} making it challenging for physicians and learners to identify the role of advocacy in their practice.^{9,10,14} Even when health advocacy is seen as a core component of physicians’ work, approaches often revolve more around medical health promotion than activism.^{10,11} And while health promotion is considered part of health advocacy by some,² there is an important, yet poorly elucidated distinction between counseling a patient to stop smoking (medical health promotion) and identifying the complexities of smoking cessation for individual patients alongside social determinations of health, and then developing a plan to help patients obtain the tools and services they need to navigate these challenges (health advocacy).¹⁰ To further complicate matters, patients appear to define health advocacy differently, suggesting that physician advocacy is better aligned with the notion of patient centeredness than how it is defined in the CanMEDS framework. Troublingly, patients also view physician advocacy as “above and beyond” usual care, perceiving that during health care encounters, their physicians rarely demonstrated the compassionate communication and empathetic listening they described as fundamental to physician advocacy.^{9,10}

Health advocacy is simultaneously everything and nothing—there are many different frameworks, capturing numerous elements of this construct that rarely seem to either reflect or translate well into most practice settings. What is certain

is that, in each potential case requiring health advocacy, the issue to be addressed is unlikely to be linear. Even in the “simple” matter of making a phone call to arrange emergency housing for the patient, the advocate needs to collaborate with the patient to understand their needs and barriers, to navigate the system to find appropriate options, and then to create a persuasive written or verbal argument to others within the system, sometimes leveraging status and relationships to lower barriers to care access.⁹ The protean nature of competencies for the HA role require a daunting skillset, ranging from empathetic listening⁹ to understanding healthcare policy and law well enough to apply them to system-level problems.¹⁹ Lack of a shared understanding amongst stakeholders undermines efforts to equip learners to competently engage in advocacy work.

Key Question 2: What are the downstream consequences of current teaching and assessment practices for the HA role?

While descriptions of health advocacy competencies are available,² how (and where and when) one develops the skills to become a competent health advocate is less clear. Additionally, since a competent health advocate must be knowledgeable, altruistic, honest, assertive, resourceful, and up-to-date on relevant issues and scientific evidence,³⁶ it appears that fundamental advocacy skills may be inherent rather than learned. Indeed, some have argued that pre-existing experiences, personal background, values, and other personal characteristics are prerequisites for becoming an effective health advocate,^{37,38} suggesting that selection into training may play a crucial role in the future of health advocacy in medicine. Others suggest health advocacy faculty must either be developed and offered in a structured manner,^{36,39–42} or appropriate resources must be made available to learners keen on engaging in advocacy activities throughout medical school.⁴³ Regardless of how, where, and when a learner develops these competencies, we contend that becoming a competent advocate relies on a developmental trajectory over a continuum of learning. Currently, however, systematic, integrated, and purposeful curricular content and structures to support and assess this learning are rarely described, and there is little guidance available to support their practical development.

For instance, current objectives for the HA role neither lend themselves to staged learning and a clear progression from novice to mastery, nor do they specify suitable contexts for training and assessing essential knowledge and skills. In a

recent content analysis of health advocacy curricular documents from each Ontario medical school,¹⁵ authors found that objectives across schools were vague, often stating that learners must demonstrate competent health advocacy by “advocating for patients” with variable levels of detail about what a trainee actually needs to do to demonstrate competence. Further, across curricular documents, objectives for postgraduate years 2-5 were lumped together, failing to delineate progressive expectations aligned with training year.¹⁵

Authors also found that this lack of clarity created considerable uncertainty and stress for learners.¹⁵ For instance, when presented with findings from the review of curricular documents, one learner admitted that she struggled to understand whether achieving competence for the HA role depended on the expectation that she counsel male patients to receive the HPV vaccine (i.e. medical health promotion), or that she march on Parliament Hill to demand a nationwide HPV vaccination program for all Canadians (i.e. activism).¹⁵ This learner’s experience aligns with recent reviews^{20,39} noting “lack of a consistent body of knowledge or skill set, and a notable heterogeneity in the methodology and resources used across the curricula”³⁹ for the HA role.¹⁹

Explicit and clear advocacy curricula and assessments rely on the development of standardized goals, content, and outcome measures.²⁰ Robust training also depends on having credible assessors.^{44,45} Currently, most clinician teachers not only lack an appropriate normative benchmark or anchor for assessing competent health advocacy, but both physicians’ uncertainty about the role of health advocacy in practice, and their ambivalence about engaging in it, raises questions about whether the current cohort of assessors can rigorously supervise, coach, or assess health advocacy.^{9–11,14} Further, physicians rarely engage in health advocacy alone, yet current objectives, milestones, and assessment structures often imply that they do. Since effective health advocacy is usually undertaken as a team sport,^{9,14,46} a key skill set requires collaborating with patients, communities, health professionals, social scientists and others who have the knowledge and access required to make meaningful change yet are rarely tapped to participate in advocacy training.^{9,14,46}

How can we expect learners to succeed in assessments of a complex and wide-ranging physician role that their education has not prepared them to enact? If health advocacy is not taught and assessed with intention, we may

do damage by instilling a sense that it is not important, or worse, by reinforcing physician-centric advocacy efforts that are neither informed by patients' voices nor by best evidence. The lack of intentional, longitudinal curriculum and credible assessors to support the continuum of knowledge, skills, and abilities required to demonstrate competent health advocacy learning is clearly problematic. By continuing to act and practice without either a fulsome understanding or requisite expertise may further undermine the importance and value of the HA role.

Key Question 3: Is it fair or ethical to train and assess learners' enactment of the HA role?

Health advocacy is assumed to be a noble pursuit, but in many cases, engaging in it may conflict with implicit conceptions of professionalism. In a recent exploration of patients' and physicians' perspectives about competent HA, one physician perceived that being a health advocate is not unlike being a modern-day Robin Hood—or a “reasonable thief” who steals resources from the system to advocate for underserved patients.⁹ Physician participants regularly noted that getting patients what they needed required some degree of dishonesty. For example, physician participants described sneaking into desk drawers and cupboards to find taxi vouchers or medical supplies for patients or fudging forms to ensure their patient qualified for an off-label medication. Competent health advocacy is, therefore, highly subjective, and these examples highlight the underexplored tensions within advocacy activities that could be assessed as either competent and patient centered, or as incompetent and poor system stewardship.

Indeed, engaging in health advocacy can be risky, and some trainees (and faculty, for that matter) may prefer to avoid getting into what Former United States Congressman John Lewis called “good trouble”—or the agentic or activist work that circumvents law or norms for the greater good.⁹ We also caution that assessor bias may creep in when evaluating both the subjectivities of health advocacy and the multiple skills required to engage in it—particularly for more disruptive forms. For instance, not only might advocacy be ethically fraught, but it also relies heavily on assertive communication—a skill known to be valued and evaluated differently based on gendered norms.^{47,48} For example, a man's assertiveness is more often assessed as confidence while a woman's assertiveness may be perceived as aggressive.⁴⁹ Even if we can agree on what constitutes the HA role, all assessment practices are vulnerable to either implicit bias or blatant discrimination,

particularly for potentially disruptive competencies like health advocacy.^{49,50}

Neither knowledge acquisition nor identity formation are neutral; in other words, our experience of what it means to be ‘professional’ or a ‘good physician’ is relative to our sociocultural context with roots in colonialism, patriarchy, and white hegemony. Many conceptions of health advocacy, particularly those associated with activism, involve advocating to both recognize and dismantle these deeply entrenched systems. Thus, Sharda⁵¹ suggests that our current conception of professionalism may be in tension with health advocacy. In other words, current notions of professionalism privilege certain identities and positionalities that may come into direct conflict with efforts to challenge the status quo—or the very notion of what it means to be ‘professional’ or a ‘good physician’. For example, in a system where white normativity and colonialism are the status quo and underpin conceptions of professionalism, engagement with either anti-racist movements in health care or medical education toward health equity for racialized populations may be considered not as health advocacy, but as ‘unprofessional’ behaviour.⁵¹ The medical education community must grapple with the ethics of teaching and assessing a competency that is both a prosocial activity and potentially ‘troublemaking.’

Recommendations

We strongly believe that health advocacy should be trained. When done well, robust teaching and assessment of health advocacy across all stages of training will signal the value of health advocacy competencies within the health care system, the medical profession, and medical education. It will support and celebrate health system change-makers and influencers, ultimately, we hope, allowing us to develop a more just health care system. It will help close the gap between the aspiration of medical education, in which all physicians act collaboratively to address health inequities, and the current reality of fragmented and inequitable care.

But to become embedded in the fabric of health care and medical education, health advocacy first needs to be valued. We worry that the pervasive ambivalence and uncertainty shrouding the HA role risks quelling the medical education community's appetite to do the hard work necessary to make training rigorous and ethically sound.

And there is a lot of hard work to do. Variations in our understanding of the definition and scope of health advocacy, the inconsistent approach to its teaching, the limited advocacy expertise among many assessors, and the underexplored ethical tensions inherent in advocacy engagement make many aspects of assessment fraught and likely unfair. We recognize that undergraduate and postgraduate medical education programs, clinician teachers, and regulatory and licensing bodies are mandated to assess the HA role now. But we contend that hasty implementation of assessment strategies risks setting up learners, their preceptors, their programs—and ultimately their patients—to fail.^{24,52} If not done well, assessment for the HA role risks further trivializing health advocacy skills and abilities, thus exacerbating challenges in translating its value for patient care. At best, inadequate, inappropriate, or poorly integrated assessment may privilege what is easy to assess over what is meaningful. At worst, health advocacy assessment has the potential to be harmful.

Prior to implementing a coordinated and comprehensive assessment strategy, we recommend that the medical education community explore the implicit assumption that all aspects of health advocacy in their current expression can or should be assessed. Fair, ethical, and authentic assessments of HA must align with explicit teaching of the foundational knowledge and skills required for competent HA, but the hidden curriculum is a powerful force. Most learners do not have formal and systematic access to rich didactic learning, robust experiential opportunities, or sufficient clinician modeling of HA. In turn, learners are struggling to understand both the nuances of health advocacy and how to integrate multiple and varied skills into competence for the HA role.

We simply cannot develop an assessment plan for health advocacy without first providing learners with both appropriate foundational knowledge and ample opportunities to see and practice the various types of HA and its attendant activities across clinical and community settings. Answers to key questions about both conceptualizations of health advocacy and the downstream effects of current teaching and assessment practices suggest that the medical education community needs to do considerable groundwork before attempting to develop and implement authentic advocacy assessments. Since most clinician teachers are unlikely to have relevant expertise in all domains required for robust, authentic health advocacy teaching and assessment,

realizing this goal depends on the meaningful and non-tokenistic engagement of diverse stakeholders—including physicians, trainees, patients, social scientists, other health professionals, regulatory bodies, curriculum designers, assessment designers, and deans. To ensure medical schools, clinician teachers, and standard-setting, certification, licensing and regulatory bodies meet their mandate to rigorously assess HA, we recommend that the medical education community must partner with other experts to:

1. *Develop a clear, shared vision of health advocacy.*

A shared vision needs to capture important aspects of HA that often take a backseat when individualistic, biomedical, and physician-centric approaches dominate. Specifically, HA needs to be understood as relational, interdisciplinary, both normative and counter-normative, systems-oriented, and collaborative. It is incumbent on educational institutions as well as certifying, licensing, and regulatory bodies to build on these shared understandings to further define and disseminate a broad conception of HA that attends to the ethical tensions inherent in advocacy work.

2. *Design, implement and integrate developmentally-appropriate health advocacy curricula across the education continuum that attends to ethical dimensions of health advocacy.*

From this foundation, we must provide opportunities for learners to begin integrating knowledge, skills, and attitudes across a variety of contexts into an approach to health advocacy that is resonant with or applicable to patient centredness, change management, quality improvement, health equity, and compassionate communication. Given that some learners may come into medicine with advocacy experience,³⁷ developmentally appropriate assessment of the HA role is not necessarily straightforward. In general, however, expectations should require learners to demonstrate an increasingly sophisticated and complex skillset as they progress through training. To establish expectations, we must engage a multiplicity of experts in assessment, including but not limited to patients (e.g. via patient and family engagement programs) and other health professionals. Since these stakeholders view advocacy and healthcare from different vantage points, their experiences and expertise will invaluablely augment those of physician assessors. Meaningful consideration and discussion about multiple forms of discrimination, implicit bias,⁵³ and their connections to health advocacy engagement, training, and

assessment must also be embedded in actions aimed at improving training for the HA role.

3. Assessment design and implementation must not only consider, but must also ensure equity, diversity, and inclusion

With the pressing focus on equity, diversity, inclusion and anti-racism (EDI-AR) in medical education, health care, and society, we encourage educators, assessors, and policy makers to apply an EDI-AR lens to the teaching and assessment of health advocacy. Making healthcare and medical education more equitable depends on reckoning with the legacies of colonialism, patriarchy, and racism. Health advocacy researchers, curriculum designers, clinician teachers, and certifying, licensing, and regulatory bodies need to delve into the ethics and logistics of designing objectives and assessments that are both inclusive and attendant to the complexities of social and health inequities. As a community, we need to think very carefully about whether the implications of racism, gender bias, or intersectional discrimination on health can (or should) be neatly translated into bell-ringer stations or multiple-choice questions. To be authentic, assessments must be robust and inclusive, rather than tokenistic and centered on white, heteronormative, and colonial ideologies. Failing to do so risks undermining health advocacy teaching, learning, and assessment—with worrisome downstream implications for patients.

Discussion

Changes to assessment could be a key driver of curricular change for the HA role, provided implementation timelines and both financial and human resources are sufficient to make necessary changes meaningful. Best efforts will fall short without a thoughtful examination of current sociocultural values, practices, and ideologies, however. Given that medicine is primarily viewed through a biomedical lens, it is little wonder that both physicians and learners perceive health advocacy as “above and beyond” what physicians need to do to care for patients.^{10,14} By shifting perspectives and viewing medicine through a social justice lens, physicians and learners will clearly see current models as wholly inadequate if diagnosis and treatment aren’t coupled with health advocacy.

Although we have provided recommendations that may be a useful starting point for the MCC, the RCPSC, and individual programs to use as they reflect on sociocultural values and re-conceptualize assessment practices, our intention is to provoke thought and explore possible next

steps, not to provide prescriptive solutions. We urge curriculum designers, faculty developers, assessment directors, clinician preceptors, medical education researchers, and policy makers to grapple with the questions we raise before acting on our recommendations. In the meantime, we remind the medical education community that learners look to clinical preceptors, their program, and their certifying, regulatory, and licensing bodies for signals about the learning and skills that are valuable for them to master. Currently, the lack of visibility and attention to the HA role in training leaves many learners wondering whether their ability to demonstrate competent health advocacy even matters.

Strengths and limitations

CIS and critical reviews are not intended to be aggregative, and we did not set out to capture the breadth of literature pertinent to the HA role. Rather, our research team critically reviewed relevant health advocacy literature and documents from multiple vantage points, permitting a robust exploration of the challenges of, and opportunities for, preparing learners to enact the HA role. As a result, stakeholders have a clear roadmap for revising and refining the HA role that is rooted in both empirical evidence and the real-world experiences of physician advocates and clinical assessors. Additionally, our critical review reflects a social justice, rather than a traditional assessment lens—a useful delimitation for an intrinsic physician role aimed at health equity.

Conclusion

We believe that health advocacy is the heart and soul of patient centered care. We are sounding the call to revisit and redouble our collective efforts to view health advocacy as a meaningful strategy to both support patient care and facilitate a more equitable society. We hope these key questions and recommendations inspire the medical education community not only to think critically about the HA role, but also to act meaningfully, ensuring that health advocacy teaching, assessment, and engagement are afforded the attention and respect they deserve across training and practice.

Conflicts of Interest: Conflict of interest: We have no conflicts of interest to declare.

Funding: None

Acknowledgment: The authors would like to thank Ms. Lindsay Cowley for her assistance preparing this manuscript for publication.

References

- Hubinette MM, LaDonna KA, Scott I, van der Goes T, Kahlke R. When I say...health advocacy. *Med Educ.* 2022;56(4):362–4. <https://doi.org/10.1111/medu.14728>.
- Frank JR, Snell LS, Sherbino J, eds. *CanMEDS 2015 Physician Competency Framework.* Ottawa: The Royal College of Physicians and Surgeons of Canada. 2015:11-12. <http://canmeds.royalcollege.ca/en/framework>
- Shaw E, Oandasan I, Fowler N, eds. *CanMEDS-FM 2017: A Competency Framework for Family Physicians across the Continuum.* Mississauga, Canada; 2017. <https://www.cfpc.ca/CFPC/media/Resources/Medical-Education/CanMEDS-Family-Medicine-2017-ENG.pdf>
- Accreditation Council for Graduate Medical Education. ACGME Common Program Requirements. Effective July 1, 2013; 2013. <http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/CPRs2013.pdf>.
- Chou S, Cole G, McLaughlin K, Lockyer J. CanMEDS evaluation in Canadian postgraduate training programmes: Tools used and programme director satisfaction. *Med Educ.* 2008;42(9):879-886. <https://doi.org/10.1111/j.1365-2923.2008.03111.x>
- Hakim J, Black A, Gruslin A, Fleming N. Are Canadian postgraduate training programs meeting the health advocacy needs of obstetrics and gynaecology residents? *J Obstet Gynaecol Can.* 2013;35(6):539-546. [https://doi.org/10.1016/S1701-2163\(15\)30913-0](https://doi.org/10.1016/S1701-2163(15)30913-0)
- Binnendyk J, Pack R, Field E, Watling C. Not wanted on the voyage: Highlighting intrinsic CanMEDS gaps in Competence by Design curricula. *Can Med Educ J.* 2021;12(4):39–47. <https://doi.org/10.36834/cmej.70950>
- Stutsky BJ, Singer M, Renaud R. Determining the weighting and relative importance of CanMEDS roles and competencies. *BMC Res Notes.* 2012;5(1):354. <https://doi.org/10.1186/1756-0500-5-354>
- LaDonna KA, Watling CJ, Cristancho SM, Burm S. Exploring patients' and physicians' perspectives about competent health advocacy. *Med Educ.* 2021;55(4):486–495. <https://doi.org/10.1111/medu.14408>
- Hubinette MM, Scott I, van der Goes T, Kahlke R. Learner conceptions of health advocacy: 'Going above & beyond' or 'kind of an expectation.' *Med Educ.* 2021;55(8):933–941. <https://doi.org/10.1111/medu.14526>
- Hubinette MM, Ajjawi R, Dharamsi S. Family physician preceptors' conceptualizations of health advocacy: Implications for medical education. *Acad Med.* 2014;89(11):1502–1509. <https://doi.org/10.1097/ACM.0000000000000479>
- Arya N. Advocacy as medical responsibility. *CMAJ.* 2013;185(15):1368. <https://doi.org/10.1503/cmaj.130649>
- Gallagher S, Little M. Doctors on values and advocacy: A Qualitative and evaluative study. *Health Care Anal.* 2017;25(4):370-385. <https://doi.org/10.1007/s10728-016-0322-6>
- LaDonna KA, Field E, Watling C, Lingard L, Haddara W, Cristancho SM. Navigating complexity in team-based clinical settings. *Med Educ.* 2018;52(11):1125–1137. <https://doi.org/10.1111/medu.13671>.
- Endres K, Burm S, Weiman D, et al. Navigating the uncertainty of health advocacy teaching and evaluation from the trainee's perspective. *Med Teach.* 2022;44(1):79-86. <https://doi.org/10.1080/0142159X.2021.1967905>.
- Medical Council of Canada. Health Advocate. 2022. Available from: <https://mcc.ca/objectives/health-advocate/>
- The Royal College of Physicians and Surgeons of Canada. CanMEDS Guide. 2022. Available from: <https://canmeds.royalcollege.ca/guide?role=HA&key-competency>
- Logiudice AB, Sibbald M, Monteiro S, et al. Intrinsic or invisible? An audit of CanMEDS roles in entrustable professional activities. *Acad Med.* 2022;97(8):1213–8. <https://doi.org/10.1097/ACM.00000000000004731>.
- Martin D, Hum S, Han M, Whitehead C. Laying the foundation: Teaching policy and advocacy to medical trainees. *Med Teach.* 2013;35(5):352–358. <https://doi.org/10.3109/0142159X.2013.770453>.
- McDonald M, Lavelle C, Wen M, Sherbino J, Hulme J. The state of health advocacy training in postgraduate medical education: a scoping review. *Med Educ.* 2019;53(12):1209-1220. <https://doi.org/10.1111/medu.13929>
- Luft LM. The essential role of physician as advocate: How and why we pass it on. *Can Med Educ J.* 2017;8(3):e109-e116. <https://doi.org/10.36834/cmej.36925>
- Norcini J, Anderson B, Bollela V, et al. Criteria for good assessment: Consensus statement and recommendations from the Ottawa 2010 Conference. *Med Teach.* 2011;33(3):206-214. <https://doi.org/10.3109/0142159X.2011.551559>
- Holmboe ES, Sherbino J, Long DM, Swing SR, Frank JR, Collaborators for the IC. The role of assessment in competency-based medical education. *Med Teach.* 2010;32(8):676-682. <https://doi.org/10.3109/0142159X.2010.500704>
- Scott IM. Beyond 'driving': the relationship between assessment, performance and learning. *Med Educ.* 2020;54(1):54–59. <https://doi.org/10.1111/medu.13935>
- The Royal College of Physicians and Surgeons of Canada. *CanMEDS 25: Ensuring value for years to come.* 2022. Available from: <https://www.royalcollege.ca/rcsite/canmeds/canmeds-25-e>
- Grant MJ, Booth A. A typology of reviews: An analysis of 14 review types and associated methodologies. *Health Info Libr J.* 2009;26(2):91-108. <https://doi.org/10.1111/J.1471-1842.2009.00848.X>
- Dixon-Woods M, Cavers D, Agarwal S, et al. Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. *BMC Med Res Methodol.* 2006;6(1):1-13. doi:10.1186/1471-2288-6-35/TABLES/2
- Depraetere J, Vandeviver C, Keygnaert I, Beken T vander. The critical interpretive synthesis: an assessment of reporting practices. *Int J Soc Res Methodol.* 2021;24(6):669-689. <https://doi.org/10.1080/13645579.2020.1799637>
- Kahlke R, Lee M, Eva K. Critical reviews in health professions education research. *J Grad Med Educ.* Forthcoming
- Norman G, Eva KW. Quantitative research methods in medical education. In: T. Swanwick, ed. *Understanding Medical Education: Evidence, Theory and Practice.* John Wiley & Sons; 2014: 349–369.

31. 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(9):1108-1113. <https://doi.org/10.1097/ACM.0B013E318226B43B>
32. Earnest MA, Wong SL, Federico SG. Perspective: Physician advocacy: What is it and how do we do it? *Acad Med*. 2010;85(1):63-67. <https://doi.org/10.1097/acm.0b013e3181c40d40>
33. Lax Y, Braganza S, Patel M. Three-tiered advocacy: using a longitudinal curriculum to teach pediatric residents advocacy on an individual, community, and legislative level. *J Med Educ Curric Dev*. 2019;6. <https://doi.org/10.1177/2382120519859300>
34. Dobson S, Voyer S, Regehr G. Perspective: Agency and activism: Rethinking health advocacy in the medical profession. *Acad Med*. 2012;87(9):1161-1164. <https://doi.org/10.1097/acm.0b013e3182621c25>
35. Meili R, Buchman S, Goel R, Woollard R. Social accountability at the macro level. *Can Fam Physician*. 2016;62(10):785-788.
36. Flynn L, Verma S. Fundamental components of a curriculum for residents in health advocacy. *Med Teach*. 2008;30(7): e178-83. <https://doi.org/10.1080/01421590802139757>
37. Law M, Leung P, Veinot P, Miller D, Mylopoulos M. A qualitative study of the experiences and factors that led physicians to be lifelong health advocates. *Acad Med*. 2016;91(10):1392-1397. <https://doi.org/10.1097/acm.0000000000001316>
38. Mu L, Shroff F, Dharamsi S. Inspiring health advocacy in family medicine: A qualitative study. *Educ Health*. 2011;24(1):1-11.
39. Howell BA, Kristal RB, Whitmire LR, Gentry M, Rabin TL, Rosenbaum J. A systematic review of advocacy curricula in graduate medical education. *J Gen Intern Med*. 2019;34(11):2592-2601. <https://doi.org/10.1007/s11606-019-05184-3>
40. Basu G, Pels RJ, Stark RL, Jain P, Bor DH, McCormick D. Training internal medicine residents in social medicine and research-based Health Advocacy: a novel, in-depth curriculum. *Acad Med*. 2017;92(4):515-520. <https://doi.org/10.1097/ACM.0000000000001580>
41. Knox KE, Lehmann W, Vogelgesang J, Simpson D. Community health, advocacy, and managing populations (CHAMP) longitudinal residency education and evaluation. *J Patient-Cent Res Rev*. 2018;5(1):45-54. <https://doi.org/10.17294/2330-0698.1580>
42. Oandasan IF, Barker KK. Educating for advocacy: Exploring the source and substance of community-responsive physicians. *Acad Med*. 2003;78(10): S16-S19. <https://doi.org/10.1097/00001888-200310001-00006>
43. Boroumand S, Stein MJ, Jay M, Shen JW, Hirsh M, Dharamsi S. Addressing the health advocate role in medical education. *BMC Med Educ*. 2020;20(1):28. <https://doi.org/10.1186/s12909-020-1938-7>
44. Kane MT. Current concerns in validity theory. *J Educ Meas*. 2001;38(4):319-342. <https://doi.org/10.1111/j.1745-3984.2001.tb01130.x>
45. Kogan JR, Hess BJ, Conforti LN, Holmboe ES. What drives faculty ratings of residents' clinical skills? The impact of faculty's own clinical skills. *Acad Med*. 2010;85(10):S25-S28. <https://doi.org/10.1097/ACM.0B013E3181ED1AA3>
46. Hubinette M, Dobson S, Voyer S, Regehr G. 'We' not 'I': health advocacy is a team sport. *Med Educ*. 2014;48(9):895-901. <https://doi.org/10.1111/medu.12523>
47. Heise L, Greene ME, Opper N, et al. Gender inequality and restrictive gender norms: Framing the challenges to health. *Lancet*. 2019;393(10189):2440-2454. [https://doi.org/10.1016/S0140-6736\(19\)30652-X](https://doi.org/10.1016/S0140-6736(19)30652-X)
48. Dielissen P, Bottema B, Verdonk P, Lagro-Janssen T. Attention to gender in communication skills assessment instruments in medical education: a review. *Med Educ*. 2011;45(3):239-248. <https://doi.org/10.1111/j.1365-2923.2010.03876.x>
49. Mueller AS, Jenkins TM, Osborne M, Dayal A, O'Connor DM, Arora VM. Gender differences in attending physicians' feedback to residents: a qualitative analysis. *J Grad Med Educ*. 2017;9(5):577-585. <https://doi.org/10.4300/JGME-D-17-00126.1>
50. Sabin JA, Nosek BA, Greenwald AG, Rivara FP. Physicians' implicit and explicit attitudes about race by MD race, ethnicity, and gender. *J Health Care Poor Underserved*. 2009;20(3):896-913. <https://doi.org/10.1353/HPU.0.0185>
51. Sharda S, Dhara A, Alam F. Not neutral: Reimagining antiracism as a professional competence. *CMAJ*. 2021;193(3):E101-E102. <https://doi.org/10.1503/CMAJ.201684>
52. Hafferty F. Beyond curriculum reform: Confronting medicine's hidden curriculum. *Acad Med*. 1998;73(4):403-407. <https://doi.org/10.1097/00001888-199804000-00013>
53. Sukhera J, Watling CJ, Gonzalez CM. Implicit bias in health professions: From recognition to transformation. *Acad Med*. 2020;95(5):717-723. <https://doi.org/10.1097/ACM.0000000000003173>