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Original Research

Exploring the perspectives of new-in-practice specialists about the Health Advocate role: "I didn't even know where to start"

Exploration des perspectives des spécialistes nouvellement en exercice sur le rôle de promoteur de la santé : « Je ne savais même pas par où commencer »

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Abstract

Introduction: Current approaches to health advocate (HA) training leave many physicians feeling ill-equipped to advocate effectively. Likewise, faculty perceive the HA role as challenging to teach, role model, evaluate and assess. Progress on improving HA training is further stalled by debate over the role's importance and whether it should be considered intrinsic to medical practice. Recent graduates are well-positioned to comment on how these challenges affect HA training and preparation for practice. Therefore, our purpose was to explore the perspectives of new-in-practice physicians who are keen to be effective advocates.

Methods: Ten early-career physicians participated in semi-structured interviews exploring their perceived competence and motivation to engage in health advocacy. Constructivist grounded theory informed the iterative data collection and analysis process.

Results: Participants wished they knew during training how much they would use advocacy in practice. While training imparted adequate patient-level advocacy skills, participants felt underprepared to enact system-level advocacy–which they conceptualized as a wide-range of activities including political advocacy. In turn, participants grappled with lack of preparation, waning motivation, feelings of futility, lack of value for advocacy and need for self-preservation. For these reasons, they questioned whether system-level advocacy should be expected of all physicians.

Conclusions: Although training may adequately prepare physicians for patient-level advocacy, system-level advocacy training remains insufficient. While patient-level advocacy is integral to good care, whether system-level advocacy should be a universal expectation deserves closer consideration. Perhaps system-level health advocacy may be better conceptualized as a specialized role requiring additional training. Regardless, physician advocates' efforts need to be valued for their contributions.

Résumé

Introduction : Les cursus actuels de formation à la promotion de la santé (PS) font que de nombreux médecins se sentent mal outillés pour défendre efficacement les intérêts des patients. De même, le corps enseignant perçoit le rôle de PS comme difficile à enseigner, à incarner et à évaluer. Un débat sur l'importance de ce rôle et sur la question de savoir s'il doit être considéré comme intrinsèque à la pratique médicale ralentit encore les progrès en matière d'amélioration de la formation à la PS. Les praticiens fraîchement diplômés sont bien placés pour commenter la manière dont ces obstacles affectent la formation à la PS et la préparation à la pratique. Notre objectif était donc d'explorer les points de vue de médecins en début de carrière qui souhaitent devenir des défenseurs efficaces des intérêts de leurs patients.

Méthodes : Dix médecins en début de carrière ont participé à des entretiens semi-structurés explorant leur ressenti de leur compétence et de leur motivation vis-à-vis la défense des intérêts des patients. La théorie constructiviste ancrée a guidé le processus itératif de collecte et d'analyse des données.

Résultats : Les participants auraient souhaité savoir pendant leur formation dans quelle mesure ils utiliseraient la défense des intérêts des patients dans leur pratique. Si leur formation leur a permis d'acquérir des compétences suffisantes en matière de défense des intérêts de leurs patients à une échelle individuelle, les participants ne se sont pas sentis suffisamment préparés à défendre les intérêts des patients à l'échelle du système de santé, ce qu'ils ont conceptualisé comme un large éventail d'activités, y compris au niveau politique. Les participants ont été confrontés à un manque de préparation, à une baisse de motivation, à une impression d'inutilité, à une dévaluation de la défense des intérêts des patients et à un besoin de se préserver. Pour ces raisons, ils se sont demandé s'il fallait attendre de tous les médecins qu'ils défendent les intérêts des patients à un niveau systémique.

Conclusions : Bien que la formation puisse préparer adéquatement les médecins à la défense des intérêts de leurs patients à une échelle individuelle, la formation à la défense des intérêts des patients à une échelle systémique reste insuffisante. Si la défense des intérêts du patient individuel fait partie intégrante de la qualité des soins, la question de savoir si la défense des intérêts des patients à une échelle systémique doit être une attente universelle mérite d'être examinée de plus près. Il serait peut-être préférable de conceptualiser la défense des intérêts des patients au niveau du système de santé comme un rôle spécialisé nécessitant une formation supplémentaire. Quoi qu'il en soit, les efforts des médecins en tant que défenseurs des intérêts des patients doivent être appréciés à leur juste valeur.

Introduction

A physician's ability to influence patient health outcomes resides not only in traditional notions of medical expertise, but also in advocating[1] "to promote those social, economic, educational, and political changes that ameliorate the suffering and threats to human health and well-being that he or she identifies through his or her professional work and expertise."[2] Recognizing the importance of advocacy in 21st century practice, curricular frameworks across the world, including CanMEDS, have formalized the Health Advocate (HA) role as an assessable competency.[3–6] Competence in advocacy requires both understanding factors (beyond the biomedical) that influence patients' health[7], and the ability to enact positive change.[8] Although training programs should be ensuring that learners have the foundational knowledge and practical skills to advocate for both individual patients and for system-level change, health advocacy remains challenging to teach, role model, learn, evaluate and assess.[9–15] In short, current HA training is not meeting learners' needs,[2,10,16–20] leaving many new-in-practice physicians feeling ill-equipped to advocate competently at all levels.[21-23]

More problematically, there remains some degree of ambivalence amongst faculty and trainees about whether health advocacy is (or should be) an intrinsic physician role.[24] Whether the lack of explicit recognition of the role in practice—as part of the 'hidden curriculum'[25] or lack of definitional clarity is to blame,[26] debate about the significance of the role persists and spurs ongoing uncertainty.[27] On one side, many physicians conceptualize work such as writing letters or ensuring timely testing and specialized care for patients, not as the "above and beyond"[28,29] work of health advocacy, but as an expected standard of care. For these physicians, many of the activities encompassed by the HA role[10] are indistinguishable from 'good care.'[28] Others are less sure that engaging in large scale activities like advocating for government funding of novel treatments is part of their job. Similarly, as it stands, the HA role also encompasses more controversial tasks like political advocacy or 'activism,'[30] which are postulated to be rooted in an ethical obligation or 'duty to society'.[31] Questions remain about the expectation of 'activism' and its congruence with a physician's role[30,31]—particularly given the ethical conundrums of balancing competing interests between individual and societal needs.[32]

Regardless of why the HA role is mired in ambiguity, current social justice movements and events including the opioid crisis and global health emergencies like COVID-19, emphasize that both patients and broader society need physician advocates. Conversations about the HA role and what it entails are particularly timely, given upcoming revisions to the CanMEDS framework adopted by medical schools in various international settings.[33] Meaningful improvements rely on sound evidence, but so far, research on the challenges of health advocacy training has largely focused on the perspectives of those not overly aware of nor interested in enacting the HA role.[18,26,34] We sought to explore health advocacy from a different angle, exploring the perspectives of physicians who envision health advocacy as a key feature of their professional work.

Specifically, since recent graduates can provide an invaluable perspective about how postgraduate medical education training influences advocacy competence and engagement, our purpose was to understand the perspectives of new-in-practice physicians who identify as motivated advocates. By exploring their experiences, the global medical education community will be better positioned to both harness the successes and address the shortcomings of current training frameworks for the HA role.

Methods

To guide our inquiry, we used constructivist grounded theory (CGT)—a qualitative research methodology useful for examining underexplored social processes such as learning to advocate. Our goal was to theorize about the challenges affecting advocacy training and enactment, not to generate a formal theory. The study protocol was approved by the Ottawa Health Science Network Research Ethics Board and the Health Sciences and Medicine Research Ethics Board at the University of Ottawa.

Recruitment

We purposively sampled specialist physicians in their first five years of independent practice working in the following 10 specialties: Internal Medicine, Obstetrics & Gynecology, General Surgery, Psychiatry, Pediatrics, Anesthesia, Emergency Medicine, Physical Medicine & Rehabilitation, Pathology, and Radiology. Of these, participants from seven specialties agreed to participate. We chose these specialties to examine how advocacy training unfolds in areas with both variable amounts and types of direct patient care encounters and differing amounts of exposure to vulnerable populations. We based our rationale for

purposive sampling on two premises. First, new-in-practice physicians are well placed to comment on how their training prepared them for independent practice.[35] Second, specialty training lags behind primary care programs in the development and implementation of advocacy curricula, thus making new-in-practice specialists uniquely positioned to discuss the affordance and limitations of current training models.[36-38]

Department & Division heads, Program directors, Department & Program Administrators and their assistants at the University of Ottawa forwarded recruitment materials by email to staff in their first five years of independent practice, including current staff physicians and recent graduates of their respective programs. Snowball sampling was subsequently used to recruit additional participants. Although we recruited physicians through one university, participants either trained or are currently practicing at multiple institutions across Canada. Additionally, the two participants recruited via snowball sampling are not practicing at the primary recruitment site.

Data collection

Individual semi-structured interviews occurred between March 2021 and April 2022. Verbal consent was obtained from each participant prior to commencing the interview. Interviews (~50 minutes in length) were conducted by JDC and LC via videoconference or telephone calls. During interviews, participants (Table 1) were asked to share their perspectives on the role of health advocacy in their practice. Specifically, we explored their perceived competence in advocacy (by eliciting reflections on experiences of successful and unsuccessful advocacy attempts), what motivates them to use advocacy in their practice, and to reflect on discrepancies between expectations of what they thought health advocacy would be during training compared to the realities of health advocacy in practice. We purposefully did not define health advocacy for participants; however, upon their request, we provided two participants with the CanMEDS 2015 definition of the Health Advocate role.[6] The interview guide (Table 2) was updated during the iterative data collection and analysis process to ensure that evolving themes were explored in adequate depth. Interviews were audio-recorded, transcribed, and de-identified prior to analysis.

Table 1. Participant characteristics

Category	Characteristics
Participants	*n* = 10
Specialties	Emergency Medicine (EM) (*n* = 1) Anesthesia (*n* = 1) General Surgery (GS) (*n* = 1) Physical Medicine & Rehabilitation (PM&R) (*n* = 3) Internal Medicine (IM) (*n* = 2) Pediatrics (*n* = 1) Radiology (*n* = 1)
Practice type	Academic (*n* = 7) Community (*n* = 3)
Practice location	Urban (*n* = 8) Rural (*n* = 2)
Gender	Female (*n* = 7) Male (*n* = 3)
Year of independent practice	1 (*n* = 3) 2 (*n* = 2) 3 (*n* = 0) 4 (*n* = 2) 5 (*n* = 3)

Table 2. Sample Semi-Structured Interview Questions

1.	Can you tell us about a memorable instance of health advocacy since you started practicing?
2.	Are there any lessons you have learned from successful or unsuccessful advocacy attempts?
3.	How do you go about identifying when advocacy is needed?
4.	What cues or drives you to feel like you should go that "extra mile" or take it to the next step in some circumstances rather than others?
5.	Did you feel adequately prepared to advocate for your patients after completing residency/fellowship?
6.	What experiences helped shaped your ability to advocate?
7.	What skills do you need to be an effective advocate?
8.	Is the advocacy you do in practice different to what you were taught in your medical training/ what you thought you would be doing?
9.	To what extent do you feel like a competent health advocate in your daily practice – any examples of why/why not?
10.	Have you identified any system level issues in your practice that would benefit from advocacy?
11.	Have you engaged in advocacy at the hospital/community/provincial/international level? How did it go?
12.	What is your strategy or approach to advocacy for system issues impacting your patients?
13.	In hindsight, is there anything with regards to advocacy that wasn't covered in your residency that should have been?
14.	Do you have any other thoughts you want to share on how your medical education prepared you for your role as health advocate in independent practice?

Interviews were participant-directed, meaning that participants decided what was important to discuss. Prompts reflect specific questions the research team may ask if they are not first introduced by the participants. New questions were added as the research process evolved.

Data Analysis

Team members engaged in three increasingly interpretive stages of coding: initial, focused, and theoretical.[39] During initial coding, JDC and KAL independently read the first four transcripts in full. To ensure that the early analysis remained grounded in the data, JDC engaged in line-by-line

coding of these transcripts, using gerunds or direct quotes from participants (in vivo codes) to describe rather than interpret participants' actions and perspectives. Next, JDC compiled a list of the most frequently occurring or compelling initial codes, working with KAL to consolidate them into preliminary focused codes that were reviewed by the research team.

Next the team engaged in multiple rounds of focused coding to build and refine categories. First, JDC trialled the relevance of preliminary focused codes identified during initial coding by applying them to subsequent transcripts. As new transcripts were generated and included in the analysis, the entire research team met frequently to discuss preliminary categories and to identify opportunities to flesh out the evolving analysis by theoretically sampling both new participants and by revising the interview guide to ask additional questions. Once the research team determined that a finalized list of categories robustly captured data generated by the exploratory research questions, the team engaged in theoretical coding to understand the relationships between individual categories.

Throughout the entirety of the analytical process, the team engaged in constant comparative analysis, meaning that data both within and across transcripts were regularly reviewed to ensure that the analysis attended to multiple perspectives, paying particular attention to discrepant cases. Constant comparative analysis was aided by team members reviewing both full transcripts and data fragments at multiple timepoints and engaging in memo writing and diagramming to capture and construct increasingly abstract ideas about the data.[37] NVivo qualitative research software was used to manage the data.

Reflexivity

In CGT methodology, findings are co-constructed by researchers and participants.[39,40] Regularly engaging in reflexivity, or the process of unpacking how researchers' knowledge, experiences, preconceptions, and perspectives might either cloud or sharpen the focus on certain aspects of data generation and analysis, is vital for ensuring transparency and rigor.[40,41]

All authors are medical education researchers who have explored HA through various professional lenses and engaged in many HA experiences. Our research team is comprised of clinicians (JDC, ND, KC) and graduate-trained scientists with extensive expertise in qualitative research (KAL, LC, ND). JDC, ND, and KC are physicians specializing in Physical Medicine and Rehabilitation—a specialty in which health advocacy is central to the work of caring for complex patients with disabilities. JDC was a resident physician at the time the research was conducted. Her interest in health advocacy research stems from advocacy experiences related to patient care, accessibility, and to advocacy for physicians in her elected positions as chief resident and on the Professional Association of Residents of Ontario. JDC explored health advocacy for her resident scholarly project because she struggled to understand what it means to be a health advocate, and she was concerned about what her lack of understanding might mean about her competence to advocate once she transitioned to independent practice. As a new-in-practice specialist and educator, her questions and concerns about the HA role persist. ND is a full professor and medical education researcher interested in workplace-based assessment. As clinician educators, both ND and KC are immersed in the practical challenges of training and assessing physicians. Because KC is within her first five years of clinical practice, she is keenly attuned to both the affordances and limitations of advocacy training. LC is a research associate with an interest in the uptake of advocacy in training and practice. KAL is a PhD scientist interested in investigating the challenges of training the HA role from the points of view of faculty physicians, trainees, and patients.

Results

During training, participants did not fully appreciate how important the HA role would be to their practice, noting "you really see how much this is such a huge part of my life and my career and I wish I had realized it more throughout training" (P3, PM&R). All described using patient-level advocacy skills "at least on a weekly basis" (P6, Anesthesia). According to participants, the work of patient-level advocacy included filling out forms, writing letters to insurers, calling colleagues to expedite investigations or consultations, cancelling a surgical case for a patient safety concern or ensuring communication and follow up of an unexpected X-ray finding. The amount and breadth of advocacy work was a revelation for participants, particularly considering how little formal preparation they reported having for what they now viewed as a fundamental feature of their daily work.

All participants identified system-level advocacy issues in their practices, most of which required large scale activities like seeking funding or appealing for better patient

services. Many were motivated to engage and change the system, but advocacy at that level was noted to be harder. Participants "care for it [the health care system] to be different. And know that it can be, and it needs to be" (P8, Pediatrics) but most did not engage at the system-level for a variety of reasons. Below we elaborate on how both lack of formal preparation during training, and the professional challenges they encountered once in practice, created a paradox for participants in which advocacy was viewed as an intrinsic, yet optional, feature of their professional work. Participants' attempts to reconcile this paradox were evident in three implicit questions we interpreted participants were grappling with as they shared their experiences and perspectives about engaging in health advocacy: "Can I?," "Will I?," and "Should I?"

Can I?

Few participants recalled encountering any explicit teaching on the HA role, and most did "not ever remember learning about [health advocacy]" (P8, Pediatrics) during training. If they did receive explicit advocacy teaching, it was "certainly nothing memorable...or impactful" (P7, IM). Instead, participants relied heavily on informal role modelling, mentorship, and learning on the job, depending on observations of, rather than explicit instruction from, physicians and other health care providers to gain necessary skills and knowledge. Despite the informal and often happenstance nature of these learning opportunities, most felt relatively comfortable advocating for individual patients. But this paucity of instruction was insufficient for developing higher level advocacy skills and most "didn't even know where to start" (P7, IM) when it came to advocating at the system-level for small- or large-scale change. Thus, despite wanting to advocate for resources or system-level changes, participants perceived they lacked the understanding to do this necessary work.

Most participants were eager to become stronger advocates, particularly at the system-level. After training, some went to considerable lengths, investing personal time and resources into learning how to be a more effective advocate at that level. Many spent considerable time "trying to figure out who to talk to. It probably took me 10 months until I spoke to one of the people that I should have spoken to right away" (P1, PM&R) and understanding the "spiderweb of different roles and responsibilities" (P9, Radiology) that make up the health system. One hired a leadership coach "for guidance on how to advocate" (P1, PM&R). Another described spending their downtime reading extensively about business strategy and ethics surrounding advocacy, noting "I have an interest in Business and my business books have taught me so much" (P6, Anesthesia). Several others sought advice from mentors, including one participant who reported that "advocacy has been one of the things that we've discussed at monthly mentorship meetings" (P3, PM&R). However, although most participants identified as health advocates and several worked to develop advocacy-related skills, all were conflicted about their willingness—and responsibility—to engage.

Will I?

Participants were unequivocal that they had to advocate when a patient was acutely struggling and "the wheels are coming off, they've got no money for medication, no access to transportation to appointments, they're in and out of hospital…you identify that nothing is going well" (P5, PM&R). Yet, because participants recognized the potential for advocacy to "ruffle some feathers" (P6, Anesthesia), participants expressed concern that if they advocated for every patient who needed help navigating the system, they risked being perceived by colleagues as needy, demanding, or annoying. For instance, regarding expediting scans for patients, one participant noted that "I can't ask all the time. I have to be very selective... [about how] I reach out directly and call-in favours" (P7, IM). Participants' concerns were not unfounded. Several reported backlash from their colleagues and institutions about their advocacy work, exemplified by one participant who reported receiving a threatening email from administrators when advocating for better patient consent procedures. However, regardless of the professional risks and repercussions, participants were clear that when a patient's well-being was at risk, 'ruffling feathers' was an imperative rather than a deterrent.

Motivations to engage in system-level advocacy were less clear-cut. Participants were primarily driven to engage at the system-level when they felt personally invested. Participant P8 (Pediatrics) who advocated for pediatric palliative care services, P4 (GS) who advocated for perioperative smoking cessation support and P1 (PM&R) who advocated for physician wellness all described that their involvement in system-level advocacy was driven by passion. Although Participant 8 (Pediatrics) recognized countless opportunities to advocate on behalf of children, they perceived their competence as an advocate was directly linked to their personal investment in a cause. Consequently, they made strategic decisions in channelling their energy because, without passion, "if you ask me to sit

on the committee to review nutritional information on all the different formulas, I'm not going to be your best advocate" (P8, Pediatrics). These reflections suggest not only that system-level advocacy requires an additional level of motivation to drive action, but also that many perceive system-level advocacy as optional.

At all levels of advocacy, external feedback impacted participants' inclination to act. Motivation was strengthened by personal and vicarious experiences with successful advocacy—with participants describing that it was "encouraging" (P5, PM&R) to receive feedback from patients or colleagues when their efforts resulted in meaningful change. Participants were also hugely influenced by mentors who boosted their confidence and encouraged them to use their HA voice. Some intentionally sought validation from a "sounding board" (P6, Anesthesia) of trusted colleagues before using their voice for advocacy.

Unfortunately, de-motivating forces far outweighed the successes and encouragement that fostered participants' willingness to advocate, particularly for system-level change. Participants described multiple failed attempts at advocacy, from trying and failing to secure funding for equipment, physician wellness programs, or for hiring more staff for outpatient allied health services: "you can ask but it feels like you just hit a wall every time. Or they say we'll get back to you and it's a year later and you're still waiting" (P7, IM). These setbacks often diminished participants' resolve to continue fighting for causes they strongly believed in: "We know what the problem is, we're trying to fix it, no one's listening to us. What do we do now?" (P2, EM). When encountering these roadblocks, some participants chose to persevere, while others found "workarounds" (P5, PM&R). Others, however, chose to bow out completely, such as one participant who disclosed during their interview that "last night [I] wrote my resignation letter because, after a year of doing this as a volunteer, I told them that I wouldn't continue to do it if it was not paid" (P1, PM&R).

Indeed, a growing realization that advocacy "doesn't count for much" (P8, Pediatrics) made participants feel defeated, influencing their decisions to either step away from, or to not embark on, system-level advocacy at all. Specifically, knowing that most academic institutions "do not care [about advocacy work] for promotion" (P8, Pediatrics), some participants have chosen to delay their engagement in larger scale activities at the system-level until they are more established in their careers. Self-preservation was also perceived as vital because "there is a lot of mental overload of being new in practice that sometimes I just can't take that little bit of extra trying to negotiate something more and maybe that will change and my approach to that will change as I get further along in practice" (P4, GS). Participant 8 (Pediatrics) echoed this sentiment by saying: "it would be really hard for me to take on something really big right now. I just feel like sometimes I'm barely treading water." Accordingly, despite their personal interests and passions, both professional demands and the lack of value attached to advocacy work made participants question not only their personal motivation, but also the broader expectation that all physicians should be health advocates.

Should I?

Barriers, motivation and lack of formal training aside, when directly asked whether the Health Advocate role should be an intrinsic feature of physicians' practice, participants reiterated that patient-level advocacy was "very intertwined with the medical care that we provide" (P5, PM&R). In the absence of a perfect healthcare system, "sometimes providing good care is a challenge. So I think you have to advocate in order to just, make sure that [patients] get good care" (P7, IM). Participants were, however, less convinced that every graduating specialist can or should be expected to engage in large scale activities at the system-level—particularly immediately upon completing residency.

> *I think within Medicine, it's so broad, you can't expect every single graduate to be able to be an excellent systems-level advocate. I think we need to be aware. I think they need to be educated about it, but I don't think they need to be able to be the one to convince the Government that they're going to give XYZ for this gap. (P8, Pediatrics)*

This perception that system-level advocacy is beyond the scope of what should be expected of every specialist was felt by several participants to be supported by lack of curricular focus on preparing trainees for this work. "You need to know how the highest decisions are being made in order to be able to influence decision-makers" (P1, PM&R) but "health system literacy is something that is deficient within our training" (P10, IM). Furthermore, there is little opportunity to learn about healthcare governance, policy or system structure - though several wished they had been exposed to these concepts during training. Indeed, when asked about gaps in advocacy preparation, participants like P9 (Radiology) described that physicians need an "extra level of training, both formal training but also on-the-job

experience" to be able to advocate effectively, particularly at the system-level.

Thus, although most participants were interested in the *idea* that physicians should advocate at all levels, comments shared by a few suggested that their personal decisions not to engage risked becoming permanent. One participant was cognizant that the stresses of modern practice were unlikely to abate as they progressed in their career. This realization, coupled with a feeling of being overwhelmed at the scope of problems health advocates face, made this participant wary of ever engaging in system-level advocacy: "I'm only one person and I cannot fix everything. I cannot burn out. We all burnout at some point" (P2, EM). Another participant seemed to hint at something more sinister driving why they—or any physician—might disengage from the Health Advocate role. Specifically, this participant seemed to suggest that their reluctance to advocate wasn't because they were unwilling to engage, but because they received strong implicit and explicit messages that they "shouldn't": "it's [advocacy] often perceived…extremely negatively, so much so that it's intimidating, you feel like you shouldn't be doing this..." (P6, Anesthesia).

Discussion

Training bodies are at a crossroads, and work is underway to re-evaluate whether current definitions of advocacy competence are congruent with the realities of training and practice.[42] We contribute to this work by reporting the experiences and perspectives of new-in-practice physicians, shedding additional light on why many physicians do not view advocacy as intrinsic to their professional role.[24,25] Our findings are particularly illuminating because they were generated by a seemingly rare cohort[18,34,43] of physicians who identify as health advocates and want to contribute meaningfully to both patient and system-level advocacy. Participant accounts aligned with previous literature describing limited explicit teaching on the HA role.[27,44,45] But, that these physicians both perceived patient-level advocacy as intrinsic to their daily work and felt capable engaging at this level is good news for regulatory-bodies and training programs. This finding may indicate that increasing attention to health advocacy and recognition of the 'hidden curriculum'[46] in recent years has resulted in gradual improvements in HA training, making graduates not only more aware of the role of advocacy in clinical practice, but also better prepared to advocate for individual patients. That participants questioned whether they or any physician could—or *should*—be expected to advocate competently at the system-level upon entering practice is less encouraging. Even worse, not only did participants perceive that this expectation may be impractical, unrealistic, and perhaps unnecessary, but they detailed a multitude of barriers preventing motivated advocates from engaging in this much-needed work.

Failing to succeed

Competence motivation theory outlines that successful and unsuccessful attempts at mastery contribute to an individual's perceptions of competence and influence their motivation to act.[47–49] Applying this theory to the construct of health advocacy training suggests that physicians need opportunities to experience successes to develop their confidence in this role. The scarcity of success participants experienced with system-level advocacy—despite investment of significant personal resources—made participants less willing to persevere despite their strong beliefs and personal passions. Whether lack of advocacy skills or inexperience is to blame, repeated failures made their actions feel futile.

The frustrations they experience enacting advocacy are compounded by both implicit and explicit messages that their efforts are neither valued nor desirable. The messages of disapproval participants received were not exclusive to system-level advocacy. Participants indicated that all forms of advocacy were commonly perceived as annoying, sometimes resulting in backlash. Participants were also troubled that their advocacy work at any level rarely counted for remuneration or promotion,[50] strongly suggesting that, despite being formalized in competency frameworks, institutions and programs do not view the HA role as intrinsic.

The HA role appears to be the only intrinsic role where greater investment and higher-level action can yield harm rather than professional advancement, setting it apart from other intrinsic roles where value is explicit – such as department heads receiving remuneration for leadership roles and scholarly productivity counting heavily for promotion. According to competence motivation theory, failures along with "lack of reinforcement or disapproval from significant social agents"[49] decrease perceptions of competence and control, which hinders motivation.

Should advocacy be a specialized professional calling?

Our findings suggest that it may be important to separate the responsibility to advocate at the patient-level from

engaging in larger scale advocacy activities at the system-level. We argue that most physicians would agree with participants that advocating for individual patients is part and parcel of good care—even if this work is challenging to consistently enact due to the personal resources required, the lack of perceived institutional value, and the potential for personal and professional harm. System-level challenges are much greater, and it is perhaps unsurprising that even highly motivated physician advocates (particularly those new to practice) have little appetite to engage in such seemingly high effort, low yield advocacy activities.

Notably, participants' perceptions of their expectations to advocate competently at all levels do not align with the graduated approach to HA competency put forward in the CanMEDS 2015 milestone guide.[51] The milestone guide clearly states that new-in-practice physicians are not expected to engage in all the activities that participants perceived as required parts of practice. Yet, participants were discouraged and demotivated when they didn't meet what they viewed as an expected competence. This discrepancy suggests that the CanMEDS 2015 milestone guide is either not taken up in, or not translating well to, Canadian postgraduate medical education. This discrepancy also aligns with a long-standing, yet growing, body of evidence suggesting a disconnect between the intentions of the CanMEDS framework and the actual experiences of trainees.[9-15,29,45]

Even if participants assumptions that new-in-practice physicians must competently advocate at all levels are incorrect, participants *wanted* to do this work. Yet, their experiences demonstrate that the work of physician advocates may not be valued in the same way that clinical and scholarly productivity or leadership activities are. Troublingly, not only did participants perceive that they were unprepared for advocacy work they were keen to do, but they provided multiple, clear examples where they were actively discouraged from engaging. Participants' accounts raise two questions that programs adopting CanMEDS around the world need to grapple with. First, do we—as a medical education community—value health advocacy? If we do, then health advocacy across all levels must be more formally and meaningfully incorporated into training. Advocates (like their research colleagues) should be provided protected time to do this difficult work. Advocacy work must also count for promotion in the same way that scholarship or leadership are.

Second, should system-level advocacy be considered intrinsic to the physician role? The potential for engagement to negatively affect both personal and professional well-being is a compelling argument for suggesting the answer might be no. But the answer also depends on how system-level advocacy is defined. Participants conceptualized system-level advocacy as a wide-range of activities, including political advocacy at the Federal level, that may not actually be work all physicians are expected to do. Participants' perspectives re-iterate that advocacy remains a murky concept. The next iteration of CanMEDS must clarify how advocacy is defined, provide clearer guidance about expectations for graduated competence. Regardless, systems-level advocacy—however it is defined—may require a more advanced skillset than the patient level advocacy participants described as the bread and butter of a physician's professional work. Participants identified clear training gaps that need to be filled for physicians to participate in any type of systems-level advocacy, including more meaningful teaching about health system literacy, policy, and governance.

Participants also suggested the intriguing possibility that perhaps system-level health advocacy should be re-imagined as a specialized professional calling that requires extra training or opportunities for continuing professional development. The Scholar and Leader roles provide a template for how residency programs might re-imagine training for health advocacy. For instance, the CanMEDS Scholar role requires trainees to be exposed to principles of lifelong learning, teaching, evidence-informed decision making and research,[52] but there is no expectation that this training will fully equip trainees for an academic career in research. This makes sense as not all physicians will want or need to participate in research as part of their career. Those who are interested in a research career often engage in specialized training, with many pursuing a Masters or PhD degree.

Similarly, although training aims to prepare individuals to take a leadership role, not all physicians are required or expected to become a department chair or division chief. A wealth of extra training is available for those choosing to go 'above and beyond' the leadership and scholarly roles expected of most physicians. Of course, because "promoting health equity"[6] is a physician responsibility, choosing to pursue or pass on various forms of advocacy engagement is not as straightforward as it is for professional goals like research or high-level leadership.

However, when re-imagining training for the HA role, our results suggest that while physicians should be exposed to and receive explicit training about all advocacy activities during their residency, expectations that they all need to engage in large-scale efforts at the system-level once in practice deserve careful consideration.

Limitations

Qualitative research aims to generate findings that are rich and contextualized, rather than representative or generalizable. We do not claim that our data is 'saturated';[53] however, we determined that our sample of 10 physicians keenly interested in advocacy (which, according to ample anecdotal and empirical evidence, is a relatively niche population) generated sufficiently rich data to answer our exploratory research questions. Our findings are specific to the Canadian context but even if not enshrined in a framework, advocacy conversations are relevant to all physicians. Similarly, although we only recruited new-in-practice physicians through one Canadian University, participants either completed residency training or are practicing at multiple institutions across Canada. As well, participants' perspectives regarding limited explicit HA teaching and lack of support for HA resonates with the broader literature, suggesting that participants' perspectives are neither institution nor specialty specific.

Conclusion

Although all clinicians need to be scholars, leaders, and health advocates, they do not necessarily all need to be researchers, deans, or political activists. If engagement in both small- and large-scale advocacy activities remains an expectation for all physicians, but they remain inadequately prepared for this work, we run the risk of exhausting their motivation, inhibiting their involvement in future advocacy endeavours, and even contributing to burnout.

Lack of clarity around the definition of HA and expectations for engagement remains a persistent problem affecting not only training but also the uptake of the advocacy role in practice. One productive way forward may be for training bodies and individual physicians to consider whether large scale efforts at the system-level should be an expectation of all physicians or re-imagined as the next level of health advocacy that can be pursued by those who are passionate about it. Perhaps additional training in system-level health advocacy is something that should be developed and offered to physicians in practice. Regardless, for health advocacy to be viewed as an intrinsic physician role, institutions and individual programs need to support physician advocates and value their contributions.

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