



Mount Saint Vincent University
Department of Applied Human Nutrition

**Activism: Does it fall within the roles and responsibilities of all physicians? Perspectives of
Atlantic Canadian physician-activists**

by
Alexandra E Bromley

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Supervisor: Dr. Jennifer Brady
Members of Thesis Committee: Dr. Deborah Norris & Dr. Gary Bloch

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Signature Page

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by
Alexandra E Bromley

Mount Saint Vincent University
Department of Applied Human Nutrition

Approved:

Jennifer Brady, PhD

Thesis Supervisor
Director of Nutrition and Dietetics
Acadia University

Dr. Deborah Norris, PhD

Supervisory Committee Member
Professor & Graduate Coordinator, Department of Family Studies & Gerontology
Mount Saint Vincent University

Dr. Gary Bloch, MD

Supervisory Committee Member
Associate Professor, Family & Community Medicine
University of Toronto

Dedication

To the physicians and other health care professionals who take activism upon themselves to improve the lives of their patients.

To Dr. Daphne Lordly, who stated that a well-rounded researcher must know how to conduct both qualitative and quantitative research. Unbeknownst to you, this sentence has had a profound impact on the future course of my career.

Abstract

Background: Health advocacy is an expectation of all Canadian physicians according to the CanMEDS framework, which defines necessary competencies for medical practice in Canada. Whether advocacy work specifically as activism is a professional responsibility is debated by physicians and is not adequately addressed in previous literature.

Objectives: My objectives for this research are threefold: 1) to glean insight into how physician-activists understand and experience activism in the profession; 2) to determine physician-activists' perspectives on physicians' roles and responsibilities to undertake activism; 3) to garner physician-activists' perceptions on the knowledge- and skill-based training needed by learners to undertake activism.

Methodology & Method: I drew on Thorne's (2016) qualitative interpretive description methodology to design this study for which I collected data via semi-structured interview with 11 physician-activists who are licensed to practice and/or teach in Canada's Atlantic provinces. Interviews were transcribed and thematically analyzed (Braun and Clarke, 2006) in MAXQDA (VERBI Software, 2021). I also collected demographic data which I analyzed using descriptive statistics to provide contextual background of the participants.

Results: From the insights of physician-activists included in this research, two organizing themes emerged. The first theme, *"Activism isn't always about the glory,"* describes how while physicians initially defined activism as public-facing and overt acts, they also provided examples of less visible, quiet, behind-the-scenes work within the important activities they engaged in to promote change. The second theme, *Not an expected duty, but an obligation for some,* describes the perception that activism cannot be a role that is enforced on the profession due to the barriers that currently exist. Despite barriers, these physicians felt an obligation to activism stemming from the belief that patients cannot be adequately treated without redressing the social inequities that affect their health outcomes. Role models and mentors were seen as integral to instilling these beliefs and supporting their activism efforts.

Conclusions & Implications: Physician-activists recognize the importance of covert, behind-the-scenes activism that contribute to systemic-level change. Including quiet activism within the policy documents that outline the roles and responsibilities of the profession will not only clarify what is expected of physicians but will also make activism more accessible and less daunting to both learners and instructors. However, if activism is to be a professional responsibility of medicine, changes in values away from patient throughput towards activism by government and society are integral.

Key terms: health advocacy, agency, activism, social justice, social determinants of health, physician competency, medical education, CanMEDS

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List of Abbreviations

CanMEDS	Canadian Medical Directions for Specialists
CaRMS	Canadian Resident Matching Service
CBC	Canadian Broadcasting Network
CFMS	Canadian Federation of Medical Students
CMA	Canadian Medical Association
CASPER	Computer-Based Assessment for Sampling Personal Characteristics
FFS	Fee-for-service
ICU	Intensive care unit
ID	Interpretive description
MCAT	Medical College Admission Test
MCCQE	Medical Council of Canada Qualifying Examination
MD	Medical Doctor
MMI	Multiple mini interview
MSVU	Mount Saint Vincent University
OSCE	Objective structured clinical examination
RCPSC	Royal College of Physicians and Surgeons of Canada
UBC	University of British Columbia
UBC-HAF	University of British Columbia Health Advocacy Framework

Introduction

The Canadian Medical Education Directions for Specialists (CanMEDS) framework lays out the seven meta-competencies that are expected of all Canadian physicians, one of which is to be a health advocate (Frank et al., 2015). Despite being endorsed by countless medical organizations, there remains controversy over the meaning of the term advocacy and about the types of activities physicians are responsible for under this competency. Some have argued this is because advocacy is focused on describing multiple activities under one umbrella term (Dobson et al., 2012). The University of British Columbia Health Advocacy Framework (UBC-HAF) provides a language to describe the term by breaking it down into agency and activism; where agency includes the activities that take place within the confines of the pre-established healthcare and community systems, and activism includes the activities that attempt to change these systems (Hubinette et al., 2017). While agency is rarely contested, whether activism belongs in the realm of medical practice is disputed, with activism that relates to social justice being fiercely debated in the literature (Goldfarb, 2022; Huddle, 2013). I interviewed 11 practicing and/or teaching physicians in Canada's Atlantic provinces using interpretive description as the guiding methodology. This understudied subpopulation of physicians offered insight into their unique understandings of activism and experiences as activists within the profession. The purpose of this study was to determine participant's perspectives on whether activism is an obligation, responsibility and/or role of physicians, as suggested by the CanMEDS framework and the Canadian Medical Association's Code of Professionalism and Ethics. My aim for this study was to clarify the definition of the health advocate role for the 2025 and future CanMEDS frameworks and thus shed light on options for educating medical trainees about competencies required for advocacy within the medical profession.

Literature Review

Becoming a practicing medical doctor in Canada

This study investigates Canadian physicians' perspectives on the roles and responsibilities of the profession regarding advocacy and activism. Part of this perspective includes how future physicians should be trained to obtain the skills for advocacy and activism, if at all. This section reviews how physicians are trained in Canada and the terminology associated with this training.

Most applicants to medical school have a minimum of a four-year undergraduate degree in a field of their choice (The Association of Faculties of Medicine of Canada, 2023). There are a few schools in Canada that consider applicants who have only completed two years of an undergraduate program. Some applicants also hold advanced degrees, such as master's and doctoral degrees (The Association of Faculties of Medicine of Canada, 2023).

At the time of writing this thesis there are 17 medical schools in Canada that award Medical Doctor (MD) degrees¹ (The Association of Faculties of Medicine of Canada, 2023). However, there are currently four medical schools that are set to open in the next few years. Toronto Metropolitan University, the University of Prince Edward Island, and Cape Breton University are expected to start taking medical students in 2025 (Cape Breton University, 2023; Toronto Metropolitan University, 2023; University of Prince Edward Island, 2021) and Simon Fraser University in British Columbia is expected to start taking students in 2026 (Kieltyka, 2022). Across these current 17 medical schools, over 2,700 students graduate with MD degrees each year (The Association of Faculties of Medicine of Canada, 2023).

Each of the Canadian medical schools have their own eligibility requirements. Some schools require specific undergraduate science courses to be taken, such as organic chemistry, while other schools do not have such requirements (The Association of Faculties of Medicine of Canada, 2023). Most schools in Canada base admission on academic performance, extra-curricular activities that are assessed through supplemental essays, and reference letters. Many of the schools also require exam scores from the Medical College Admission Test and the Computer-Based

¹ There are 17 Canadian medical schools where an MD degree can be obtained. They are listed here in geographical order from the eastern provinces of Canada to the west: Memorial University of Newfoundland, Dalhousie University, Université Laval, Université de Sherbrooke, Université de Montréal, McGill University, University of Ottawa, Queen's University, University of Toronto, McMaster University, Western University, Northern Ontario School of Medicine, University of Manitoba, University of Saskatchewan, University of Alberta, University of Calgary, University of British Columbia (The Association of Faculties of Medicine of Canada, 2023).

Assessment for Sampling Personal Characteristics, more commonly known as the MCAT and CASPER (The Association of Faculties of Medicine of Canada, 2023).

The MCAT is a standardized test that is used in Canada, the United States, and Australia (The Association of Faculties of Medicine of Canada, 2023). It is comprised of four sections,² that have a total testing time of 6 hours and 15 minutes. The test is designed to assess problem solving and critical thinking, as well as knowledge of natural, behavioural, and social science concepts that are related to the field of medicine. Each of the medical schools in Canada that use the MCAT for admission have a minimum cutoff total score and individual section cutoff scores. If an applicant does not achieve these cutoff scores, their application is not processed. This also occurs for grade point averages (The Association of Faculties of Medicine of Canada, 2023).

The CASPER test is called a situational judgment test that is designed to assess soft skills that are thought to be important to medicine, such as professionalism and empathy (The Association of Faculties of Medicine of Canada, 2023). This test is used by eight of the Canadian medical schools. It is assessed in varying ways. For example, Dalhousie University uses it to eliminate students from the applicant pool if they score 1.5 standard deviations below the mean, whereas other schools use the scores from the CASPER to make judgements on students who are on the cusp of being admitted (The Association of Faculties of Medicine of Canada, 2023).

Following the application of testing scores, academic records, supplemental essays, and reference letters, some students are invited for an interview (The Association of Faculties of Medicine of Canada, 2023). These are conducted in a style known as the multiple mini interview (MMI). Unlike traditional interviews, interviewees move through different stations of the MMI, with each station having a different evaluator. There are usually between six and ten stations, and stations tend to last less than eight minutes (The Association of Faculties of Medicine of Canada, 2023).

Successful applicants enter undergraduate medical school, which is usually a four-year program³ (The Association of Faculties of Medicine of Canada, 2023). Medical school is generally divided up into two segments, each lasting two years: the pre-clerkship and the clerkship years

² The four sections are: 1) Biological and Chemical Foundations of Living Systems, 2) Chemical and Physical Foundations of Biological Systems, 3) Psychological, Social, and Biological Foundations of Behaviour, and 4) Critical Analysis and Reasoning Skills (Association of American Medical Colleges, n.d.)

³ McMaster University is the only university in Canada that offers an accelerated three-year medical education undergraduate program (McMaster University, n.d.).

(Berndl, 2007). During pre-clerkship, students spend the majority of their time learning the foundational knowledge and skills of the biomedical sciences, where much of the education takes place in traditional lectures and laboratories. The clerkship years are where students begin to gain hands-on, practical experience, learning to effectively communicate and work with patients. Fifteen months prior to graduating medical school, students can apply to write the Medical Council of Canada Qualifying Examination Part I (Medical Council of Canada, n.d.). This exam assesses medical knowledge and clinical decision-making skills. Graduates that pass this exam can move onto the next stage of training which is residency (Medical Council of Canada, n.d.). At the end of the four years of medical school, those who graduate earn their MD degree (Berndl, 2007).

In the final year of undergraduate medical school, students apply for residency positions (Canadian Resident Matching Service, n.d.). This is where newly graduated doctors train in their specialty of choice. Students are ranked by programs through many means, including scholarly achievements, letters of recommendation, and experience. The matching process occurs through the Canadian Resident Matching Service (CaRMS). CaRMS service uses an algorithm to match students into residency programs, based on the preference of the applicant and the ranking of each applicant by the residency programs (Canadian Resident Matching Service, n.d.). Once matched into a residency program the trainee becomes a resident. These programs vary in length from two to seven years (Berndl, 2007). Since each residency program varies in content, the specifics of residency training are not discussed here. However, in each program, trainees practice medicine under the supervision of senior physicians (Berndl, 2007).

For some physicians, the completion of residency is the end of their formal training (Berndl, 2007). However, some residents subspecialize and become fellows, by completing a fellowship. Fellowships range in length from one to three years. Once residency and/or fellowship is completed, depending on the specialty, these physicians are known as attendings, where their work is no longer being supervised (Berndl, 2007). Although attendings can practice medicine without supervision, education does not end. Physicians in Canada have a duty to continue educational endeavors. The Maintenance of Certification Program requires that physicians complete a certain number of hours of training, such as attending accredited conferences and workshops (Royal College of Physicians and Surgeons of Canada, n.d.a). Failure to do so results in an inability to practice medicine in Canada (Royal College of Physicians and Surgeons of Canada, n.d.a).

Inclusion of “advocacy” by medical governing bodies in Canada and globally

Governing bodies of medical establishments across the globe and in Canada include advocacy as part of the professional roles of physicians. The Royal College of Physicians and Surgeons of Canada (RCPSC) developed The Canadian Medical Education Directions for Specialists framework, commonly known as CanMEDS. CanMEDS outlines the professional competencies expected of all physicians practicing in Canada (Frank et al., 2015). This framework consists of seven meta-competencies that are further broken down into key and enabling competencies. Since the first edition of the CanMEDS framework, which was released in 1996, one of the meta-competencies has always been for physicians to take on the role of being a health advocate⁴ (Frank, 2005; Frank et al., 2015; Societal Needs Working Group, 1996). CanMEDS is endorsed by 12 Canadian medical organizations, including the Canadian Medical Association, the College of Family Physicians of Canada, and it is endorsed by all provincial and territorial medical governing bodies (Frank et al., 2015). This framework has also been adopted by dozens of countries outside of Canada on all continents except Antarctica.⁵ CanMEDS is thus considered to be the most widely used and recognized physician competency framework globally (Frank et al., 2015).

Other countries who have not adopted the CanMEDS framework also include advocacy among their professional competencies. The American Medical Association (2001) has the Declaration of Professional Responsibility. This document proclaims the commitments that all physicians practicing within the United States of America must abide by. The eighth commitment is to “advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being” (p. 1). The Australian Medical Council (2009) has the Code of Conduct which outlines the expectations of all doctors in Australia. In this document they acknowledge that there are health disparities that exist among those residing in Australia due to differences in “social, cultural, geographic, health-related and other factors” (p. 17). Therefore,

⁴ The other meta-competencies of the 2015 framework are: scholar, professional, communicator, collaborator, and leader. The seventh competency, medical expert, is obtained by integrating the other six competencies (Frank et al., 2015).

⁵ The specific countries who endorse the CanMEDS framework are not included in any of the official documents released by the Royal College of Physicians and Surgeons of Canada. This is because often only certain organizations or jurisdictions will use the framework, not necessarily the entire country. However, in a personal communication with the administrative assistant of CanMEDS and Faculty Development, some of the countries who are known to use the framework in some capacity include the Netherlands, Switzerland, Germany, South Africa, Saudi Arabia, Qatar, Russia, Chile, China, and Japan (A. P. Cota, personal communication, December 21, 2022).

one of the principles within the code of conduct is health advocacy which states that physicians must, “use [their] expertise and influence to protect and advance health and wellbeing of individual patients, communities, and populations” (p. 17).

Defining physician advocacy & activism

Advocacy has been established as an important competency and professional role by countless medical establishments. Despite this, there is confusion regarding what being an advocate actually means within the profession of medicine (Dobson et al., 2012; Earnest et al., 2010). Therefore, no discussion of advocacy can begin without first having a basic understanding of the current controversy. To be able to examine advocacy, a definition of the term must then be specified to frame the rest of the discussion.

It has been argued by some that the reason why there continues to be confusion around advocacy is because it is attempting to describe multiple activities under one term (Dobson et al., 2012). A team of researchers in British Columbia, Canada have been working to understand what advocacy means to physicians. Hubinette et al. (2014) interviewed 11 family physicians and determined that physicians saw advocacy at three different levels: clinical, paraclinical, and supraclinical advocacy. Clinical advocacy included those activities that were directly related to patient care, such as diagnosis and treatment, diagnostic screening, providing education, promoting lifestyle changes, and helping individuals navigate the healthcare system. Paraclinical advocacy were the activities that helped connect patients to resources that were not directly related to the healthcare system, such as helping patients fill out forms for social services or connecting patients to resources in the community. Supraclinical advocacy were the activities that were focused on the social determinants of health that had a goal of structural change, such as lobbying for policy reforms. Interestingly, this study found that the definitions of advocacy between physicians did not overlap. Those who defined advocacy as clinical activities did not mention supraclinical activities as being a part of the roles and responsibilities of the profession; while those who used supraclinical activities as their definition did not acknowledge clinical advocacy, rather, they saw these activities as simply good medical practice (Hubinette et al., 2014).

In 2012, Dobson and colleagues asserted that advocacy should be divided into two separate categories: agency and activism. Agency activities are those where the physician helps the patient to navigate the healthcare system to access services that a patient would find difficult or impossible

to do on their own. Where agency includes the activities that occur within the confines of the established healthcare and community systems, activism includes the activities that attempt to modify or completely alter the systems that are in place. These activities go beyond helping one individual patient, but instead help future patients and populations by establishing lasting systemic change. Thus, the terms advocacy, agency and activism are interrelated, in that both agency and activism activities are forms of advocacy (Dobson et al., 2012).

In 2015, Hubinette and Dobson conducted a study in which they interviewed 10 physicians who self-identified themselves as advocates to further understand the types of activities in which physician-advocates engage. They found that advocacy activities could be divided into five categories which were further divided into patient, practice, and community levels. Clinical advocacy and paraclinical activities were found to be at the individual patient level and remained mostly unchanged from Hubinette et al.'s study in 2014. There was an additional category at the practice level, which was practice-based quality improvement. Advocacy at this level was aimed at improving health outcomes for a specific population within a specific practice. Community level advocacy was divided into two categories: activism and knowledge exchange. Activism included activities that were similar to Hubinette et al.'s (2014) understanding of supraclinical advocacy and included activities such as writing letters to government in support of action on specific issues. Knowledge exchange included activities that were aimed at disseminating information, such as instructing medical trainees on the social determinants of health or giving an interview on a specific health topic (Dobson et al., 2015).

Subsequently, the agency-activism framework initially proposed by Dobson et al. in 2012 was modified to include the advocacy activities brought to light by Dobson et al (2015). These modifications became the University of British Columbia Health Advocacy Framework (UBC-HAF) (Hubinette et al., 2017). The UBC-HAF divides advocacy not only into agency and activism, but further divides these two categories into directed and shared, resulting in four quadrants of health advocacy. Denoting an advocacy activity as shared or directed distinguishes between who determined the need of the patient, community, or population (Hubinette et al., 2017).

The UBC-HAF provides examples to better illustrate what types of activities fall within each quadrant (Hubinette et al., 2017). An example of directed agency would be a physician calling a radiologist to get an urgent scan for a patient. In this example, the physician has determined what the need of the patient is. If a patient had determined what end of life services they wanted, and a

physician advocated to make these services available to them, this would be an example of shared agency. In both examples, the physician is working within the pre-established healthcare system, which defines agency activities. The essential difference between shared and directed agency is the difference in who is determining the need for service—the physician, or the patient/community/population the physician is serving (Hubinette et al., 2017).

In agency, regardless of who is determining the need, the physician is working within the confines of preexisting systems; whereas activism activities are those that attempt to change a system in some way. An example of directed activism would be an emergency room physician who noticed an increase in traumatic head injuries and then decided to lobby to local government to increase the stringency of bicycle helmet laws. In this scenario, the physician has used their expertise to determine the needs of the population they serve. An example of shared activism would be a physician who supports a community organization who is lobbying for policy changes to improve pollution levels. In this example, the community has determined their need, to improve the air quality of their community, and the physician assists. This assistance could take many forms, from simply signing a petition, to providing medical information that demonstrates the connection between air pollution and health. In both examples, the goal of the activity is for systemic-level change (Hubinette et al., 2017).

The work of the research team in British Columbia demonstrates the wide breadth of advocacy activities that physicians engage in. The UBC-HAF provides a language to reduce the confusion that has plagued previous research on the topic. You will likely note in this literature review that the term advocacy is usually used when describing the previous research. This is because this research only reports on advocacy in general, rather than activism and agency specifically. Using the UBC-HAF thereby dividing the health advocacy role into four quadrants provides the clarity that is needed to adequately discuss health advocacy.

Although the UBC-HAF defines activism as an “action that brings about institutional (e.g. practice-level, hospital-level, health care system-level), social, economic, or political change,” this definition is far from universal (Hubinette et al., 2017, p. 131). It has been noted that the definition of activism varies considerably across time and space, and even varies between individuals (Schewdler & Harris, 2016). This is evident even across prestigious English dictionaries. Although the definitions are consistent, in that they are all directed towards making change at a political or social level, the methods by which this is accomplished vary. For example, the Cambridge

Advanced Learner's Dictionary & Thesaurus (2013) and the American Heritage Dictionary of the English Language (2022) both imply that activism is a public act, as the Cambridge dictionary states that activism is a "noticeable action" and the American Heritage Dictionary states that the acts of activism are "often confrontational," and uses demonstrations and strikes as examples. Other dictionaries, such as the Merriam-Webster Dictionary (2023) and the Oxford English Dictionary (2023), state that activism includes "vigorous action," however, the term vigorous does not necessarily mean that the action is public. Other dictionaries, such as the MacMillan English Dictionary for Advanced Learners (2006) and the Oxford Advanced Learner's Dictionary (2023), only state that the intended change is often associated with being a member of an organization.

Even when physician-activists were brought together at Yale University in 2010 for the Health Activism in the 20th Century symposium, the definition of activism they prepared was vague. Attendees of the symposium developed a working definition of activism, which read, "energetic advocacy in a civil society" (Huang, 2011, p. 53). This definition does not help to clarify the terms advocacy and activism, nor does it clarify what types of activities are and are not considered activism. It is also unclear what would constitute an act as "energetic." Those who attended the symposium generally agreed that defining activism was not of paramount importance (Huang, 2011). However, other researchers would likely disagree. Without an established definition it is impossible to specify what activities are required to meet the expectation of being a competent health advocate in the CanMEDS framework (Hubinette et al., 2017).

If asked to imagine what an activist looks like, an image of a person with a megaphone, surrounded by a group of protesters with picketing signs, likely comes to mind. Activism is often equated with vociferous and public demonstrations demanding change. Feminist scholarship challenges this view of activism. These scholars have pointed out the inherent gender bias in the conflation of activism with highly visible public acts, such as protesting and lobbying to government, which have been the purview of elite men who engage in political action (Abrahams, 1992). The work that is done outside of the public eye, which has historically been done by women, that contribute to social movements is often overshadowed by these public actions of men. The work that is done behind the scenes is often just as, if not more so, important as the work that attracts media attention. But since this type of work tends to be invisible, it is often not acknowledged as activism (Abrahams, 1992).

Martin and colleagues (2007) proposed a revised definition of activism based on feminist scholarship that is inclusive of the small-scale acts that often go unrecognized as activism. They suggest that activism should include the “everyday actions by individuals that foster new social networks or power dynamics” (p. 79). They include this within the definition of activism because they see these actions as the “precursor to political action that transforms a community, develops a formal organization, or extends in scale to reach social networks beyond the initial embeddedness of the instigating activist” (p. 79). This definition recognizes the importance of individuals who know their community well, and thus know the needs of their community and how to address those needs. As such, they are able to create positive change in their communities, even if their activism activities are small and/or informal and only initially affect their immediate community. Outside of the community, the activism may be invisible, however, according to Martin et al. (2007), a person who is able to create a positive social change outside themselves, that may only be visible to those who are in proximity to the activism act, is still considered to be an activist.

For the purposes of this research, I will be using the UBC-HAF to define activism, in that, activist activities have the intended purpose of change. However, my definition is also inclusive of this feminist perspective. Therefore, while activism efforts can include public demonstrations to affect systemic-level issues, it also includes those that occur in private or behind-the-scenes on a local scale.

CanMEDS definition of the health advocate meta-competency

The language of the UBC-HAF can be applied to understand the types of activities that are expected of the CanMEDS health advocate role. The 2015 CanMEDS framework defines the health advocacy role as physicians who:

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 their needs, speak on behalf of others when required, and support the mobilization of resources to effect change. (Sherbino et al, 2015, p. 24)

This meta-competency is broken down into two key-competencies. The first is that a physician must be able to “respond to an individual patient’s health needs by advocating with the patient within and beyond the clinical environment” (p. 26). The second key-competency is to “respond

to the needs of the communities and populations they serve by advocating with them for system level change in a socially accountable manner” (Sherbino et al, 2015, p. 26).

Although the terminology is not specifically used, it is reasonable to conclude that both agency and activism activities are included within these definitions. Agency activities belonging within the realm of medical practice, in that physicians see agency as being one of the roles and responsibilities of being a medical doctor, is not often contested in the literature, whereas activism commonly is (Hubinette et al., 2017). This will become evident in the following sections that review the literature on physician perspectives of advocacy work. Despite this debate, the language used by the CanMEDS framework when outlining the second key-competency of health advocacy implies that the RCPSC, and those medical governing bodies within Canada who endorse their framework, are taking the stance that activism activities are within the obligations of the profession because of the expectation to produce “system level change” (Sherbino et al, 2015, p. 26).

While the language implies that both agency and activism are expected, what is less clear is whether directed agency and activism are required, or even supported. The previous CanMEDS framework had four key-competencies instead of two (Frank, 2005). In these key- competencies physicians were expected to:

1. Respond to individual patient health needs and issues as part of patient care;
2. Respond to the health needs of the communities that they serve;
3. Identify the determinants of health of the populations that they serve; and
4. Promote the health of individual patients, communities, and populations. (Frank, 2005, p. 23)

Poulton and Rose (2015) note that the 2015 edition takes away the language that indicated that physicians should be advocating on the behalf of patients. The RCPSC confirms this in their CanMEDS Tools Guide, by directly stating that “advocacy [is done] with the patient, rather than for the patient” (Takahshi et al., 2015, p. 224). While the 2005 CanMEDS framework language implied both shared and directed advocacy activities were expected, the new CanMEDS framework has removed all language for directed advocacy work. As noted in the study by Hubinette et al. (2014), those who engaged in supraclinical advocacy did not see clinical advocacy activities as advocacy, but rather, saw those activities as basic, good medical practice. It is possible that CanMEDS does not include directed agency under this role, because they too do not acknowledge these activities as those that are specific to advocacy, rather, they see these activities

as the basic job description of being a physician. However, this would only explain the removal of directed agency, not directed activism. Regardless, it can be concluded that the CanMEDS framework is stating that the expectations of a physician who is acting as a competent health advocate will be engaging in shared agency and shared activism activities.

Physicians and medical trainee perspectives of health advocacy & its inclusion as a professional responsibility

Despite the incorporation of advocacy into professional roles and competencies, little research has been conducted to determine how physicians feel about this being an expectation of them. A common study that is referenced when discussing physician attitudes towards advocacy is by Gruen and colleagues (2006). Although dated, this study is commonly referenced due to its sample size and geographical reach. The survey was of 1662 physicians from four different specialty types across the United States. They found that over 90% of the respondents rated advocacy to be an important role for physicians, and this was fairly consistent across specialties. This study is cited across other literature as evidence that, in general, physicians agree that advocacy is an important role of physicians (Gruen et al., 2006). This general finding has been supported by more recent studies, albeit those with smaller sample sizes. A survey of 76 internal medicine residents at UBC found that 96% viewed advocating for population health needs as being a part of their job, and 95% agreed that it was their role to act as a health advocate beyond the individual needs of patients (Strafford et al., 2010). Another survey of 134 residents and fellows at Warren Alpert Medical School of Brown University found that 94% agreed with the statement, “as a physician I have a duty to advocate” (Garg et al., 2019, p. 34).

Although there appears to be consistency in the literature that physicians accept the general idea of advocacy, physicians may not believe that being an advocate is among one of the most important of their roles. For example, a study by Stutsky et al. (2012) sent a survey to Canadian physicians to determine how important they found each of the CanMEDS roles. From 88 participants they determined how frequently physicians performed each role and they determined the criticality of each by asking how serious the consequences would be if a role was not performed correctly. They determined the overall importance of the role by multiplying the frequency and criticality, for the highest possible score of 25. They found that the health advocate role received the lowest overall importance score of 11.93 ± 4.66 , with the lowest scores for both frequency and

criticality. Medical expert was given the highest overall importance score, followed by communicator, professional, collaborator, scholar, and then manager⁶ (Stutsky et al., 2012). It is not surprising then that in a survey of psychiatry residents, only 44% felt that being a health advocate was an important role of their professional identity (Vance et al., 2019).

Those non-Canadian countries who use the CanMEDS framework, also appear to rate health advocacy as the least important of the meta-competencies. A study in eastern Denmark surveyed 8794 physicians in the area to also ask physicians about how they perceived the importance of each of the meta-competencies (Ringsted et al., 2006). This study also found that the health advocate role was rated the least important of the seven competencies (Ringsted et al., 2006). The United States does not use the CanMEDS framework, however, as noted earlier, advocacy is still an important concept for physicians in the United States. A team of researchers asked first year medical students about their perceptions on whether or not health advocacy should be a core competency for physicians (Griffiths et al., 2022). In the study the researchers thematically analyzed the reflections of 292 first year medical students at the San Francisco School of Medicine. They found that overall, there were mixed feelings about whether health advocacy should be included. Some students felt it was important to teach about advocacy during medical school to promote it as being a part of the culture of medicine. However, other students expressed concerns, often stating that it would just be a distraction from the more important biomedical content they needed to learn (Griffiths et al., 2022).

Level of physician and medical trainee engagement in health advocacy activities

The research done to date indicates that there is a feeling that advocacy is, in general, a good thing to include as an expectation of the profession. However, of the other competencies and roles of physicians, it appears to be the least valued. This may explain the findings across the following studies that indicate that physicians are not engaging in advocacy as much as they endorse it.

The study by Gruen et al. (2006) is also commonly cited to show this mismatch between endorsement and engagement. The researchers divided advocacy efforts into three categories: community participation, political involvement, and collective advocacy efforts. They compared

⁶ The meta-competency of Manager from the 1996 and 2005 CanMEDS frameworks was changed to Leader in the 2015 update.

how many of the respondents rated each of these types of advocacy work as important to the number of respondents who had participated in that activity in the last three years. Collective advocacy had the highest agreement, with 97.0% of respondents stating this was an important duty of physicians. Despite this, it had the lowest participation rate, with only 24.3% stating they had been involved in the last three years. Political involvement had the lowest agreement, but still the overwhelming majority of respondents at 91.6% agreed it was important, but it also had low participation, at 25.6%. Community participation, where 94.9% agreed it was important, had the highest participation, at 54.2%. Overall, the researchers concluded that far fewer physicians actually engaged in the health advocacy activities that they allegedly supported (Gruen et al., 2006).

Other studies have also found that engagement of physicians and medical trainees in advocacy activities are low. A study conducted at UBC of internal medicine residents found that only 24% of respondents were currently involved in advocacy related activities (Stafford et al., 2010). More recent studies conducted in the United States have also found this. In a survey of psychiatry residents, although 47% said that they planned on becoming involved in advocacy work in the future, only 38% indicated that they had previously participated in advocacy work and only 17% were currently engaged (Vance et al., 2019). Garg and colleagues (2019) asked residents and fellows specifically about political advocacy. They also found that current engagement was low, and the plan to engage in the future was low. They asked how often respondents engaged in each activity on a 5-point Likert scale that ranged from never (1) to always (5). The activity with the highest involvement was using the internet, such as using social media or email, to contact an elected official. This activity got an average rating of 1.7 [95% CI: 1.5-1.9]. Calling an elected official, visiting an elected official, and writing a letter-to-the-editor or opposite the editorial page all received a score of 1.2 [95% CI: 1.0 – 1.4]. Therefore, overall, they found that current political activism was low. When asked if they planned on being involved in advocacy in general in the future, the overall rating was neutral, with an average score of 3.3 [95% CI: 3.1-3.5] (Garg et al., 2019). A survey of 240 medical students across the United States asked how important it is to be politically involved in health-related matters at the local, state, or national level. Almost 93% felt that it was at least somewhat important, and 45.4% felt that it was very important (Chimonas et al., 2021). However, when asked if they planned on becoming involved in healthcare policy issues,

only 30.4% strongly agreed, and only 19.2% strongly agreed that they planned on taking on a leadership role in healthcare policy issues (Chimonas et al., 2021).

When Gruen et al., (2006) was asking physicians about political advocacy, it was specifically stated that this advocacy excluded voting. Grande et al. (2006) conducted a study that looked exclusively at voting behaviour in physicians. Grande et al. (2006) justifies that voting is the “most basic expression of civic participation and community engagement” (p. 585). They therefore argued that since the medical profession is expected to be especially involved in civic participation, it follows that those who belong to the profession should vote. The study compared voting rates of physicians, lawyers, and the general population in the United States for the congressional and presidential elections between 1996 and 2002. The survey contained 1,274 physicians, 1,886 lawyers, and 347,710 people of the general population. After adjusting for characteristics that are known to affect the rate of voting, such as income and education, it was still found that physicians vote at significantly lower rates than lawyers and the general population. Across the four years, the pooled adjusted odds ratio for physician voting was 0.70 [95% CI: 0.61-0.81]. This led the researchers to conclude that physicians were less involved in civic participation compared to the average person in the United States (Grande et al., 2006).

Although a smaller survey, the study by Garg et al. (2019), who surveyed residents and fellows, found similar rates of voting. They found that 80% of respondents were registered to vote and 88% of those registered did vote in the 2012 presidential election (i.e., 70.4% of total respondents). However, fewer reported voting in state or local elections. Only 37% of those registered to vote stated that they always participated in these elections (Garg et al., 2019). Voting is one of the easiest ways that physicians can be engaged in activism, in that voting can lead to systemic change. However, the low rates of voting and engagement in advocacy efforts in general, indicates the low level of importance physicians are placing on their role as health advocates.

Barriers to performing advocacy & activism specifically

Overall, the literature indicates that although physicians agree with the general concept of advocacy, there are much lower levels of engagement. There have been many reasons that have been suggested as to why this might be, such as a scarcity of resources (Earnest et al., 2010) and selection criteria for medical school placing too much of an emphasis on biomedical knowledge (Luft, 2017). One of the issues has already been discussed here, which is a general state of

confusion of what advocacy in medicine is. Beyond this, the major trends appear to be a lack of interest, a lack of time, fear of repercussions, and a lack of knowledge.

As discussed, physicians appear to value the health advocacy role the least, compared to the other CanMEDS roles (Ringsted et al., 2006; Stutsky et al., 2012). Some researchers have given reasons for why this might be. For example, Verma et al. (2005) were surprised to find that both faculty and residents viewed advocacy as “charity” work. They also reported a loss of altruism throughout their training, which made them feel less inclined to participate in this, so-called charity work (Verma et al., 2005). This loss of empathy and altruism has been reported in other literature. One study conducted a systemic review of literature published between 1990 and 2010 on the topic (Neumann et al., 2011). Eighteen studies met the inclusion criteria and fifteen of these studies indicated there was a significant decrease in empathy as medical training progressed (Neumann et al., 2011). This could be partly responsible for the reports of burnout among physicians. Some literature indicates that learned helplessness develops alongside this burnout (Fried et al., 2019). Physicians report feeling frustrated when their advocacy efforts fail and therefore feel powerless to contribute to meaningful systemic change (Fried et al., 2019).

Lack of interest in advocacy work has also been attributed to lack of exposure. At the time of writing, only three studies could be identified that looked at physicians who were specifically engaged in advocacy. Two of these studies were trying to uncover why these physicians became and continue to be involved in advocacy work (Law et al., 2016; Mu et al., 2011). Both studies found that it was common for these physicians to have experienced injustice and socioeconomic disadvantage early in life (Law et al., 2016; Mu et al., 2011). Therefore, it has been argued that one of the reasons why advocacy is difficult to teach to Canadian medical students is because medical students have a tendency to come from similar socioeconomic backgrounds of high monetary privilege (Bhate & Loh, 2015).

A study investigated the socioeconomic characteristics of Canadian medical students and found that they were not representative of the general population (Khan et al., 2020). Parents of medical students were significantly more likely to hold postsecondary degrees, and significantly more likely to have professional or high-level manager positions than the general population. When looking at household income, medical students were much more likely to come from a high-income household. Almost 63% of medical students came from homes who had a household income of over \$100,000, when only 32.4% of working Canadians between the ages of 45 and 64

years had incomes of this level. This study also compared the ethnic background of the medical students to Canadians between the ages of 15 and 34 to match for age. They found that the majority of medical students, at 72.6%, identified as White. However, this number was lower than age-matched Canadians of the general population, of which 88.2% identified as White. The most commonly reported racialized group within the medical students were those who identified as South Asian, at 8.8%, compared to the general population at 7.0% (Khan et al., 2020). This data is consistent with previous research that has investigated and compared Canadian medical students to the general population (Dhalla et al., 2002). Since medical students have a high level of homogeneity coming from a background of socioeconomic privilege, many will not have first-hand experiences with injustice, which could lead to a general disinterest in advocacy. First year medical students also commented on social capital (Griffiths et al., 2021). They stated that because physicians have a tendency to come from a place of privilege, even if there are physicians who want to engage in advocacy activities, it is possible they could drown out the voices of others that need to be heard, including their own patients (Griffiths et al., 2021). This would be particularly true in instances of directed advocacy.

As previously discussed, the process of getting into medical school is extensive. With high levels of competition, students must set themselves apart from other applicants with high test scores and grade point averages, as well as extracurricular activities (Grafton-Clarke, 2016; Sreekumar, 2016). Students of socioeconomic disadvantage do not have the same opportunities as others who have the option of tutoring for difficult classes, can afford preparation classes for the MCAT and CASPER, can afford to take time off from work to study for these exams, and do not have to work during their undergraduate education so that time can be devoted to studying, extracurriculars, and volunteering (Grafton-Clarke, 2016; Sreekumar, 2016). It is therefore unsurprising that most successful applicants to medical school come from backgrounds of high monetary privilege.

Another major barrier to engaging in advocacy appears to be a lack of time to do so. This barrier appears to be particularly prominent during residency. In a survey of residents, the few who had previously engaged in advocacy efforts were asked when this participation occurred (Stafford et al., 2010). There was an increase seen in advocacy involvement from high school to college and university. There was then a peak in advocacy engagement during medical school, with a steep decline in residency. Residents stated that the lack of time, rest, and an increase in stress during

residency greatly impacted their ability to be involved in advocacy efforts (Stafford et al., 2010). However, first year medical students also expressed concern that spending time learning about advocacy in medical school could take away from time spent learning about other important concepts (Griffiths et al., 2021). These students and physicians in other studies also note concern that engaging in advocacy work could take time away from individual patients (Fried et al., 2019; Griffiths et al., 2021).

There has been a trend noted that issues that are particularly controversial or political often do not receive the advocacy work they require (Abrama et al., 2022). This was seen recently in the United States with the overturning of *Roe v Wade*, making access to abortion no longer a constitutional right. Abrama et al. (2022) noted that many individual physicians and medical organizations have chosen not to take a stance on this social justice issue even though it is directly related to medicine and health (Abrama et al., 2022). However, physicians who may want to take a stance on these highly controversial issues may fear being ostracized or reprimanded by licensing bodies or fellow co-workers (Liebe et al., 2022). Additionally, taking a stance on these issues could also make individual patients or communities feel isolated if they do not share the same beliefs, thus degrading the relationship between physician and patient (Griffiths et al., 2021; Liebe et al., 2022).

Finally, another common theme seen in the literature is simply a lack of knowledge on how to be an advocate. One survey found that only 12% of physicians felt that they received adequate training in medical school, and only 18% felt they received adequate training during residency (Garg et al., 2019). In another survey, only 19% of residents indicated that they could describe what a physician advocate does (Vance et al., 2019). Overall, these residents did not feel confident in their ability to be health advocates, with only 26% stating that they felt confident in their health advocacy abilities. These insecurities to advocate were greater for activism efforts on a larger scale, compared to agency efforts. Where 59% of respondents felt they were confident in advocating for the health and well-being of individual patients, only 26% felt confident in their ability to advocate for optimal patient care systems, only 22% felt confident in advocating for the health and well-being of communities and populations, and only 13% felt confident in their ability to advocate for changes in health policy (Vance et al., 2019).

The issue of activism and social justice

A conversation about advocacy must involve the discussion of the social determinants of health, and the discussion of the social determinants of health inevitably leads to an examination of justice (Hubinette et al., 2017). This is because often the social determinants of health lead to inequitable burdens of disease, particularly among marginalized groups (Hubinette et al., 2017). Despite the impact that justice related issues have on health, there is a general trend seen in the literature that as advocacy efforts move away from direct patient care, the more there is disagreement about whether an activity falls within the jurisdiction of physicians. Prior to the creation of the UBC-HAF, Gruen et al. (2004) proposed a different framework for breaking down the various advocacy activities physicians may engage in. There are five levels of advocacy in this framework: individual patient care, access to care, direct socioeconomic influences, broad socioeconomic influences, and global health influences. The researchers divide these five categories of advocacy activities into two more categories: professional obligations and professional aspirations. They argue that the first three categories fall under obligations, and as the name suggests, these are the advocacy activities that are the responsibility of all physicians to be engaged in, whereas the latter two categories are not obligatory (Gruen et al., 2004).

The researchers use ischemic heart disease as an example to illustrate the first three categories of advocacy (Gruen et al., 2004). At the individual patient care level, physicians diagnose and treat the condition within their scope of practice. If the patient is a smoker and this is impacting the patient's prognosis, the physician could refer the patient to a smoking cessation program in the community, which would be an example of access to care advocacy (Gruen et al., 2004). If using the UBC-HAF, one could argue that these are agency activities, since treatment is occurring within the systems already available. The next level of advocacy according to Gruen et al. (2004) are direct socioeconomic influences. If the physician in this example noticed that many patients with ischemic heart disease were also smokers, they might take a public stance on smoking policy and lobby for changes regarding smoking (Gruen et al., 2004). This would be considered an activism activity since the goal of the advocacy effort is system-level change.

These three domains of advocacy, individual patient care, access to care, and direct socioeconomic influences, are among the professional responsibilities of all physicians, according to Gruen et al. (2004). They argue that direct socioeconomic influences are included within the professional obligations of all physicians because there is abundant data that confirms the link

between the socioeconomic influence and health outcomes. In the example of ischemic heart disease, smoking is the direct socioeconomic issue that is related to the health outcomes of the community as seen by increasing cases of ischemic heart disease and the poor prognosis of those who already have the disease. Other topics that advocacy activities could target that would fall in this category could include obesity, nutrition, and illicit drug use. According to this research team, they also feel that this type of involvement is feasible when considering all other professional responsibilities and demands of physicians. However, they also note although it is an expectation for physicians to engage in all three of these levels of advocacy, individuals can pick the specific types of activities to engage in based on their expertise, personal interests, and life situation (Gruen et al., 2004).

The last two categories, broad socioeconomic, and global health influences, fall within the professional aspirations category (Gruen et al., 2004). According to the researchers, broad socioeconomic influences are those activities that target socioeconomic issues whose link to a specific health outcome is not clear, and/or the activity would involve a commitment that is beyond what would be deemed feasible for all physicians. Activities within this category, according to the researchers, are those that target disparities within a population that are more indirectly related to health, such as income and education disparities (Gruen et al., 2004). If this applied to the example of smoking and ischemic heart disease, the physician might notice that those who smoke tend to have less access to education or are more likely to live in poverty. Therefore, the physician may choose to engage in activism activities to lessen the disparities of education and poverty in the population. In this case, this would not only be activism, but activism that is directed at social justice.

The final category is global health influences, which are those activities that target the distribution of resources, knowledge, and opportunities around the world (Gruen et al., 2004). The researchers note that it would be a valid argument to state that broad socioeconomic and global health influences that target the larger social determinants of health could have a greater impact by improving the health of more people, when compared to the categories that they deem to be professional responsibilities. However, Gruen and colleagues do not believe they should be considered professional responsibilities because it is currently not possible to determine the fraction of health problems that occur due to these broad social determinants of health. They also argue that because the link between certain social determinants of health and health outcomes is

less direct, there is no clear rationale for a physician being more qualified than an average member of the public to be involved in these issues. Therefore, it is their opinion, that these two activity categories fall outside of required professional responsibilities, and instead belong within aspirations. However, it is important to note that Gruen and colleagues do not divide responsibilities and aspirations to discourage the types of activism that fall within the aspirations category. They just believe that it is not reasonable to expect these activities to be part of the duties and responsibilities of all physicians, and instead, it should be left up to the discretion of individual physicians to decide if they want to pursue this type of activism (Gruen et al., 2004).

This division between responsibilities and aspirations highlights the controversy that exists over whether advocacy work in the form of activism to address the social determinants of health should be a part of medical practice. Huddle (2013), a physician scientist in the United States who specializes in medical ethics, published a paper that is commonly referenced when discussing social justice work among physicians. He appears to agree with Gruen et al. (2004) that social justice does not belong in the obligations of the profession, however, he is more severe in his stance, stating that it does not belong in the profession at all, even as an aspiration. He builds on the idea of Gruen et al. (2004), that the general public would be just as well-equipped to engage in social justice issues as those within the medical profession. It has been argued by others that the reason physicians should be these advocates is because of their unique position in society, where they have a high level of public trust, and have more opportunities to influence policy due to relationships with policy makers and national leaders (Earnest et al., 2010). Huddle, however, warns of “seductive hubris.” Seductive hubris was the term given by Pellegrino (1973) to capture the idea that physicians have a tendency to assume they have “some special authority or capability in the resolution of all social issues” (p. 144). Huddle states that physicians should contribute to societal deliberations only where their medical expertise allows. To delve into social justice issues that are removed from direct medicine while acting in the role of a physician would be falling prey to this hubris, according to Huddle (2013).

Huddle (2013) is not the only physician who feels this way. Goldfarb, the former Associate Dean of Curriculum at the prestigious University of Pennsylvania’s Perelman School of Medicine, published an opinion piece in the Wall Street Journal entitled, *Take Two Aspirin and Call Me by my Pronouns*, commenting on his observations that medical school curriculum is spending too much time focusing on topics related to social justice, leading to poorly trained physicians

(Goldfarb, 2019). He expands on this idea in a book he published under the same title (Goldfarb, 2022). Goldfarb, like Huddle, feels that physicians are not the profession who is best equipped to deal with social issues. He states many times in his book that he does not believe there are disparities in health outcomes due to systemic racism, but he does admit that there are other social issues that need to be addressed, such as poverty and crime. But he states:

These are social responsibilities that are the domain of politicians, social workers, and voluntary agencies. The idea that physicians have a role in alleviating these social problems will only lead to disappointment all around and less physicians available to practice the craft of healing people. (Goldfarb, 2022, p. 58)

Goldfarb (2022) and Huddle (2013) therefore feel that the obligation of the profession begins and ends with the physical needs of individual patients, and their duty to these patients does not extend beyond the clinical encounter.

Despite the existence of these opinions to the contrary, the United States and Canada both deem that social justice falls within the professional responsibilities of physicians. The United States has the Physician Charter, that was published by the American Board of Internal Medicine (2002) with assistance from the American College of Physicians and the European Federation of Internal Medicine. This charter is endorsed by the American Medical Association, along with over 100 other medical organizations (American Board of Internal Medicine, n.d.). The Physician Charter has three fundamental principles and one of these is the principle of social justice⁷ (American Board of Internal Medicine, 2002). Under this principle, physicians are obligated to “work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category” (p. 1). The charter also outlines nine professional responsibilities. Among these are the commitment to improving quality of care, the commitment to improving access to care, and the commitment to a just distribution of finite resources (American Board of Internal Medicine, 2002). All these commitments are examples of how to meet the principle of social justice.

Canada does not have a charter for physicians, although some have argued that one should exist (MacCarthy, 1999). However, the Physician Charter for the United States is endorsed by several Canadian medical establishments, including the RCPSC and the Canadian Medical Association (CMA) (American Board of Internal Medicine, n.d.). The CMA (2018) instead

⁷ The other principles are the principle of privacy and patient welfare, and the principle of patient autonomy.

published the Code of Ethics and Professionalism, which outlines the required ethical and professional obligations of the entire medical profession. Among the fundamental commitments is the commitment to justice,⁸ which is similar to the commitment of social justice outlined in the United States' charter. Under the commitment to justice, it states that physicians must, “promote the well-being of communities and populations by striving to improve health outcomes and access to care, reduce health inequities and disparities in care, and promote social accountability” (p. 2). This is expanded upon in the section on the professional responsibility to society, where it states that physicians must, “contribute, individually and in collaboration with others, to improving health care services and delivery to address systemic issues that affect the health of the patient and of populations, with particular attention to disadvantaged, vulnerable, and underserved communities” (Canadian Medical Association, 2018, p. 7).

Although the term justice is not used in the CanMEDS framework specifically, it is reasonable to state that the health advocate role also includes a call to justice. In the enabling competencies of the health advocate role, it states that physicians must “identify” and “address the determinants of health” (Sherbino et al, 2015, p. 26). Although not specifically defined in the CanMEDS framework, the determinants of health are defined in the CanMEDS Teaching and Assessment Tools Guide (Takahshi et al., 2015). In this document they divide the determinants of health into the social and the physical determinants of health and provide examples of each. Included in the examples of the social determinants of health are education, employment, poverty, transportation, discrimination, and exposure to crime and violence. For physical determinants of health, they include examples such as climate change, housing, toxic substances, and barriers, particularly barriers for those with disabilities (Takahshi et al., 2015). If the enabling competencies of the CanMEDS framework state that it is the role of physicians to identify and address the determinants of health, it follows that the CanMEDS framework is also endorsing the idea that physicians are responsible for engaging with social issues and social justice.

Huddle (2013) adamantly disagrees that social justice advocacy falls within the realm of professional obligations of physicians, and he believes that the Physician's Charter is mistaken in including social justice as one of its fundamental principles. The main reason he gives for why it

⁸ The Canadian Medical Association (2018) outlines seven commitments of the profession. The others include: 1) Commitment to the well-being of the patient, 2) Commitment to respect for persons, 3) Commitment to professional integrity and competence, 4) Commitment to professional excellence, 5) Commitment to self-care and peer support and, 6) Commitment to inquire and reflection.

should not belong in the legislation regarding medical practice is because it is impossible to have consensus across all members of the profession. For the medical establishment to state that one of their commitments is to social justice, there would need to be a specific definition of what that looks like, and the profession would have to outline what in society is unjust and needs to be rectified. However, it would be impossible to have all physicians agree on one vision. He therefore argues that it is not only unreasonable, but also in itself unjust to make all physicians prescribe to one certain ideology surrounding social justice (Hubble, 2013). A study that asked surgical faculty, residents, and fellows about their opinions on the inclusion of social justice advocacy in the profession, echoed these concerns (Liebe et al., 2022). Some participants felt it was inappropriate for medical societies to take a stance on social justice movements because not all members will necessarily agree with the movement and therefore, it was unfair for a society to speak on behalf of all its members. Many felt that since not every physician will be aligned with certain social justice movements, engaging with these movements could also make fellow colleagues feel isolated or unsafe in the workplace (Liebe et al., 2022).

Huddle (2013) states that the profession has only one obligation to justice and that is, “to treat medically alike patients alike,” and all physicians already agree to this one obligation (p. 374). Therefore, Huddle believes that the obligation of the physician to justice ends at the clinical encounter. Others have argued that treating alike patients alike is only the definition of equity in medicine (Hixon et al., 2013). They argue that patients do not exist in a vacuum and therefore to truly treat medically alike patients alike and to achieve medical equity, physicians must address the other factors of their patient’s lives (Huddle, 2013).

Little research has been conducted on how physicians feel about the inclusion of social justice being among their responsibilities. However, a survey of 123 surgical faculty members, fellows, and residents at three tertiary care settings in the United States asked respondents to simply reply with yes or no to the question of whether they felt that individual surgeons should be involved with social justice advocacy (Liebe et al., 2022). Seventy-two percent of the participants indicated that they felt it was their responsibility (Liebe et al., 2022).

Although just under three quarters of physicians in Liebe and colleagues’ (2022) study agreed with the general idea of social justice inclusion in their work, when other studies have asked about specific advocacy topics, there is an increase in disagreement. For example, the previously mentioned study by Gruen et al. (2006) that investigated physicians’ perspectives of advocacy,

also asked participants to rate the importance of various specific advocacy topics. As they suspected, as advocacy topics moved away from direct patient care, there was increased disagreement about whether the activity was important (Gruen et al., 2006). This was particularly noticeable for issues that were related to social justice. For example, 81.9% of participants rated advocacy activities related to reducing obesity and better nutrition as very important, and 76.9% rated tobacco control as very important. Whereas only 41.6% rated increasing basic literacy as very important, and only 22.6% rated reduction in unemployment as important (Gruen et al., 2006).

The study by Gruen et al. (2006) is not the only study that has found that the profession of medicine does not prioritize social justice issues. A recent study surveyed medical students in the United States and asked them to rate how important it was for physicians, both individually and collectively, to advocate for, what they termed, various “medical issues” and “social issues” (Chimonas et al., 2021). Once again, the more direct the effect on health, the more important it was rated. For example, under medical issues, more than 80% rated drug addiction and treatment, and nutrition, obesity, and food safety as very important, whereas social issues had much lower ratings. These social issues also had higher numbers of students believing these issues were not important to advocate for at all. For example, only 1.7% said that drug addiction and treatment, and nutrition, obesity, and food safety were not at all important to advocate for. Whereas 5.8% of students believed it was not at all important to advocate for human rights. The researchers concluded that although students appear to be eager to learn and be involved in advocacy as it relates to direct health issues, they may not fully appreciate how the social determinants of health relate to health outcomes. They came to this conclusion because, in general, social issues were rated lower than the direct medical issues, but also because some of the social issues, including immigration, economic issues, transportation, and crime/criminal justice issues had particularly low ratings of importance, with less than 50% rating these as very important, and more than 15% rating them not at all important (Chimonas et al., 2021).

Current state of health advocacy in medical education training in Canada

Since one of the major roles of Canadian physicians is being a health advocate, as outlined by the CanMEDS framework (Frank et al., 2015), it would be reasonable to expect that Canadian medical schools and residency programs would be training future medical professionals to become competent health advocates. However, there is no standardized curriculum on training advocacy

across Canadian medical schools, nor a minimum of required hours set to train this competency (Canadian Federation of Medical Students' Government Affairs and Advocacy Committee, n.d.).

The Canadian Federation of Medical Students (CFMS) is an organization that was established in 1977 to serve medical students (Canadian Federation of Medical Students, n.d.). The CFMS conducted a scan of 14 of the 17 medical schools in Canada to assess their advocacy curriculum (Canadian Federation of Medical Students' Government Affairs and Advocacy Committee, n.d.). They found that the advocacy topics that were covered varied, as well as the depth and breadth of these topics. They also found that most of the advocacy training that was being done was conducted in lecture-based formats with very few schools incorporating other teaching formats, such as small group discussions or experiential learning. The CFMS also found that the role of advocacy received very little attention in their education compared to the six CanMEDS roles even though medical students demonstrated an expressed interest in getting more training in the health advocate role (Canadian Federation of Medical Students' Government Affairs and Advocacy Committee, n.d.). This is consistent with other literature that has found that medical students and residents have shown interest in and have requested more training in advocacy (Garg et al., 2019; Griffiths et al., 2021; Poulton & Rose, 2015).

The newest CanMEDS framework introduced milestones (Frank et al., 2015). Milestones are updated continually and are uploaded to the CanMEDS Framework Milestones Guide which is available online (Royal College of Physicians and Surgeons of Canada, n.d.b). This framework provides a description of what a physician should have accomplished for each enabling competency at each stage of their career. The stages start at entry to residency through five more stages to advanced expertise (Frank et al., 2015). For example, according to one of the milestones, a resident that is transitioning to practice should be able to “contribute to a process to improve the health in the communities or populations they serve” (Royal College of Physicians and Surgeons of Canada, n.d.b). Although the inclusion of milestones may make what is expected of residents clearer throughout their training, these milestones appear vague and do not offer specific instructions on how they should be achieved.

The RCPSC has a resource called the CanMEDS Teaching and Assessment Tools Guide which is available online and it includes educational resources on each of the meta-competencies (Takahshi et al., 2015). There are seven teaching tools provided to help educators train medical students and residents. It includes formats for lectures to teach the foundations of advocacy and

worksheets for students. One of the reflections acts as a case report, where students evaluate the health advocacy taking place within their practice environment and assess it for strengths and areas for improvement. Another worksheet helps students to identify different resources in the community so they could refer future patients when needed (Takahshi et al., 2015).

In addition to the teaching tools, the tool guide also offers four assessment tools for educators (Takahshi et al., 2015). The first is a multisource feedback sheet, that is for generally assessing the strengths and weaknesses of the trainee on various advocacy tasks. Two of the resources are rubrics for assessing short answer and essay questions. The final resource is a scoring rubric for an objective structured clinical examination (OSCE). The resource gives three possible scenarios for this OSCE. The first scenario involves a patient whose disability insurance was denied. The second scenario is about a young woman who sustained a head injury from falling off her bicycle while not wearing a helmet. The final scenario is a student who notices that there has been an increase in lower-limb diabetic ulcers in their rotations. They are asked what they would do if asked if they had noticed an area to improve patient care (Takahshi et al., 2015). These scenarios appear to place a priority on advocacy as agency, rather than as activism. It is also unlikely that a student would bring issues of social justice into these scenarios.

This priority placed on agency is further seen in the contradictory language used in the tool guide. As discussed previously, although the word activism is not specifically included in the CanMEDS definition of health advocacy, it is clear that shared activism is an expectation of the meta-competency since there is a focus on change at a systemic level. This expectation is known since the second key competency states that physicians must advocate for “system-level change” (Sherbino et al, 2015, p. 26). However, within the CanMEDS tool guide it states, “while advocacy at the population level is an essential role for the profession to undertake, the prospect of incorporating such activism into regular, everyday practice may be daunting for clinicians and learners” (Takahshi et al., 2015, p. 224). However, it does not offer guidance on how to make the learning feel less daunting. It goes on to say, “many clinicians will identify more readily with ‘agency,’ which entails working within the system day to day to meet the health needs of a specific patient or community” (Takahshi et al., 2015, p. 224). Since no suggestions are made to help rectify these concerns, one could argue that the document implies that activism should be ignored as a learning objective, even though they deem activism as “essential” (Takahshi et al., 2015, p. 224).

Poulton and Rose (2015) from Dalhousie University conducted a literature review to determine the current state of health advocacy education for Canadian physicians. They found that there is an overall lack of literature on the topic, which is itself a major barrier to training advocacy. One of the other major barriers they found has already been extensively discussed here, which is the lack of clarity around what the health advocate role is and what the expectations of the role are. Other major barriers they noted in the literature is a lack of a gold standard to assess advocacy and a lack of role model physicians in practice (Poulton & Rose, 2015).

There have been various suggestions on how to improve advocacy training. Included in these suggestions are identifying and specifying measurable educational outcomes for students (Luft, 2017), and forming partnerships with community organizations where students can gain meaningful, hands-on advocacy experience (Griffiths et al., 2021; Mu et al., 2011). Of those who support the notion of improving advocacy training in medical education, there is a general feeling that there is a need to “advocate for advocacy” (Luft, 2017, p. 114). It is felt by many that the importance of advocacy needs to be realized so that institutions will begin to prioritize it and begin to incorporate advocacy into the culture of medicine (Earnest et al., 2010; Griffiths et al., 2021; Luft, 2017).

However, since advocacy within the profession is debated, there are those who oppose these efforts to improve education in health advocacy in medical education. In fact, Huddle (2013) not only discourages it in early medical education, but states that efforts to include social justice advocacy training will inevitably fail. He states that some students will come to medical school with an already established propensity for wanting to specifically help marginalized groups, and only these students will respond to training efforts. He states that these students will likely end up in medical specialties related to public health and health policy. However, those students who are not interested in taking on this role will not become interested by imposing it in the curriculum, he argues, because becoming moral cannot be ascribed to a person just because they are told. These students will likely choose different specializations than those who are particularly interested in advocacy. Huddle notes that it is important to recognize that specialties where advocacy will not play a predominant role are just as legitimate and praiseworthy as those where advocacy is more prominent (Huddle, 2013).

As has been seen, Huddle is arguably one of the most outspoken about his disagreement with the inclusion of advocacy in the profession, with perhaps the exception of Goldfarb. However,

even Huddle (2013) agrees that some advocacy training should be offered. Since some specific medical professions will need to know how to be advocates, he believes these opportunities should be offered at the end of residency for those students, such as those who go into public health medicine. However, he believes that this should be towards the end of training, because physicians need to learn to treat all people first, rather than learning how to serve only marginalized populations. He also argues that this training should not be compulsory. Since his whole argument is based on the notion that advocacy should not be a requirement for all physicians, training in advocacy should only be for those students who are interested (Huddle, 2013).

Of the published literature, Huddle (2013) and Goldfarb's (2022) opinions appear to be the minority. Earnest et al. (2010) worries that this kind of thinking will lead to a new specialty of physician advocates who take on the responsibilities of advocacy for the entire profession. Earnest et al. (2010) notes that not all physicians will become cardiologists, and yet, it is expected that every medical trainee learns about the details of the circulatory system and how it fits into their area of expertise. Earnest et al. (2010) believes this is also true of advocacy. If the majority of the profession is in agreeance with Earnest et al. (2010), then significant changes need to be made to medical education to better teach, assess, and foster advocacy.

Significance of current study

As described, even though CanMEDS mandates all physicians to be competent health advocates, what this means is debated within the literature. This confusion regarding the expectations of the role appears to be in part due to a lack of specificity in the language used in describing the role. Confusion also arises because there is disagreement between physicians on what this role should and should not include. For all the CanMEDS meta-competencies to be followed and endorsed, physicians and trainees must first agree what the responsibilities of the profession are to advocacy. What competent advocacy looks like in daily practice then needs to be explicitly defined.

Determining whether activism falls within the health advocate meta-competency has significant implications for medical education. Future generations of physicians must be trained accordingly to adequately fulfill the health advocate role. If activism is an expectation of this role, then trainees need to be instructed on how to accomplish this. Therefore, discussing what the responsibility of the profession is to activism needs to discuss education concurrently. A discussion

of the health advocate role in the absence of education could result in an abstract ideal of what health advocacy should be, rather than what is realistically feasible.

Only a handful of studies have investigated the perspectives of those physicians who are actively involved in advocacy and to my knowledge, no studies have looked at physician-activists specifically. I therefore was interested in investigating the perspectives of this understudied subset of physicians. I believed they could offer a unique view as to what activism in medicine is, if they feel advocacy as activism is a professional responsibility, and how the skills for activism can/should be trained. Findings from this research have the potential to help clarify the definition and key competencies of the health advocate role for the 2025 and future CanMEDS frameworks and can shed light on how medical trainees should be instructed to obtain this competency, if at all.

Research Questions

1. How do physicians who engage in activism understand and experience activism within the profession of medicine?
2. What are the attitudes of physicians who engage in activism towards physicians' roles, responsibilities, and obligations to engage in activism?
3. What are the attitudes of physicians who engage in activism towards medical education as it relates to physician activism?

Methodology

Positivist methodologies have historically dominated literature within health research and continue to do so today (Swift & Tichler, 2010; van Hoonaard, 2019). However, quantitative research is not effective for all research questions. Qualitative methodologies are often used when researchers want to understand a phenomenon from the perspective or lived experience of an individual or population (Hammarberg et al., 2016). In this study I was interested in the perspectives of physicians about their roles as health professionals in advocacy as activism aimed at creating social and/or structural change in mostly any capacity. This research was less interested in what physicians are activists for, rather it was more interested in whether activism is, or should

be, a role and responsibility of physicians in general. Since I was interested in gleaning emic perspectives of physician's attitudes towards the engagement in advocacy as activism, a qualitative approach best suited the aims of this research.

Qualitative research comprises an array of methodological approaches including phenomenology, grounded theory, and ethnography (Thorne, 2016). Although diverse in their philosophical underpinnings and associated methods, these methodologies are generally designed to glean insight about the meanings of participants' lived experiences and are typically guided by an established theoretical tradition and/or the aim of generating new theoretical insights. These methodologies are also well established, extensively described in the literature on qualitative methods, and guided by various rules and traditions that are pointed to as evidence of rigour and credibility (Thorne, 2016).

However, Thorne (2016), a nursing scholar, asserts that these commonly used methodologies are often not effective or adequate for research that is needed to garner practical applications in applied settings, such as in the context of health professional practice. Thorne notes that nursing scholars have felt bound to these commonly used methodologies because of the widely held view that their use is indicative of rigorous research and for fear that their research may be deemed sloppy or unscientific. As a result, Thorne observed that qualitative researchers whose research was intended to further garner findings with practical application would either contort their research questions to fit within particular methodological parameters or would attempt to give long explanations to justify their choice to pick and choose parts from different methodologies. However, this often led to criticisms of "methodological slurring," which threatened the integrity of qualitative inquiry within health sciences (Thorne, 2016).

According to Thorne (2016), nursing researchers needed a qualitative methodology that met two specific needs: 1) the ability to answer real-world questions and produce research with practical application, such as in clinical settings; and 2) to design a study that is inspired by proven elements from pre-existing qualitative methodologies, instead of using only one traditional qualitative methodology. Researchers needed to be able to borrow pieces from different methodologies and then integrate them together to design the best study to answer their specific research questions, while still maintaining scientific integrity.

Thorne (2016) noted that those who chose to "blend and borrow" from other qualitative methodologies published articles that had a similar "look and feel" even though there was no name

to describe what they were doing (pp. 35-36). Although this research was legitimately conducted, it was often criticized by “methodological police” (p.35). In the interests of codifying and bringing better legitimacy to this emerging methodology, Thorne named what these researchers were doing and developed a framework: interpretive description (ID). Although ID was initially developed specifically to meet the needs of qualitative researchers in nursing, it has been adopted by other disciplines, including other health care sectors and education (Thorne, 2016).

ID is not an entirely novel or formal method that outlines a specific set of steps or rules to follow (Thorne, 2016). Instead, it provides a language to describe the decision to use components or modified versions of other qualitative methodologies. Under ID, researchers are expected, and thus have the space to justify their decisions to handpick elements from other methodologies. Thus, ID allows the researcher to design a study that will best address their research question, without having to follow the strict rules of one “pure” methodology. Therefore, each study that utilizes ID looks different, as each study is designed based on the specific research question at hand (Thorne, 2016).

I decided to use ID for this study to justify the borrowing of techniques from phenomenology and grounded theory. For example, in purist phenomenology, researchers are interested in the lived experience of individuals to understand more deeply what it means to be human (Thorne, 2016). This study was also interested in lived experiences, however, I was only interested in the lived experiences of some key informants insofar as their experience can help to shed light on the problem of how to instruct medical trainees, if at all, to become competent health advocates. This study also borrowed techniques from grounded theory, in the sense that a specific theoretical framework was not used to analyze the data. However, instead of analyzing the data with the intention of generating new theoretical frameworks, as in grounded theory (Thorne, 2016), the results of the data analysis were used to make concrete suggestions to improve the profession of medicine’s understanding of their obligations, responsibilities, and roles to activism.

A note on writing style

As the reader, you will likely notice that much of this work is written in first-person voice. There are quotes taken directly from the transcripts of the participants. Including these direct quotes improves the credibility of the work by providing support to back up the interpretations made by me, as the researcher (Hammarberg et al., 2016). However, perhaps more importantly, if

I were to write about the participants only in third person, it would be in stark opposition to both the ontology and epistemology of qualitative research itself (Gilgun, 2005). The purpose of this research, and most other qualitative research, is to investigate the lived experience of a particular group. Therefore, to not include these first-person accounts would be equivalent to silencing them (Gilgun, 2005). In the results and discussion, I chose to lightly edit the quotes taken from the participants. This editing was done, not with the intention of controlling participant language, but to simply increase the ease of readability by removing filler and repeated words.

Also written in first person voice are my thoughts, interpretations, and conclusions as the researcher. While it was easy for me to appreciate the importance of including participant quotes, I continued to struggle with the inclusion of my voice, as this was not consistent with the knowledge paradigms I had been previously instructed in. Prior to this project, the majority of my training had been positivist in nature. Having completed two previous Bachelor of Science degrees, with two independent quantitative research projects, I have been trained to write myself out of the research. We are taught in positivism that there is one single reality that exists that can be uncovered by objective observation (Guba, 1981). As Chamber's (1982) so succinctly puts it, "knowledge is treated as something outside rather than inside the minds or brains of individuals" and therefore, "personal opinion or preference and speculative imaginings have no place in science. Science is objective" (as cited in Webb, 1991, p. 748). Therefore, when instructed to write in first-person voice, I was initially uncomfortable.

I was encouraged to explore the root cause of this unease and I realized that it was a result of the internalization of these positivist teachings. This internalization was not only due to the formal curriculum, but more so from the hidden curriculum of health sciences, which often views qualitative research as inferior science, or not science at all (Thorne, 2016; van Hoonaard, 2019). I have seen this firsthand through the emphasis placed on assignments whose goal is to critically analyze the quality of positivist research while at the same time, the complete lack of qualitative exposure in the mandatory curriculum of both of my undergraduate degrees.

Positivist research dominates health science publication (Swift & Tichler, 2010; van Hoonaard, 2019). I saw this firsthand when Dr. Brady and I conducted a review of the *Canadian Journal of Dietetic Research and Practice* and we found that qualitative research made up the minority of dietetic publications over the last 10 years (Bromley & Brady, 2022). Similar findings have also been reported in studies of publishing in medical journals. Shuval et al. (2011) reviewed

67 medical journals over a ten-year period. They found that although there was a 2.9% absolute increase in qualitative publications during that time, they concluded that the overall number of qualitative publications remains low in medical research, with qualitative research still making up less than 5% of publications (Shuval et al., 2011). Some assert that research that is reviewed by publishers in the health sciences are automatically rejected by reviewers because of their own biases against qualitative research (Webb, 1991).

However, with the assistance of my supervisor Dr. Brady, and other mentors, I have come to understand how qualitative research is conducted and have become aware of this bias that is instilled within the curriculum. With this understanding I have developed a much deeper appreciation for the qualitative sciences and the rigour with which they are conducted. At the centre of this appreciation is the fact that not all research questions can be answered with the use of the scientific method and therefore qualitative research is simply a necessity to better understand the world (Swift & Tichler, 2010; van Hoonaard, 2019).

I have also gained an appreciation for using first-person voice in my writing. Although positivist research has the appearance of objectivity, many question if this is truly ever possible (Webb, 1991). Every researcher comes to their project with their own biases, values, interests, and personal beliefs that influence the research at every part of the research process. Personal decisions mold what is being studied, how it is studied, and how the data is interpreted. Even Watson and Crick, the two traditional scientists who are credited with the discovery of the double helical structure of DNA, have discussed the importance of the social aspects behind their research, which ranged from their competitive nature to be the first to make the discovery (of which is still arguable), to drinking in pubs and playing tennis while discussing ideas with those in related fields. It is therefore felt by some that writing in third person, regardless of the methodology, is a form of deception. To write in third person is to falsely convey that the methods used were sterilized of all human influence (Webb, 1991). Writing about my research in first-person voice is therefore done to increase the transparency of the research process and how I came to the conclusions I did. The discomfort is also no longer present, because as I came to appreciate the importance of qualitative research, I now take pride in the notion of conducting my own among other qualitative scholars, of whom I have the upmost respect.

Reflexivity

Positivist research and qualitative research are rooted in divergent epistemological positions. Positivism has the underlying assumption that there is only one, true reality that can be uncovered with appropriate scientific methods (Guba, 1981). It therefore holds that one can objectively break down this reality into individual variables, and the researcher can look at one of these variables in objective isolation. Included in this removal of potentially confounding variables is any influence of the researcher. While this may be accurate to some extent when chemicals or physical events are being researched, this is impossible when human beings are the subject of inquiry. Qualitative epistemologies maintain that there are multiple realities due to each person viewing the world from their own unique perspective, based on their experience. Not only can characteristics of the researcher themselves influence what is said or how a participant behaves, but the researcher's interpretation of events can also be influenced by their unique worldview (Guba, 1981).

The different epistemological approaches that underpin quantitative and qualitative research means that the rigour of each must be evaluated differently. Credibility is the analogous concept in qualitative research to internal validity in quantitative research. If a positivist study has internal validity, it means that the results of the study are true and not due to a methodological error or confounding variable (Cozby & Bates, 2012). For a qualitative study to be credible, it means that the interpretation of the results is consistent with the experience of those who participated in the study, or others who have had similar experiences (Hammarberg et al., 2016). To increase the credibility of a qualitative study, it is important for the researcher to demonstrate transparency. Including direct quotes from participants, as mentioned above, is one way to increase transparency. Another way is through reflexivity, as is discussed here (Guba, 1981; Hammarberg et al., 2016).

Acknowledging the need for reflexivity is indicative of the ontological and epistemological viewpoints held by the researcher (Guba, 1981; Olmos-Vega et al., 2022). Practicing reflexivity increases the transparency of the study by helping to explain to the reader why certain methodological decisions were made and how interpretations and conclusions were come to. In an effort to practice reflexivity, I meticulously explained each research decision I made in this project, as will be seen in this thesis.

Qualitative researchers embrace that subjectivity is always going to be present, and in doing so, they recognize that their own experience can colour the interpretation of the data. Therefore, reflexivity also provides dedicated space for the researcher to explore and address potential biases

so they can look at the data with some distance (Olmos-Vega et al., 2022). To accomplish this, I relied on journaling and memoing. As I will discuss in more detail in the next section, I used the computer software program, MAXQDA (VERBI Software, 2021) to transcribe and thematically analyze participant interviews. Within this software I used the free memo function to keep a journal about the project. These entries were dated and contained a wide breadth of topics, including, but not limited to, feelings I had towards the project, initial impressions following participant interviews, reflections on how I felt the ideas from participants were connecting or diverging, and new information I learned that I thought might be relevant later.

Additionally, I used the in-document memo function to insert thoughts and ideas regarding specific participant quotes. I used this function most often when a participant statement invoked a strong emotional response that was either positive or negative. When I found myself eagerly agreeing with participant statements, I tried to expose myself to material that presented ideas that were in opposition and reflected on the differences; when I found myself fundamentally disagreeing with a participant quote, I explored why this might be.

I reviewed these memos and reviewed previous course work I had completed on positionality and intersectionality. From these, and drawing on the work of Bauer's (2021) adapted Wheel of Power and Privilege, I constructed a list of various personal characteristics and beliefs that I explored in my reflections. In the interest of space, how each personal characteristic could have influenced my analysis and the efforts I took to explore and reflect on each is not discussed. However, this brief description is shared here to increase the transparency of the research process.

I acknowledge that I hold a place of great socioeconomic privilege. I am a citizen of both Canada and the United Kingdom and therefore hold a place of privilege as a White settler. I am a cis-gendered female. Although I identify as bisexual, this identity is invisible as I am married to a cis-gendered man. I live in an urban area rather than rural, and although I am a student with a low-income job, my husband earns enough to comfortably provide for us. This thesis is being completed as apart of my third post-secondary science degree and starting this year I will begin medical school. I am a student registered with disability services, however, my disabilities are invisible to the people around me, so I am viewed as an entirely able-bodied person. Although I was raised Roman Catholic, I currently identify as an atheist. My political views are left leaning and are uninfluenced by religion. Therefore, besides being female, I occupy the highest position

of privilege in Canada. Due to my other positions of privilege, being a woman rarely impacts me negatively.

Method

Participants

In this study I was interested in the perspectives of fellow and attending physicians who identified as activists within the Atlantic provinces (Nova Scotia, New Brunswick, Prince Edward Island, Newfoundland and Labrador). The following was the inclusion and exclusion criteria for this study:

Inclusion Criteria:

- Fellows or attending physicians of any medical specialty.
- Currently practicing within the Atlantic provinces of Canada.
- Self-reported to be involved in activism-specific advocacy within their profession.

Exclusion Criteria:

- Medical students, medical residents, and retired physicians.

The definition I used for activism on the recruitment poster was, “those activities whose goal is systemic level change.” In the recruitment letter I expanded this to describe potential activities that physician activist might engage in by writing, “activism can take many different forms including, but not limited to, supporting or providing input on social justice issues on social media platforms, sitting on a community board, lobbying to elected officials, or engaging in protests.” As was discussed in the literature review, activism can be interpreted in different ways that are too complex to explain on a small recruitment poster or in a short recruitment letter. Therefore, when interested participants contacted me for information regarding the study, I asked them to briefly describe the types of activism work they engaged in to assess whether they met the inclusion criteria of this study.

Those who engaged in activism work whose primary focus was to make systemic change to improve overall patient wellbeing or whose work was focused on redressing social injustice were asked to schedule an interview. Activism topics could range from more direct patient health

outcomes, such as smoking, to less direct health outcomes, such as poverty and education. If a participant had contacted me whose activism work focused only on the interests of physicians, such as advocating for higher pay or to advance the interests of the profession itself, I had planned to explain to those enquiring that this study was specifically interested in those whose activism work targeted redressing the socially patterned inequities that contribute to unfair distribution of disease. However, no physicians who were involved in activism that only focused on physician interests approached me to be involved in this study.

The participants needed to be fellows or attending physicians of any medical specialty, or were once attending physicians who now devoted their time to teaching medical trainees. As stated, I was interested in determining how medical trainees should or could be educated to become competent advocates. And as was discussed, there is debate within the literature whether advocacy instruction should take place, if at all, during undergraduate medical school and/or during residency (LaDonna et al., 2020). Therefore, the perspectives of interest were those who had already completed both levels of training, that being undergraduate medical school and residency. Although fellows are still considered to be in training, this is advanced sub-specialty education that not all physicians require. Therefore, only undergraduate medical students and residents were excluded from this study. The purpose of excluding retired physicians was to obtain current perspectives of the profession.

The participants may have completed their training anywhere in or outside of Canada but must have had experience practicing within the Atlantic provinces. The purpose of restricting the geographic area was to narrow the context of the participants. As credibility is the analogous concept to internal validity, transferability is the analogous concept in qualitative research to external validity in quantitative research (Guba, 1981; Hammerberg et al., 2016). If a study has external validity the results are generalizable, meaning that the findings of the study will be true across time and space and regardless of context (Cozby & Bates, 2012; Guba, 1981). However, this is unobtainable in qualitative research, since qualitative research is always dependent upon the context of the lives of the participants (Guba, 1981). If the context of two groups is similar enough, then the findings from one group can be transferred, or assumed to be akin, in the other group (Guba, 1981; Hammerberg et al., 2016). Therefore, narrowing the context, such as only interviewing physicians in a similar geographic region, can help to make assumptions about that particular area as a whole. The Atlantic provinces have a unique culture that could have potentially

made their perspectives distinct from physicians elsewhere in Canada. Limiting the study to this region makes it reasonable to assume that the results of this study are true of other physician-activists who are apart of the Atlantic Canadian culture. Whereas, if the study population had been expanded to include all of Canada, it is less likely that assumptions could be made about the feelings of all Canadian physician-activists within the limited number of interviews that are possible in this master's project.

Recruitment

This study used a purposive sampling technique. Purposive sampling is a non-probability sampling technique in which participants are selected because they possess some characteristic or experience that is of interest (Thorne, 2016). In the case of this study, the characteristic of interest was experience engaging in activism as a physician.

This study was advertised in the monthly newsletter from the Medical Society of Prince Edward Island and the New Brunswick Medical Society. Both were able to use the recruitment poster and recruitment letter, which can be found in **Appendix 1**. Doctors Nova Scotia and the Newfoundland and Labrador Medical Association declined to advertise this study in their newsletters. However, the policy advisor at Doctors Nova Scotia circulated the study among physicians that they felt met the criteria for the study. Attempts were made for the study to be circulated among the medical faculties at both Dalhousie University and Memorial University, and other physician organisations, such as Society of Rural Physicians of Canada, but the study was either unable to be advertised or no response was received.

Some participants were recruited through snowball sampling. Physicians who participated in this study were asked if there was anyone within their network who might be eligible and interested in participating. They were invited to pass along the information about the study. In some cases, the participant provided contact information of their colleagues so I could reach out to their contacts directly.

Other participants were recruited through individual scouting efforts. Physicians who are involved in outstanding advocacy work often make media news headlines. Therefore, online news outlets, such as the Canadian Broadcasting Network, were used to search for physician-activists. When potential participants were found through these means and contact information was available, they were sent the recruitment letter inviting them to participate in the study.

Sample Size

According to Thorne (2020), sample size is only an “artifact” from the way research has previously been done. Instead, for ID, a researcher should judge their sample size as sufficient once they have obtained an answer to their research question that they deem to be satisfactory. However, all researchers must provide a sample size for ethics approval (Thorne, 2020).

One way of determining whether a sample size is sufficient is when saturation is reached. This is when no new ideas are appearing with subsequent interviews (Hammerberg et al., 2016; van den Hoonaard, 2019). Guest and colleagues (2006) conducted a study to determine how many interviews it took to reach saturation. Sixty women were recruited across two different countries. It was found that 73% of all codes that were generated across the study were found in the first six transcripts, and 92% were found within the first 12. The researchers therefore concluded that the majority of codes could be generated within six to 12 interviews (Guest et al., 2006).

However, it is the opinion of Thorne (2016) that stating saturation has been reached is not an appropriate descriptor one can give their own work. In health sciences, for which ID was designed, one must always consider that a patient could experience a disease or a condition in a completely novel way because of the fact that they are their own unique individual. This idea can be applied to any qualitative research. Therefore, for a researcher to state that their research has reached a point that no new variations could possibly emerge is in direct opposition to the epistemological views of the methodology and qualitative research as a whole. Thorne asserts that saying a qualitative study has reached saturation is a “hollow” statement (p. 107). She believes qualitative researchers make this claim in an attempt to prove rigour in their research to those who are unfamiliar with the intricacies of qualitative scholarship (Thorne, 2016). Thorne is not the only one who rejects the idea of saturation as a justification of sample size, as it has been questioned by others (Hammerberg et al., 2016).

However, since it remains deeply entrenched in the culture of research, sample sizes are required. It is common of qualitative methods, including ID, to set upper and lower limits for participant numbers (Thorne, 2016). Thorne thus maintains that for smaller ID studies, it is acceptable to set arbitrary sample sizes, as long as the researcher makes it clear to the reader that further research will need to be conducted to continue to reveal novel human experiences. Therefore, based on the findings from the Guest et al. (2006) study, I decided to interview a minimum of eight participants, and a maximum of 12. Although it is never possible to know that

all variations of experience have been explored, this range allowed for some assurance that most ideas that exists within this population would be seen, while balancing the practical constraints of this master's level project.

Data Collection

I used semi-structured interviews as the primary method of collecting data. After a physician activist had agreed to participate, I scheduled an appropriate time for the interview. Since many of the participants lived well beyond Halifax, all interviews took place over Microsoft Teams. I sent a meeting link for Microsoft Teams to the participant prior to the interview date and a reminder email was sent one business day prior to the scheduled time of the interview. When possible, interviews were scheduled for an hour and a half. Although interviews were only projected to take one hour, an additional half hour was scheduled to give ample time to conduct the interview and to provide time to obtain informed consent. However, due to the limited time of physicians, the majority of the interviews were only able to be scheduled for one hour.

I conducted all of the interviews. The interviews were recorded within Microsoft Teams. These meetings were automatically saved within my personal, secure Mount Saint Vincent University OneDrive. Microsoft Teams records both audio and video information. Participants were invited to turn off their camera if they felt more comfortable, however they were informed that video information would not be analyzed. Interviews were also recorded using an external audio recorder that was placed beside the speaker of my computer where I was conducting the interviews. This allowed for a backup copy of the interview, in case of any technical difficulties with Microsoft Teams.

The interview questions were open-ended, subjective questions whose aim was to understand the experiences, perspectives, and attitudes towards activism in medicine and the potential training of skills for activism. Following the interview, the participants were also asked to complete a data form. This form asked for demographic information as well as information regarding medical training. The participants were asked to fill out this form and return it by email at their leisure. A reminder email was sent two weeks after the interview if it had not been received. The purpose of this data form was to gather contextual information about the participants. The interview schedule and the data form can be found in **Appendix 2** on data collection.

Data Analysis

The information from the data form was analyzed using descriptive statistics. For example, the percentages of physicians who identify with each gender and ethnic group, the average age of participants, the number of participants from each province, where medical training was obtained, and the average number of years since graduating medical school, was reported. This data was used to improve the transferability of the study by providing a rich description of the context of the participants (Guba, 1981).

The interview data was analyzed using thematic analysis. The thematic analysis followed the six-step method outlined by Braun and Clarke (2006). The first step is for the researcher to familiarize themselves with the data. Since this study used interviews as its primary method, the interview data was first transcribed (Braun & Clarke, 2006). Transcription took place in the program MAXQDA, a computer software designed for qualitative analysis. To increase the familiarity with the data, I conducted all transcriptions. The data was then reread in an active manner by taking notes, memoing initial impressions, and highlighting sections of interest (Braun & Clarke, 2006). This annotation all took place within the MAXQDA software.

The second step of analysis was the generation of initial codes (Braun & Clarke, 2006). Once I familiarized myself with the data and reviewed my initial list of impressions and ideas, I began to generate codes. Codes are words or phrases that can be applied to the transcript that allow the researcher to compare transcripts in a meaningful way (Braun & Clarke, 2006). Since this analysis took place in the MAXQDA software, the transcripts were highlighted and tagged with an appropriate code electronically. Commonalities between transcripts, which was seen through repeated or interrelated codes, was noted during this process. These interrelated codes helped generate initial themes, which is the third step of Braun and Clarke's (2006) thematic analysis.

As discussed above, the credibility of this study was enhanced by using direct participant quotes and practicing reflexivity. However, another common way to increase credibility is through member checks (Guba, 1981). For interviews, member checks can be conducted by having the participants review a copy of their transcripts to not only verify that what they said is accurate, but that the interpretation of their ideas is also correct (Guba, 1981). At this stage of the research process, some qualitative studies may complete these member checks. However, I chose to forgo these member checks, as it is not generally recommended in the ID methodology (Thorne, 2016). The central characteristic of ID, as the name suggests, is that the researcher is acting as an

interpretive agent. In this interpretation, the researcher deduces larger themes from multiple, individual accounts. It is therefore not always appropriate to confirm whether the participants agree with the interpretation, as they are unable to see the individual perspectives and experiences of the other study participants (Thorne, 2016).

As per the fourth step of the Braun and Clarke (2006) thematic analysis, initial themes were reviewed. I first read all the coded data that fell under each of the themes to determine if the codes fit together and determined the cause for any inconsistencies. Often the initial themes that are developed in the third stage of analysis are not appropriate after further reflection on the data. For example, one theme may need to be broken down into separate sub-themes, or there is not enough data to justify a separate theme. An initial thematic map was developed at this stage, as is recommended by Braun and Clarke, that included the initial themes and subthemes.

To improve the credibility of qualitative research, peer debriefing is recommended (Guba, 1981). Peer debriefing is the process of discussing the data with others to determine whether the primary researcher's interpretations are reasonable (Guba, 1981). As such, Dr. Brady and I met several times to discuss the data. As is expected with peer debriefing, Dr. Brady posed questions about the data and my interpretations for me to reflect on which helped in rethinking and refining the themes (Guba, 1981). After I was satisfied with the developed themes on the coded data, I reread all the transcripts again to ensure that revised themes fit the entire dataset (Braun & Clarke, 2006).

Once the thematic map was sufficient, the themes were refined and renamed as required (Braun & Clarke, 2006). In this refining process, I wrote an analysis of the data and explained the essence of each theme, how it related to the other themes, and how it related back to the research questions. At this stage, although working titles for each theme had been established, the titles were reconsidered to ensure that when the reader sees them, they immediately have a general idea of what that theme is about. Once all of this was completed, the final step was to write up the report to convey a consistent narrative of the themes to answer the research questions, which resulted in this thesis paper (Braun & Clarke, 2006).

Sandelowski and Barroso (2003) outline the four ways in which qualitative data can be analyzed and presented: topical survey, thematic survey, conceptual or thematic description, and interpretive explanation. A topical survey uses qualitative methods, such as using individual interviews, however, the resulting analysis is not qualitative in nature, as the results are only

interested in quantifiable codes, such as reporting on counts or frequencies. A thematic survey, although often still interested in some numerical findings, places an emphasis on finding and describing themes in the data. Conceptual or thematic description takes this a step further and not only places its sole emphasis on the development and integration of themes, but these types of studies also often bring in concepts of theoretical frameworks from external sources to explain the data obtained in the study. The last category, interpretive explanation, is the most abstracted from the data collected in the study and has the goal of developing an entirely new explanation of a phenomenon (Sandelowski & Barroso, 2003).

According to Thorne (2016), interpretive description studies will generally fall within the middle two categories of thematic survey and conceptual or thematic description. As you move outward from the topical survey, the interpretation becomes increasingly abstracted from the original data. This research was not aimed at explaining a phenomenon. Instead, it was focused on obtaining the perspectives of physicians to make concrete suggestions for the field, so I chose to write the results most consistently with thematic survey. Although interpretation took place to bring the results into a cohesive narrative, I chose to stay actively grounded in the words of the participants.

Ethical Considerations

Ethical clearance for this study was obtained through both Acadia University and Mount Saint Vincent University's Research Ethics Boards. The main ethical consideration within this study was concerned with informed consent and confidentiality. Prior to the interview, informed consent was obtained. The participants were given the information sheet and consent form prior to the interview date. These forms can be found in **Appendix 3**. The information sheet included the purpose and procedure of the study, any possible risks and benefits, participation and withdrawal information, participant rights, who to contact for further information regarding the study, and how the study results were to be presented. In most cases, participants returned the consent form prior to the scheduled meeting day. On the day of the interview, I confirmed the participant had read through the information sheet and consent form and asked if they had any questions. I then reviewed the most important parts of the information and consent form again with the participant to ensure they understood what they were consenting to. Following the interview, before the

participant closed the call, they were informed again of their right to withdraw from the study and given instruction on how to do that.

As stated previously, interviews took place and were recorded over Microsoft Teams. Microsoft Teams allows only for the recording of both audio and visual information, however, only the audio information was required for analysis. Following the interview, the mp4 video file was converted into a mp3 file using the software program VLC (VideoLan, 2006) so that only the audio information was retained. Once it was confirmed that the mp3 file conversion was successful, the original mp4 file containing video information was permanently deleted. The deletion of visual information of the participant added an additional layer of security to ensure participant anonymity.

To ensure there was no violation of confidentiality, all data collected during this study was stored using participant identification codes, rather than the participant's name. Excel was used to generate random three letter codes that served as the identification codes. The only documentation that connected data from the participant and their identification code was the consent form. All other data collected during this study, including the data form, audio files, and the transcripts, used only the participant identification code. In this report direct quotes from the participants have been included. However, the name of the participant nor any identifying information was included with the quotation.

There were no paper copies of any participant information or data. All forms and data were stored electronically only within my MSVU OneDrive or securely on private electronic devices that were only accessible to the research team. The audio recordings of the participant interviews were deleted following final data analysis. The consent forms, data forms, and interview transcripts are to be stored within the MSVU OneDrive cloud network for five years following the completion of the study. After this period of time all electronic data will be permanently deleted.

Results & Discussion

As briefly discussed in the previous section and as the name suggests, ID requires a fine balance between describing the data obtained from the participants and the researcher interpreting these findings to produce meaning (Thorne, 2016). Thorne states, the purpose of ID “is not simply to uncover marvellous stories of human experience” (p. 206). To provide only these stories would

merely be a description of the data. For a description to be interpretive, the researcher must explore the “associations, relationships, and patterns within the phenomenon that have been described” and combine them into a cohesive narrative (p. 56). Furthermore, ID acknowledges that this interpretation by the researcher, even when done through the most rigorous of means, remains at least somewhat dependent on the factors that have moulded the researcher (Thorne, 2016), as discussed in the reflexivity, and writing style sections of this thesis. Thus, it is my belief that separating the results and discussion, i.e., the description and the interpretation, would violate the principles of ID itself, and therefore, these sections have been combined here.

I organized the complex attitudes, ideas, and experiences of the participants, as they relate to the objectives of my research, into two global themes. One of these global themes was separated into two sub-themes. A visual display of these themes can be found in the thematic map in **Figure 1** below. The act of organizing the data into themes is in itself interpretation, as this involves recognizing commonalities and relationships between participant experiences, and in some cases, relating this to other literature.

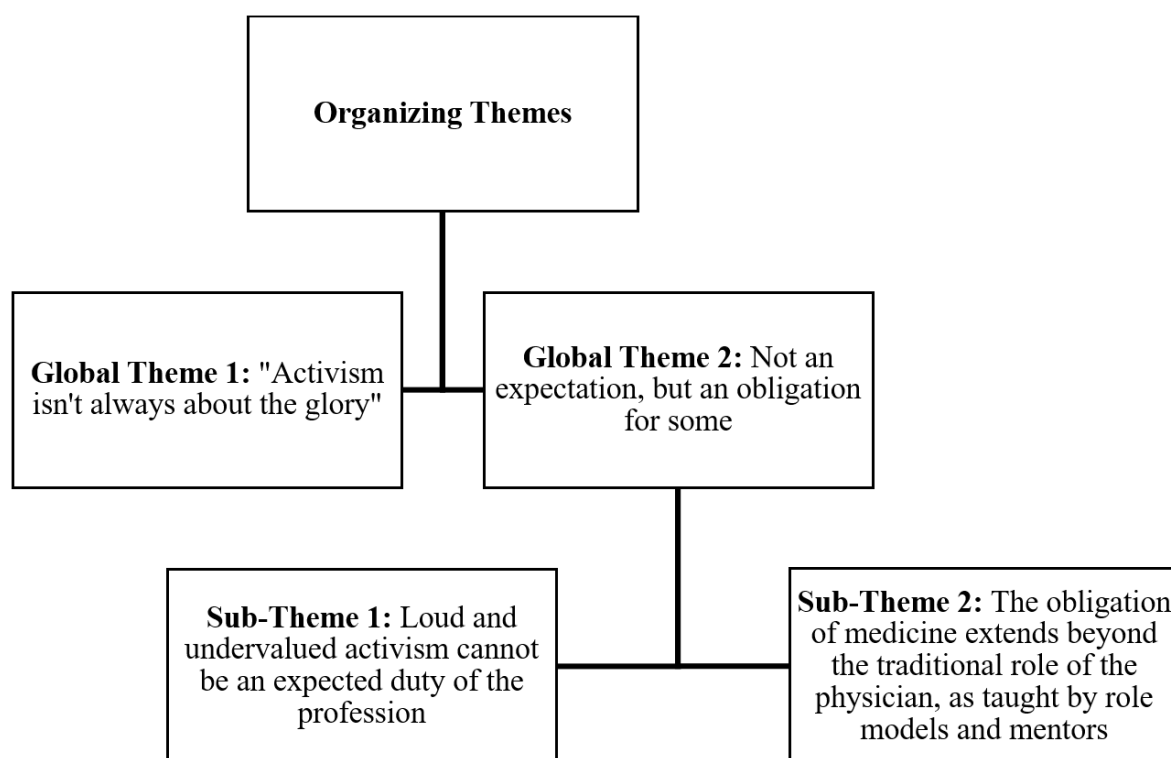


Figure 1: Thematic map

This section begins with participant demographics, and then continues to discuss the themes. The first theme addresses the first research question, whose purpose was to understand how physician-activists understand activism within the profession of medicine. The second theme addresses the other two research questions. Recall that the second research question had the goal of determining the perspective of physician-activists towards whether physicians had a responsibility to engage in activism. The second sub-theme of this global theme specifically addresses the third research question, whose purpose was to determine the perspectives of this group towards education for the skills related to activism.

Participant Demographics

As briefly discussed in the methods section above, qualitative investigation is always reliant on the context in which the research takes place (Guba, 1981). The results from one qualitative study can only be applied to another group if the context of the participants is similar enough. To make the determination of whether the results are transferable, a rich description of the context must be supplied (Guba, 1981). Therefore, I begin the results and discussion section providing a contextual description of the participants. A summary of the participant demographics can be found in **Table 1**.

A total of 11 physicians participated in this study of which 10 (90.9%) were female and one (9.1%) was male. No participants in this study identified as being gender diverse. The age of the participants ranged from 36 to 52 years with the average being 43.1 ± 5.6 years of age. Three (27.3%) of the participants identified as South Asian and eight (72.3%) of the participants identified as White.

All physicians who participated in this study were trained in Canada where seven (63.6%) of the participants completed their undergraduate medical training in the Atlantic provinces, either at Memorial University or Dalhousie University. The other four (36.4%) participants completed their undergraduate medical training in another Canadian province, three (27.3%) of which trained in Ontario, and one (9.1%) in Quebec. Graduation from medical school ranged from 1996 to 2014, with the average participant graduating 15.6 ± 6.4 years ago.

The only Atlantic province that was not represented was Prince Edward Island. Four (36.4%) of the participants were practicing in New Brunswick. Two (18.2%) of the participants practiced only in Nova Scotia and four (36.4%) of the participants practiced only in Newfoundland

and Labrador. One (9.1%) of the participants practiced in both Nova Scotia and Newfoundland and Labrador concurrently.

Eight (72.7%) of the participants completed a family medicine residency program. Two of the physicians who completed family medicine completed an enhanced skills program, one in care of the elderly, and one in emergency medicine. Three (27.3%) of the participants did not complete a family medicine residency, two (18.2%) of which specialized in pediatrics and one (9.1%) in orthopedic surgery. Two (18.2%) of the participants completed a fellowship. The orthopedic surgeon completed a fellowship in foot and ankle reconstruction and one of the family medicine physicians completed a fellowship in public health and preventative medicine.

The topics these physicians engaged in as activists were incredibly diverse. As stated, this research was not interested in the types of activism physicians engaged in. Instead, I was interested in their attitudes towards activism based on their experiences of engaging in this work within the profession. However, some of the activism topics participants engaged in included: the rights of 2SLGBTQIA+ persons and access to gender affirming care, medical assistance in dying, physician recruitment and retainment, climate change, poverty, and racism and sexism within the profession of medicine.

I was unsurprised that the participant demographics revealed a relatively homogenous group, of which the majority were White women. Previously discussed research showed that Canadian medical students are a homogenous group, of which the majority are White, and this has been relatively stable over the last two decades (Dhalla et al., 2002; Khan et al., 2020). Additionally, Canadian census data also helps to explain why the majority of participants in this study were White. While 16.1% of Canada's total population identifies with a racialized group, with South Asian being the largest of these groups at 7.1% of the total population (Statistics Canada, 2022), there is less ethnic diversity in the Atlantic provinces. Statistics Canada (2021) only presents ethnic diversity data in the form of word cloud infographics for each of the Atlantic provinces and only includes those ethnic categories that more than 2.0% of the population identify with. The only minority groups included in the word clouds were Chinese in the Prince Edward Island infographic, at 2.0% of the population, First Nations (North American Indian) in Newfoundland and Labrador, at 2.2%, and Mi'kmaq, in Newfoundland and Labrador and Nova Scotia, at 3.5% and 2.2% respectively. Although exact numbers on the proportion of racialized groups in each province is not reported by Statistics Canada (2021), this data makes it clear that

there are lower numbers of racialized groups in the provinces that this study investigated, compared to Canada as a whole.

It is unclear why the majority of the participants were female. There are three major types of medicine: family medicine, medical specialists, and surgical specialists (Canadian Institute for Health Information, 2020). Although there are more women in family medicine, compared to the medical and surgical specialties, as of 2020, there are still more men in family medicine, making up 52% of the discipline (Canadian Institute for Health Information, 2020). Studies have reported gender differences in the willingness to participate in different types of research (Ding et al., 2007; Lobato et al., 2014; Markanday et al., 2013; Nuzzo & Deaner, 2023), however results are inconsistent and do not provide insight into this specific study. Additionally, although there are gendered differences in how people engage in activism, there does not appear to be a gendered difference in the rate of activism involvement (Coffé & Bolzendahl, 2010; Dodson, 2015).

As discussed previously, qualitative inquiry is interested in uncovering the perspectives of individuals and evaluating the similarities and differences between accounts to understand social phenomenon (Thorne, 2016). Thus, seeing as many novel perspectives as possible can lead to a better understanding of the phenomenon in question. There are many factors that can lead to novel experiences and perspectives, which can include the influence of both gender and race. If the majority of perspectives come from a specific group, such as White women, the perspectives of other groups, which may be very different, are simply not accounted for.

To demonstrate this point, two recent studies can be used to show how race could potentially impact views towards activism. In the first example, an online survey conducted by the Pew Research Center found that Hispanic and Black individuals were more likely than White people to look up information on protests and rallies, were more likely to make a post on social media to support a cause, and were more likely to encourage others to take action regarding issues that were important to them (Auxier, 2020). Findings from another study that examined activism involvement within Black individuals, help to explain why activism may be higher among those who belong to a racialized group (Krueger et al., 2022). This study looked at multiple factors of identity to see which predicted activism involvement. They found that strength of racial identity and experience of racial stress were positively correlated with involvement in activism (Krueger et al., 2022). These studies illustrate that the behaviour of different groups towards activism varies due to differences in experience.

As stated, qualitative methodologies are bound to the context of the participants. Therefore, the fact that the participants come from a fairly homogenous group is not a limitation of the study; it is simply a feature of qualitative research. However, the homologous participant group in this study illustrates why Guba (1981) stresses the importance of providing a rich description of the participants.

Global Theme 1: “Activism isn’t always about the glory”

This theme describes participants’ understanding of activism in the context of their roles as physicians. In short, participants understood activism as those actions that have the goal of creating change in general. However, most participants also distinguished between changemaking activities that constitute activism and those that constitute advocacy. Most participants understood activism to include activities that are explicitly public, highly visible, and often confrontational, or what some participants described as “loud” activities. Thus, most participants felt that for change-making activities to be considered activism, they had to not only encourage change, but also must be overt acts. In line with participants’ descriptions, I use the term “loud activism” to refer to these activism activities. Conversely, most participants described change-making that occurred behind-the-scenes or in private as advocacy activities, rather than as activism. I use the term “quiet activism” to refer to these covert, change-making activities that some participants described as advocacy. However, when physicians were asked to describe their activism involvement, all included the behind-the-scenes, quiet acts that promoted change as examples, despite the fact that this contradicted their original definition.

Interviews began by exploring what physicians understood activism to mean in the context of medicine and their roles as physicians. Recall that the UBC-HAF describes advocacy as an umbrella term that comprises activism and agency (Hubinette et al., 2017). It specifically defines activism as an “action that brings about institutional (e.g. practice-level, hospital-level, health care system-level), social, economic, or political change” (p.131), while agency includes actions that help patients navigate existing healthcare and community systems (Hubinette et al., 2017). I used this framework as a guide to understand and compare participant responses in my interpretation.

The majority of participants indicated that they had never given much thought to the definition of activism or whether or not there was a difference between activism and advocacy. In fact, most participants used the words activism and advocacy interchangeably until they were

Table 1: Participant Demographics

Demographic	Mean \pm Standard deviation (n=11)
Age (years)	43.1 \pm 5.6
Time since graduating medical school (years)	15.6 \pm 6.4
Number of participants (%) (n=11)	
Race/Ethnicity	
• White	8 (72.7)
• South Asian	3 (27.3)
• Other	0
Gender Identity	
• Female	10 (90.9)
• Male	1 (9.1)
• Gender diverse	0
Location of undergraduate medical training	
• Atlantic provinces	7 (63.6)
• Ontario	3 (27.3)
• Quebec	1 (9.1)
• Outside of Canada	0
Location of residency training	
• Atlantic provinces	7 (63.6)
• Ontario	4 (36.4)
• Outside of Canada	0
Residency training	
• Family medicine	8 (72.7)
• Pediatrics	2 (18.2)
• Orthopedic surgery	1 (9.1)
Completed a fellowship	2 (18.2)
• Foot and ankle	1 (9.1)
• Public health and preventative medicine	1 (9.1)
Current location of practice	
• New Brunswick	4 (36.4)
• Newfoundland & Labrador	5 (45.5)*
• Nova Scotia	3 (27.3)*
• Prince Edward Island	0

* One of the physicians included in this study practices in both Nova Scotia and Newfoundland & Labrador. Each of the percentages was still calculated based on 11 participants.

specifically asked if there was a difference between the two. Once asked, all participants believed that there was a distinction. One participant explained:

[Activism] is distinct from advocacy in the sense that activism speaks to broader populations or bigger issues that might affect lots of different people versus advocacy, which can include that, but it also includes the single patient things.

This participant followed this definition up with an example:

I might call Pharmacare and start yelling at them about, ‘why isn't my patient covered for X, Y, Z? Because I really think they need that medication.’ Versus activism which is, ‘why don't we have national Pharmacare like, yesterday?’

This definition and example given by the participant is aligned with the definitions presented in the UBC-HAF. The difference I noted was that the term advocacy was being used in replacement of agency. The example of getting a specific medication covered for one patient is an example of directed agency, according to the framework. In this example, the physician has determined the need of the patient based on their expertise, which is determining the specific medication the patient requires. They are then using their influence as a physician to help the specific patient access this medication, within the confines of the preexisting system. The second example this participant gives is in line with the definition of activism given in the UBC-HAF. In this example, engaging in activities to attempt to have medication coverage for all, would involve activities that would change the current system of drug coverage in Canada.

Although not all physicians were as succinct in explaining the difference between activism and advocacy as the participant above, the majority of participants saw advocacy as those activities that affected individual patients under their direct care; whereas they saw activism as those activities that affected larger issues and groups of patients, that extended beyond their day-to-day practice. Another participant concisely described this point of distinction in stating, “I feel like activism is more getting to the root of some of the systemic problems for a bigger population.” Hence, I noted that participants understood activism in a way that aligns with the UBC-HAF, despite only one participant indicating that they were familiar with this framework.

However, affecting change at a systemic level was not the only way that physicians understood activism. Another way they distinguished between advocacy and activism was the degree to which the activity was public-facing, which is not a distinction that is used in the UBC-HAF. Many described activism activities as “loud,” while advocacy activities were seen as “quiet.”

In other words, for participants in this research, activism activities included actions where the activist and their actions are visible and identifiable to the public. In contrast, participants saw advocacy and advocates as affecting change in behind-the-scenes ways that are not publicly visible and that do not delineate from the established roles, responsibilities, and relationships among the various organizations, institutions, and processes within the healthcare system. For example, one participant stated:

When I think about activism, I think about people who are out in the communities and known for advocacy around specific things. Activism feels a lot more of a louder action than advocacy can look like. I think advocacy can look really quiet sometimes. But I've never really thought about the difference between those two things before. But I do think there is a difference. And I think activism is probably a bit louder and visible than a lot of the advocacy that physicians engage in.

Another participant agreed with this sentiment:

Activism means thinking about a patient, or a patient population, or a community and thinking about some of the issues that might affect a lot of folks and thinking about how do we, in a bigger sphere, a more public sphere, make noise about getting things done or making change.

These two examples exhibit how physicians characterized activism as not only making change at a systems level, but also bringing these issues into the public domain in “loud,” or publicly visible ways. This was evidenced by the way they described their engagement as activists; many of the participants described being involved in rallies and campaigns, talking to the media, lobbying to government, and posting on public social media.

However, some participants questioned whether public visibility had anything to do with determining if an activity was considered to be activism. When reflecting on their efforts to make change, these participants did not as readily distinguish between activities that may be considered activism and those that may not. One participant provided two examples of questioning whether public-facing activities are the only activities that could be considered activism.

I think people tend to think of activism as the really public stuff. So, what are you doing on social media, or media interviews, or out in the streets – which I do think a bit more as activism... But I am the person who will phone bank for two hours to try to get people to

come to an event. So that might be activism, even though it's not public and known and things you can point to, to say, 'that's what I do as an activist.'

At another point in the interview this participant questioned, "we have a rally on Saturday and I'm in charge of bringing samosas. Is that activism?" In these examples, the participant is acknowledging all the labour that is required behind the scenes to sustain activist movements.

Engaging in activism was one of the inclusion criteria for participation in this research, as was indicated on the recruitment poster and recruitment letter. Nevertheless, the view that activism only includes "loud," publicly visible activities undergirded some participants' reluctance to consider themselves activists. One participant who had not previously considered themselves to be an activist, but identified themselves as an advocate explained:

I guess I've never really identified with the thought of being an activist. I suppose, to me, the connotation for [activism] has always been a bit more public facing—going out there and spreading the word and drumming up support. Where in my world, that sort of quieter advocacy is just seeking out what the problem is, gathering the facts and information, and putting together some sort of rationale for why there needs to be change.

This participant had made a significant impact for the underserved population in their province for which they provide specialized care, through changes in policy and the implementation of new programs. They accomplished these changes through less visible actions, such as through research, as they described above. Despite the changes they had made, they could not identify with the title of activist. Actions such as phone banking to promote a campaign, supplying food for campaigners, and conducting background research to provide arguments for why change is needed, would not be considered activism if one were to define it with the criteria of being overt.

As stated, the UBC-HAF does not distinguish activism from other change-making activities based on the degree to which an activity attracts public attention. Thus, I considered these behind-the-scenes activities, described by the participants here, to be activism, based on the UBC-HAF, simply because they are apart of the activities that facilitate change. If you recall the feminist scholarship I discussed in the literature review, I also interpreted these activities to be activism because they are the precursor to change, they have the potential to foster new social relationships and power dynamics, and they can contribute to positive change outside of the individual who is doing the action (Abrahams, 1992; Martin et al., 2007). The initial definitions of activism given by participants aligned with, that I began to call, loud activism. However, when participants were

asked to give examples of their activism activities, all participants included quiet examples, such as these. I felt their inclusion implied that these participants viewed quiet activities as equally important as loud activism.

More specifically, I noted that participants commonly identified two types of quiet activism activities. The first type of quiet activism that was commonly provided as an example was research. I want to clarify here that quiet activism does not mean that the act must be anonymous. Research and gathering information is often not an anonymous act. Researchers must apply for ethics approval, colleagues may be aware of their research endeavors, and researchers may interact with participants. However, I categorized research as quiet activism because the researcher is not obligated to use the findings for loud activism activities, such as lobbying to government. Instead, other activists can take the findings generated from the research activities of quiet activists and use them to guide public or “loud” activism. One participant, who identified with the title of activist, described how a large part of their activism work is research. They stated:

My role is more data gathering to try to identify the problems in the system so that they can kind of be knocked out one by one. Because it is hard to attack a problem unless you can define it.

This participant’s explanation for why they are involved in research is in line with the feminist scholarship on activism. As Martin et al. (2007) pointed out, one of the reasons why quiet activism is important is because it is often the precursor to change. Conducting research to determine the problems that are present and how these problems can be addressed, as the above participant described, is the necessary precursor. As another participant stated, the data from the research is important “because people don’t want to change policy just because we said so.” This underscores the importance of research that must come before public activism as it is needed to formulate an argument regarding what needs to change or how.

The second form of quiet activism that I noted as being commonly discussed by participants was finding the right person to speak publicly, which participants believed is one with lived experience of oppression or unfair circumstances for which change is being sought. An insight shared by many participants was the perceived authority that their voice carries because they are physicians, which was a concern for participants because it typically meant that the insights of those with lived experience were not centered. As one participant stated, “when a physician speaks everybody shuts up and listens.” This participant went on to talk about the equity-

seeking population they serve, and how it is not appropriate for physicians to speak on behalf of these populations:

I am not the person to be talking about the kind of [discrimination] that [the racialized population I serve] face. I am not the person to be talking about that. I have not felt those effects. I am not a scholar on those things. But boy, if I started opening my mouth, everybody would be all over me like white on rice.

Here, this participant is describing how physicians experience a certain type of privilege that makes others believe that what they say is important. Although physicians have expertise in health and the human body, they do not necessarily have expertise garnered from lived experience. This is particularly true of topics that require lived experience to fully understand. If a physician were to speak on the behalf of a particular population, the value that is automatically placed on physician opinion would overshadow the voices of those who need to be heard. This is consistent with previous literature on the topic, where concerns have previously been noted by medical trainees that their social capital can result in their voices drowning out others, including their own patients (Griffiths et al., 2021).

The participant above went on to describe how they can be an activist, without speaking on the behalf of their patients:

So, my activism role is to think about why aren't folks who are the right people to be talking about these things, talking about these things? And what can I do to facilitate them being able to do that?

Here, they are stating that their role as an activist is not always to speak on behalf of the population they serve. Instead, it is the feeling of this participant, that their role as the activist is to find someone else who has that lived experience and knowledge to speak for their community and to try to take action to remove barriers for them to speak. Another participant echoed this statement, speaking about another equity-seeking population. This participant was given an assignment during their residency training to teach their class about a particular population, when they came to the realization that it was not appropriate for them to do so. They stated:

I did some research and then realized that I needed to talk to people from the community with lived experience to be able to understand [their situation] and that really, they needed to teach us about them. That was really the only way to make that work.

This participant then took action to remove barriers to get people from the community from this specific population to come to the university and educate the group of residents. Part of this action was to find money within the university to pay these individuals for their time. In doing so, this participant was not engaging in loud or public displays of activism. Instead, they were completing the behind-the-scenes work to get the most knowledgeable people to speak; thus, their efforts were virtually invisible to their classmates.

This act of finding the appropriate people from an underserved population to educate a small group of residents was a local action. However, I once again considered this to be activism based on Martin et al. (2007) because it created new social relationships and influenced power dynamics. A relationship was built between the community and medical trainees, and it reversed the power dynamic between the equity-seeking population and the physicians by centering the expertise of individuals from that population.

Although many participants did engage in activities that are commonly understood as activism, such as speaking at rallies and being interviewed on television, all physicians also engaged in, what I consider to be, an expanded definition from the UBC-HAF's view of activism, in that these perspectives were in line with feminist scholarship. The inclusion of these quiet examples by physicians demonstrated that activism by physicians often involves using their influence and unique skill set to effect system-level change through behind-the-scenes actions. Their inclusion also demonstrates the belief that these less visible activities are just as important as the loud and public activism activities. As one participant perfectly articulated, "activism isn't always about the glory."

Global Theme 2: Not an expectation, but an obligation for some

This organizing theme describes participants' attitudes towards the degree to which activism may be considered a professional responsibility. This theme comprises two subthemes. The first subtheme, titled *Loud and undervalued activism cannot be an expected duty of the profession*, addresses physicians' perspectives on the expectations of the profession of medicine in relation to activism. Since most physicians associated activism with only the loud activities described in the previous theme, they felt it was not a reasonable expectation to make of all physicians. They felt loud activism could not be an expectation because of the belief that only particular personalities and temperaments are amenable to this type of work. They also felt that it

was not an expectation of the profession because it was not encouraged by society and government. They felt that physicians are only valued based on how quickly and efficiently patients are moved through the healthcare system. This is evidenced by the fee-for-service (FFS) pay model, by which most physicians are compensated. An FFS model also meant that activism had to occur outside of office hours. This is a barrier as it takes time away from other responsibilities, such as family and interests outside of medicine.

Despite being hesitant to call activism a professional expectation and regardless of the barriers, physicians in this study continued to engage in activism. The reasons for why and how physicians came to be engaged in activism are addressed in this second subtheme, entitled *The obligation of medicine extends beyond the traditional role of the physician, as taught by role models and mentors*. Physicians in this study felt that their duty to the patient extended beyond the traditional view of medicine and thus beyond the clinical encounter. They felt that only addressing the physical ailments of individual patients was not enough to fulfill their duty to treat and cure illness, and thus felt a moral obligation to do more for their patients. This subtheme goes on to describe how physicians developed this calling from role models and mentors.

Sub-theme 1: Loud and undervalued activism cannot be an expected duty of the profession

This first subtheme captures one facet of participants' attitudes toward the roles, responsibilities, and obligations that physicians have to engage in advocacy and/or activism. In short, participants described how they saw advocacy as a professional responsibility, but saw activism as a supererogatory role. Participants pointed to the relative privilege that physicians hold in society as rationale to expect them to effect change. They recognized that their privilege makes others feel obliged to listen. As one participant stated, physicians have "privilege afforded to us by the nature of the letters after our names" which allows for the "ability to speak and act with pretty minimal ramifications." All the physicians felt that the privilege they are afforded should be used in some way for good. As one participant stated, physicians "have that privilege of having a voice that a lot of other citizens don't...And so, you should use that power for good." However, "doing good" equated to a responsibility to engage in advocacy, not activism, which one participant described thus:

Activism, I think is a res—No. I will not say activism. Advocacy. Advocacy is the responsibility of every physician. Is every physician of a temperament to go yelling in the

streets about big social issues? No. Is that okay? Absolutely. Do I think everybody has to be like me or I have to be like them? Absolutely not. Is everybody going to pick the same issue? No. But if we are all not engaging in advocacy, whether it is at the level of the patient or the level of society, then I think we are not fulfilling our professional responsibilities.

For this and other participants, physicians' privilege warrants their responsibility to improve the world around them through advocacy whether their efforts be at the practice-level or addressing systemic-level issues.

The distinction drawn between physicians' responsibilities to engage in advocacy but not activism was informed, in part, by participants' understandings of advocacy and activism as described in global theme 1, but also by three key barriers that participants believed prevent physicians from engaging in activism. The first barrier that participants cited was related to individual-level factors, namely personality and temperament of physicians themselves. Participants felt that it was unreasonable to expect all physicians, whose personalities and temperaments may not be well suited for the public and confrontational nature of activism, which was understood as "loud," highly visible, and confrontational activities, to have to engage in change-making in this way. The importance of individual personality is also highlighted by the quote above. This participant's understanding of activism as activities that are loud, public, and include "yelling in the streets," informed their view that activism cannot be a professional expectation since not all physicians are of this temperament. Another participant agreed in stating:

I have a different approach to life than many people. I'm very open and an extrovert, I guess. And that makes [loud activism] easy for me... I've played in bands. I can stand up in front of a crowd and speak. And I don't worry about the consequences—I mean, I worry about the consequences, but I don't worry as much about consequences of me speaking out as other people do. I have the confidence to do that. But I don't think that's from [medical] training. That's somewhat personality to some degree. Not everybody has the ability to do that.

This participant is expressing that their comfort with public speaking and being mostly unconcerned about potential punishment are inborn features of their personality. They feel that since these qualities are innate, it cannot be an expectation placed on all members of the profession of medicine since not all members possess the characteristics suitable for loud activism.

A second common barrier that impedes physicians' engagement in activism that was cited by participants is the devaluing of activism work by colleagues within the profession as well as by the public and governments, which prioritize throughput, and is reinforced by the FFS compensation model. Due to the unequal distribution of physician specialties that engage in activism, there are only some specialties who engage in unpaid work. Participants noted that government and society have expectations of what physicians are supposed to do, which does not include advocacy or activism. One physician describes how society sees physicians as cogs within the machine of the healthcare system, and what comes with being this specific cog is the expectation to fulfill a specific role. They stated:

There are incentives that society puts on us, right? So, society puts on us the widgets. I get my widgets. I got to do my widgets. I got to see my patients and see my patients and see my patients. That is the expectation of society, and I must respond to what society says I'm supposed to be doing... that's part of my professional obligation. To respond to what society says I'm supposed to be doing.

They then on to say, "throughput is what we're valuing, but we don't value these kind of bigger, broader things." This participant is highlighting that government and society feel that the most valuable thing physicians can provide is moving as many patients as quickly and efficiently through the healthcare system as possible.

Many felt that this expectation was enforced through the current pay model by which most physicians are compensated. Although other payment models exist, the majority of physicians in Canada are compensated using the FFS model (Canadian Institute for Health Information, 2019). In this model, each medical service has a fee associated with it, and the physician is compensated by receiving clinical payments from the government based on the number and types of services they provide (Canadian Institute for Health Information, 2019).

In this model, there are large differences in pay between physician types, with family medicine receiving the lowest incomes from clinical payouts (Canadian Institute for Health Information, 2019). In 2019, the average clinical payment made to family physicians across the country was \$280,000, whereas the average for medical specialties was \$360,000, and \$490,000 for surgical specialists. The highest paid specialty was ophthalmology, with an average clinical payment of \$791,000, over \$500,000 more than a general practitioner (Canadian Institute for Health Information, 2019). Although not explicitly discussed by the participants, general

practitioners also have higher overhead costs than other specialities, with the average family doctor in 2017 spending 27.43% of their income to run their practice (Canadian Medical Association, 2017). Recently, opinion articles are surfacing with titles such as, *Family Doctors are Suffocating in Overhead Costs*, that assert that family physicians are experiencing a disproportionate effect of inflation (Stewart, 2022).

Some physicians thus discussed the issues of engaging in unpaid work being more burdensome for specific specialities. One physician stated, “income may be a factor, depending on the type of medicine you are doing.” Another participant echoed this:

[Activism is] unpaid work, right? That's the other thing. That's what you always have to balance out because the fee-for-service system is what most physicians work within. You have to still be able to keep your lights on, and pay your debts, and all that in addition to the unpaid work that you're doing.

It has been commented on in the literature that there are ethical implications of the FFS model, in which it encourages physicians to increase the quantity of patients seen, rather than focusing on the quality of care provided (Mitchell, 2017). This sentiment was endorsed by participants in this study, who also felt that this model actively discourages activism work. For example, one participant stated:

We are renumeralated, we are celebrated, we are paid basically by seeing patients, diagnosing patients, treating patients. That is the pay model. That is the expectation. That is the benchmark of what we're meant to be doing with our time. There is no fee code for calling your MLA [Member of the Legislative Assembly] to talk about why transgender children should be able to be addressed with their pronouns in school.

Participants felt that the FFS model sends implicit messages about what is valued, and what is valued is throughput of patients. They felt that this model discourages activities such as activism that do not increase the efficiency of direct patient care. Since physicians are not compensated for activism efforts, such as the rights of transgendered persons, as in the example given by the participant above, the government indirectly tells physicians what their responsibilities are.

Two of the physicians disclosed that they were in salaried positions. They both felt that this pay structure allowed them more space to engage in activism. One of these salaried physicians stated this, while sympathizing that family doctors in particular likely struggle to engage in activism work:

I'm a salary physician, so I don't get paid by the number of people I see in the run of the day. So, if I need to write a letter on a patient's behalf... it's not going to take away X number of dollars for the extra person I could have seen in that time. So, I think for family doctors in particular, it can be very challenging for them to find the time to do this type of work because it's not that it's not important to them, it's just that their structure of their work probably doesn't allow for it in the same way that mine does.

One participant shared that they believed that practitioners in family medicine, public health, psychiatry, and pediatrics tend to undertake more activism work relative to their colleagues in other disciplines. This participant felt that these faculties are regarded with the least respect and prestige, which they feel is further evidence that activism is not valued.

All doctors have privilege but not all doctors have all privilege of all the sorts. And so, if you think about who ends up doing a great deal of the activism work, it tends to be psychiatrists and family doctors. Lots of family doctors. Lots of public health doctors. You will note that those in the schema of how privilege and prestige and incomes are distributed among physicians, that those—paediatrics as well—tend to be the least prestigious, the least remunerated specialties.

This participant's insight is corroborated by the relative average clinical payouts of various medical specialties. Although public health physicians were not reported on, family physicians, pediatricians, and psychiatrists are within the four physician types who receive the lowest clinical payouts (Canadian Institute of Health Information, 2019).

Participants stated that activism was not done for monetary reward, and they acknowledged that physicians are generally paid very well, with one physician discussing that physicians often can afford vacation homes. "Normal people don't have cottages. That's not normal." However, participants also acknowledged that by the lowest paid specialties engaging in the most activism work, it sends the message that the work is not valued. They additionally acknowledged that there is an unfair burden for these specialties being the ones who take on the unpaid work. As one participant stated:

You get into inequities around who is caring about these issues, who is involved with them, and then who is then losing income while others who are not as involved are not giving that up.

Finally, with activism efforts not being valued, and thus done outside of business hours, these unpaid activism efforts have an additional barrier of time. Every participant mentioned time as a barrier to activism. Many participants discussed how the current healthcare system is “really strapped for resources” and therefore it was hard to take time away from seeing individual patients. As one participant stated, “how do you find time to do [activism], right?... you do it off the corner of your desk, or you do it on the weekends, or the evenings.” Although these participants believed in their activism efforts, they did acknowledge the toll it takes when the system creates an environment that mandates activism to be done outside of the office for many physicians. As one participant stated:

I'm doing this advocacy, activism, whatever, off the side of my desk. In my downtime. Which is also the time that I'm supposed to be being a [parent] and, you know, a partner and a human, and I don't know—maybe having some fun?

Another participant echoed this, speaking about demands inside and outside of the practice of medicine that make finding time for activism difficult.

We have jobs, we have families, we have lives and communities we have, you know—I'm a hockey player, I've got games to play. I've got other things that I want to do. My mom passed away a month ago, so I have to go deal with the fallout of that. And I have an easy life compared to many people... I come from a fairly stable background so I'm very lucky and even then, finding the time to do this work is not easy.

This participant went on to say they felt the activism work is important, in that it needs to be done. But it is not a reasonable expectation to place activism within the professional duties of the job, because many simply do not have the time, especially in a system that asks so much of physicians already.

So adding [activism] to somebody's job who's just trying to stay afloat, and trying to keep their practice going, and trying to look after all the patients—the millions of patients that keep asking for help all the time, and then trying to also help out at the hospital and trying to also, you know, this and and and and and, and then being sick with Covid, and their kids having illness at home or whatever. Like it's another piece of the puzzle that needs to be done. But it's so hard because we're already so stretched so thin as it is.

In summary, physicians felt conflicted over whether activism can be a professional responsibility within the health advocate role. Participants unanimously agreed that general

advocacy as agency for individual patients is important, and activism to improve the system and lives of patients should be done but feel that this activism cannot be a reasonable expectation of every physician. Those who only see activism as the loud activities feel it cannot be an expectation because not everyone has the personality that allows for engagement in this type of work. However, even if one were to consider quiet activism as well, other barriers still exist. Since activism is not valued by the government and society, it is thus not compensated and therefore, there is no allotted time to engage in it. Since activism must then take place outside of work hours, those who want to engage in activism must sacrifice other responsibilities outside of their profession, such as time with their families and non-medical pursuits. I contend that it is unreasonable for a profession to demand members of its workforce to volunteer their time to achieve the expected roles of the job. I interpreted these discussions with participants to mean that if activism is to be a mandated professional responsibility, not only would the definition of activism require expansion to include quiet activities, but the system would also have to be adjusted to support these pursuits.

Subtheme 2: The obligation of medicine extends beyond the tradition role of the physician, as taught by role models and mentors

Despite the barriers described in the first sub-theme, physicians in this study described how they are still actively involved in and promote activism efforts within the profession. Overall, this sub-theme addresses why these physicians felt the drive to engage in these efforts. This sub-theme starts by discussing how physicians felt that the traditional view of medicine, in which the physician treats only the ailments of the patient in front of them, is outdated. Participants saw this traditional view as inadequate because they felt treatment must expand beyond the clinical encounter to truly meet the needs of patients. They felt they must also treat the forces that affect the environment their patients live in. The participants in this study not only saw this as a duty, but as also a moral obligation. Finally, how these views came to be are discussed, which was mainly through the influence of role models and mentors. Role models and mentors inspired their activism work by demonstrating that change was possible and taught them the necessary skills for activism. They also discuss the importance of mentorship that continues in their practice.

The traditional view of medicine has always been orientated towards treating the ailments of the individual patient. As the philosopher Jacob Needleman writes, there was a time when,

“there was no question about their responsibility [as a physician]. The well-being of the individual patient was the alpha and omega of their work” (2014, para. 6). Although few would deny that the social determinants of health play a large role in health outcomes, it remains unclear in the literature what role, if any, and to what capacity, physicians should contribute to addressing them. As discussed in the literature review, some physicians, such as Huddle (2013) and Goldfarb (2022), feel that physicians have no role to play in redressing social inequities. Thus, one could infer, that physicians such as Huddle and Goldfarb ascribe to more traditional views of medicine in that they feel that the responsibilities and obligations of physicians do not extend beyond the clinical encounter. Participants in this study disagreed, viewing this traditional role of medicine as outdated and narrow. The following participant articulates this, stating that the view of treating only individual patients is obsolete:

If you asked [other physicians] who don't have a similar lens to me, they might say no. They might say our job is to work with individuals and pay attention to their very basic physical needs. I would say that that's more of an, in quotes, “old school” approach to medicine.

Another participant perfectly illustrated why the traditional view of medicine is no longer adequate. They describe how the use of only classic medical treatments is failing a patient who is regularly admitted to the emergency room where the participant works:

We see a guy regularly with diabetic ketoacidosis⁹—a significant complication of diabetes. He's in the emergency room all the time and I cannot look after this guy. I can deal with his diabetes every time he comes in. We fix that for that day. He goes home, and he's homeless, and he uses drugs, and he has no social supports, and he's not educated, and there's very little out there to help him in the community. My job in the emergency room is useless with this guy. I mean, he's going to die. Not because I can't look after his diabetes, but because he can't look after his diabetes because of his social circumstances.

This patient demonstrates how social circumstances profoundly impact health outcomes. In this case, this patient is an example of why those with diabetes, who live in socioeconomic

⁹ Diabetes mellitus is a condition in which the body is unable to regulate blood sugar levels, also known as glucose. Diabetic ketoacidosis is a complication from this condition, that if left untreated, can lead to acute kidney failure, coma, and eventually death (Jones, 2021).

disadvantage, have higher rates of hospital admissions and readmissions for diabetic ketoacidosis¹⁰ (Everett & Mathioudakis, 2019). If one ascribes to the traditional view of medicine, the duty of the doctor would end with reversing the ketoacidosis in the emergency room. However, this participant articulates why this view that the doctor's duty ends at the clinical encounter is unacceptable. Without activism efforts to improve the environment where patients live, this patient, and others like them, will suffer an untimely death. The physicians in this study feel that these adverse health outcomes from only practicing within the traditional medical roles of doctors are simply an unacceptable standard.

Another participant explained how the duty of physicians needs to be extended to include activism efforts. This participant discussed that the classic phrase, "do no harm," is an insufficient standard for practicing medicine. Although I want to note that it is erroneously believed that "do no harm" is found in the Hippocratic Oath,¹¹ it is still seen as one of the fundamental and traditional roles of physicians (Smith, 2005). In modern medical ethics that have been adopted by Western medicine, by Beauchamp and Childress (2009), the principle of not causing harm is known as nonmaleficence.¹² The participant stated:

The whole roots of medicine, if you want to think about it as of healing people, is the Hippocratic Oath that we take when we become doctors, and that is very much centered on no harm. There's doing no harm, but then there's also taking that a step further and

¹⁰Although some costs associated with the management of diabetes are covered through public healthcare in Canada, others are often not. For example, alcohol swabs, syringes, and glucometers are some of the out-of-pocket costs associated with diabetes management. These costs are part of the reason why some patients are unable to comply with self-monitoring and treatment recommendations (Diabetes Canada, 2023).

¹¹ It is a common misconception that taking the Hippocratic Oath is a requirement of graduating medical students (Gamble et al., 2019). Oath taking is not mandatory in Canadian or American medical schools (Scheinman et al., 2018). It is also erroneously believed that the origin of the famous Latin phrase *Primum Non Nocere* (above all, do no harm) was from the Hippocratic Oath (Smith, 2005). Not only is it not from the Hippocratic Oath, but it was also not within any of the Hippocratic writings, which were written in Greek. It is unknown where this phrase originated, however, it has persevered as a tenant of medical ethics (Smith, 2005). If oaths are taken in modern medical education, they are often taken at commencement or written by the graduating class (Gamble et al., 2019). Sometimes other oaths are taken, such as the Declaration of Geneva, which was developed following World War II. However, the original text of the Hippocratic Oath is never used in modern medical schools. The original text of the Hippocratic Oath is thought to have been written around 400 BCE by a group of physicians who followed Hippocrates' teachings, not by Hippocrates himself. The true author of the original text is unknown. The original text, which swears before the ancient Greek Gods, states that the physician shall not "administer poison to anyone" nor "counsel any man to do so." It also states that the physician shall not "give no sort of medicine to any pregnant woman, with a view to destroy the child." These statements are inconsistent with medical assisted suicide and abortion in modern care (Scheinman et al., 2018). In schools that claim to use the Hippocratic Oath it is the revised version, sometimes known as the Lasagna Oath. This revised oath was rewritten by Dr. Louis Lasagna, the Academic Dean of the School of Medicine at Tufts University in 1964, to be more consistent with modern values in medical practice (Gamble et al., 2019).

¹² The others ethical principles are: respect for autonomy, beneficence, and justice (Beauchamp, 2010; Fisher, 2013).

recognizing the responsibility to reduce harm. And there's a lot of harm that is being done to people by way of marginalization, oppression, poverty, policies. There's so many things and ways that as a society we're harming people. And I think a part of a role of a physician is to work to reduce those harms and therefore, I think we have every role then to advocate and to participate in activism.

In saying that physicians need to not just avoid harm, but also prevent harm, they are stating that the modern principle of nonmaleficence is not enough. If the duty of the physician is to treat and cure illness, this participant felt that societal wrongs that cause and/or worsen illness must also be treated. Another participant echoed this by stating, “if we aren’t doing the activism and advocacy, as well [as clinical duties], then we aren’t completing the full circle of our jobs.” Thus, this participant also felt the call to activism to redress social inequalities and improve the delivery of care.

Many of the participants discussed that addressing social issues through activism was not only to fulfill their duty as physicians. They also felt this should be a moral calling of all people. For example, one participant discussed how they believe that looking after fellow human beings is a responsibility of all, not just physicians. They stated:

I think when we see that there are things happening that are wrong or that need to be improved and deficits or gaps in social justice, that as human beings we have an obligation to try to look after each other.

This participant felt that all people have a moral obligation to look after others in whatever ways are available to them. Since physicians have a special skill set and have a voice that carries weight, this participant felt they are morally obligated to use it. However, they admit to thinking that these beliefs might be “idealistic.” When another participant was asked why they engaged in activism, they also believed we have a moral calling as human beings to try to make the world a better place. Since this calling was so obvious to them, there was no reason to waste time investigating why they became engaged in activism in the first place. They stated:

I've never really interrogated [why I became involved in activism], I'll be honest. I've never really interrogated it, and I guess it feels a bit navel-gazey to kind of spend a bunch of time thinking about well, why do I care about the underprivileged? It feels very, um, who cares? I don't have a real problem. They do. I'm not a particularly “prayer-prayer” kind of person, but if the point of being here is to make it better, then like, let's just do that.

While these physicians were guided by a moral underpinning to engage in activism work, another participant acknowledged that it is likely other members of the profession may not necessarily feel the same way. They stated:

It's more my personal moral kind of make up, I guess... But I don't know that everybody has that same moral makeup. Everyone's a little bit different in terms of where they stand on that moral spectrum.

Based on commonalities I saw between participants, I interpreted this moral obligation to treat more than the patient as developing due to the influence of role models and mentors, who instilled this as a social and/or professional norm. Role models demonstrated the importance of addressing injustices and mentors provided the support, knowledge, and skills for activism. These role models and mentors came at different stages of life. For some participants there were prominent role models and mentors present in childhood, while others came at various stages through their education.

Three of the participants specifically mentioned their parents as being influential in becoming involved in activism. One participant spoke of their mother who was a high school teacher who modeled the importance of going beyond the call of duty.

I remember being in the car with her when she was going to pick up teenagers who were in a dicey situation. They called her because they couldn't call their parents. So, I think I come from a family who was willing to swerve out of their own lane to help people.

In this situation, the participant's mother acted, perhaps unknowingly, as a role model and mentor. Some might feel that picking up a student would be a supererogatory role of a teacher. However, this participant's mother felt an obligation to help her students beyond the classroom. By bringing her child with her to pick up her students, it instilled the same obligation within her child who would then become a physician who would help patients beyond the clinic or hospital.

A different participant laughed while telling a charming story of their first activism experience in grade school. In this story, this participant's father acted as a role model and mentor by not only encouraging their child's activism, but also by teaching them concrete skills they could use to achieve the change they wanted.

I remember being 11 [years old] and being unhappy with the toilet paper in the bathroom. It was these one-ply squares of toilet paper...And I was like, "why can't we just get rolls of toilet paper?" And the school board said "no." And so, dad is a teacher, and used to really

push me to think about, what was I going to do? How was I going to advocate for things that I believed in? And so, he's like, "well, have you heard of a petition before? You could do a petition." And I remember in grade six doing this petition to change the toilet paper in the bathrooms. And I got everybody in the school to sign it and they had to change the toilet paper.

By introducing his child to petitions, he validated and instilled the norm that as people, we have an obligation to stand up and speak up for the topics we believe in.

Those who had a natural interest in activism, such as the participant who started the toilet paper petition, purposely looked for activism opportunities during their post-secondary education. For example, this participant went on to say:

I think that I sought out opportunities to practice activism at an early age and I'm not talking about being 11 [years old] with a toilet paper petition. But like I did my [specific undergraduate] degree because I wanted to understand how the system worked and how does change happen?

Those who purposefully looked for activism opportunities found the mentors they needed to teach them the skills they wanted to learn. However, for most participants, finding mentors and role models occurred by happenstance. For example, one participant discussed how their thesis supervisor in their undergraduate degree before medical school was a large influence on recognizing the importance of social justice activism.

In undergrad my thesis supervisor was a psychiatrist who was also head of an [activist] organization. And so, she was like my window into [realizing that] I have a responsibility to look at global health and I can do my bit to make the world a better place. So, I learned from her quite a bit.

Another participant described the attending on her family medicine rotation as being a role model that inspired their later activism work. This attending physician made house calls and this participant went with them. This participant was not necessarily describing house calls as activism. But the fact that this attending physician felt the need to leave the clinic to treat some of his patients in their homes inspired this participant to do more for their patients, which eventually escalated to activism. When asked if there were educational experiences that were particularly helpful in preparing them for activism, they responded with this story:

Well, what comes to mind is just working with people that didn't follow what we were being told is the traditional way of taking care of patients... When I did my family medicine rotation, on the way back from his clinic, we did three house calls and had the cup of tea with the missus. That was the beginning stages. I realized that we can be out of our routine and out of our comfort zone to try to meet people where they are. So, there's experiences like that that you're like, "oh." It just sort of opens the window to like, "oh, house calls. That's still a thing? Okay, well I can be uncomfortable." And then I remember the first time I did a house call, and it was just so eye opening. Just kind of solidified that that is how you can reach a lot of people who don't get serviced.

For this participant, this was the first time they had thought about engaging in advocacy. They explained that exposure to mentors such as this, caused them to become an activist “organically” over time. Other participants, who were also not influenced towards activism from childhood, described similar experiences. Since they had not been specifically looking to become involved in activism, some expressed surprise that they are doing this work today, with one physician stating: “I never thought that this would have happened,” referring to them being an activist.

The experiences of these participants, in role models and mentors being important in initiating activism engagement, is seen in other literature. Recall the study I previously discussed by Krueger et al. (2022) that found racial identity and racial stress were predictors of activism involvement. Although these factors played a role, the authors found that the single most important predictor of activism involvement among Black undergraduate students was subjective norms of social justice. Researchers in this study used the validated Social Justice Scale that assessed the test-taker’s attitudes towards social justice based on 22 items. This scale is made up of four subscales, one of which is social justice subjective norms,¹³ which are the beliefs and attitudes towards social justice that are instilled through the influence of others. Of all the factors evaluated in this study, including the strength of racial identity and racial stress, the influence of others was the most important, as social justice norms were the most positively correlated with activism efforts (Krueger et al., 2022).

This study by Krueger et al. (2022) and the experiences of the participants here, directly oppose the views of Huddle (2013), that I discussed in the literature review. Recall, Huddle

¹³ The other three subscales are attitudes towards social justice, social justice perceived behavioural control, and social justice behaviour intentions (Krueger et al., 2022).

maintains that only those who are interested in advocacy and activism prior to medical school will pursue opportunities to engage in more advocacy. Based on this, he believes that incorporating social justice advocacy into the curriculum is futile, as this will not change the perspectives of students (Huddle, 2013). While he appears to be correct in saying that those who are previously interested will pursue activism engagement, I argue that he is incorrect in saying that curriculum that encourages social justice activism is ineffective. Based on the experiences of the participants in this study, physicians who are not necessarily interested in activism prior to medical school can become interested and involved when exposed to those who model this behaviour. I therefore assert that intentional exposure to mentors who are activists that can instill activism as a norm within the culture of medicine will increase the number of new physicians who engage in activism.

Since most physicians were not heavily involved in training new physicians, many participants were hesitant to comment on how to best train the skills for activism. However, those who were involved in training agreed with this. For example, one participant stated:

The majority of our learning in all of our medical training is mentorship. Learning by doing, seeing, interacting under the supervision of your physician teacher. So really, I think that's pretty much one of the main ways medical students and learners can learn about activism. Although those who were less involved in training new physicians were tentative to pointedly state this, it was made clear to me that role models and mentors are the best way of training future activists. I come to this conclusion because this was the sole commonality across all participants when they were asked about what influenced them to become involved in activism and/or what was helpful in preparing them to become activists.

Mentorship did not end once physicians became attendings. Participants discussed the ongoing importance of mentorship in their current roles, as both learners and teachers. One of the major barriers to activism work for many of the participants was being one of the few physicians who were doing the work. As one participant honestly described:

The burden of care [of specific activism activities] is on a small number of providers of us who are doing it. And it's hard to walk away from because it's really important. And I don't want to walk away from it, of course. But there's a burden that comes with being either the only or one of the few doing a thing.

This highlights one of the many reasons why participants stated that more physician-activists are needed within the profession. However, it is also part of the reason why many of these physicians

acted as mentors to other physicians, in that, they wanted to support and be supported by others doing similar work. As one participant said, “that’s why it’s important, I think, to have support and have mentorship so that people who have potential to be advocates can feel supported in taking on those things.” Another participant discussed how their mentorship provided support to others who are doing similar work in other locations:

We live in a province where there’s a lot of geographical isolation. We trained a physician who went to work in the western part of the province. We come together on a monthly call so that she’s still supported. And even though she’s out there alone she’s kind of piggy backing off a lot of the stuff that we have underway to advocate for that to happen in her own area. There’s power in numbers.

Physicians spoke extensively of the importance of encouraging other activists, since, as was discussed in the previous sub-theme, support is lacking from government, society, and the medical institution itself. However, support was not the only benefit of continuing with mentorship. Another benefit that was noted is that being a mentor for others helped combat burn out. As one participant stated:

Activism can be tiring work and sometimes what keeps us going is seeing the energy of the people who come after us. One of the greatest joys of being engaged in activism is having people learning from us and sort of saying, you know, “I’m very passionate about this too, how do I do anything about this?” And like coaching people who come after us, whether it be younger staff or learners, is really where we benefit. We get a renewed surge of energy and we’re able to transfer some of those skills...it is sort of nice to be able to pass this along.

Thus, role models and mentors not only inspired physicians to initially become engaged in activism but it also inspired them to keep going. It was discussed in the literature review that the feeling of burnout and seeing personal advocacy efforts fail can lead to physicians discontinuing their engagement in advocacy (Fried et al., 2019; Verma, et al., 2005). This quote, and other participant responses, indicated that mentoring new learners and continuing to be motivated, encouraged, and supported by their colleagues’ activism, can help combat this barrier.

In summary, Although participants felt that activism could not currently be a professional expectation of every individual physician, they felt this was an ideal to strive to. Despite barriers, these participants felt compelled to engage in activism, as this was the only way they could fulfil

their duty to their patients. By not addressing the issues that exist in the environments in which their patients live, they felt they could not comprehensively and thoroughly address their illnesses. Physicians came to this understanding and felt a moral obligation to do this work from mentors and role models who instilled these norms. The profound effect of mentorship has resulted in these physicians continuing to be connected with their mentors for support and has inspired many to be mentors for the future generation of physicians.

Strengths & Limitations

One of the main strengths of this research is that it begins to fill a gap in the literature. As stated in the literature review, very few studies have examined the perspectives of physician's who identify themselves as advocates, and those studies that have, have mostly only examined why physicians became interested in being an advocate (Law et al., 2016; Mu et al., 2011). Furthermore, to my knowledge, no studies have looked at the perspectives of physician-activists specifically. As the next section will demonstrate, there are important implications at policy and educational levels that are dependent on this gap in the literature being filled.

Another strength of this research was that all efforts were made to design a rigorous study, based both on classic texts, such as Guba (1981), and more modern literature, such as Thorne (2016). Some examples of improving rigour included providing thorough explanations for methodological and analytic decisions, demonstrating transparency with a personal reflexivity section, practicing reflexivity throughout the investigation through memoing and journalling, using a demographic survey to provide a rich description of the participants, conducting all transcription and coding myself, and the use of peer debriefing when interpreting the results.

The final strength I want to highlight is the number of physicians interviewed. Thorne (2016) feels that for smaller ID studies, arbitrary sample sizes can be set, as long as the researcher acknowledges that further investigation will always be necessary. For this study, I had set the sample size at 10 participants based on previous research on adequate sample sizes for interviews (Guest et al., 2006). Albeit, this previous research was inconsistent with ID, in that the goal of was to determine when saturation was achieved. As discussed in the methods section, Thorne (2016) rejects using the term saturation to justify the end of data collection. As a nurse, Thorne approaches each patient with the knowledge that they could experience a phenomenon in a novel way, and therefore she feels that claiming confidence that no new variations could appear with further

research is “antithetical to the epistemological foundations of practice knowledge” and thus, is antithetical to ID (p. 107). Therefore, ID maintains that data collection should continue until the researcher deems their research question to have been adequately answered. Although I would not be so bold as to state that I encountered all variations in ideas of physician-activists within the Atlantic provinces of Canada, I can confidently say that by the sixth interview, very few new ideas emerged. I thus contend that enough physicians were interviewed to adequately answer my research questions for the demographic region that my study targeted. However, it needs to be noted that the culture of the Atlantic provinces is unique from the rest of Canada. Future research should investigate the perspectives of other physician-activists in other regions of the country and should seek the perspectives of physician-activists from more diverse backgrounds.

Although I assert that enough participants were obtained for the objectives of this study, other aspects of recruitment remained a limitation. As discussed in the first theme, some of the physicians in this study did not self-identify as an activist because they connoted activism activities as including only those that were loud and public facing. Although some physicians, that I would call quiet activists, were recruited for this study through individual scouting efforts, it is likely that others, who did not identify with the activist title, that saw advertisements for this study did not reach out to be interviewed. As I discussed above, participants in this study underscored the importance of quiet activism efforts and as I will discuss below, these quiet activities being called activism have important implications for the profession of medicine. A more robust understanding of activism in the profession will require both the perspectives of loud and quiet activists and thus, future research should target those physicians who engage more heavily or exclusively in quiet activism.

The second limitation regarding recruitment was time. As was also discussed, much of the activism work that physicians engage in must occur outside of office hours. Physicians, especially those who engage in unpaid activism efforts, have limited spare time due to the obligations they feel towards activism, and other competing demands, including professional duties, and other responsibilities and pursuits outside of medicine. This was evident by the struggle participants had finding a time to speak with me. Some physicians I contacted stated that although they were interested in the research, they unfortunately did not have time available to participate. Others who did participate were often only available during other activities, such as a long morning commute, or only became available due to unexpected changes in schedule, such as a spontaneously

postponed patient procedure. As a result, it is likely that physician-activists who would have met the inclusion criteria for this research, simply did not have time to contribute their voices. Additionally, the barrier of time made follow-up interviews simply unfeasible. Secondary interviews have benefits, such as being able to ask clarifying questions from the first interview, time to probe deeper into ideas invoked from the previous session, and allowing time to build rapport which can increase participant comfortability leading to the divulgence of more sensitive information (Knox & Bukard, 2014).

Conclusions & Implications

This study reported on the perspectives of 11 physicians within the Atlantic provinces of Canada who were involved in activism efforts within the profession of medicine. These insights were obtained using the methodology of ID, which allows the researcher to design a study using justified methods to best answer their research question (Thorne, 2016). I therefore used semi-structured interviews and demographic surveys as my method to glean insight into the lived experiences, attitudes, and beliefs physician-activists had towards their understanding of activism, the responsibility of the profession of medicine to activism, and how activism skills should be taught, if at all, during medical education. Two major themes emerged that framed the answers to this inquiry. I briefly summarized these here. Since ID also places value in its ability to take results obtained through research and apply the findings for practical use (Thorne, 2016), this section concludes with what I feel are the most important implications of this research to the profession of medicine.

The first organizing theme was “*Activism isn’t always about the glory,*” which summarized how physician-activists understood activism. This group of physicians saw activism not only as the activities that made change, but also initially defined it as those activities that are overt and public facing, where the activist and the act are highly visible. I denoted these activities as “loud activism,” based on the wording used by participants. Loud activism included activities such as involvement in protests, speaking at campaigns, lobbying to government, and being interviewed by the media. However, when asked to describe the types of activism activities they engaged in, all participants also included and described “quiet” activities. Participants usually referred to these activities that occurred behind-the-scenes and outside of the public eye, as advocacy. However,

since these activities contributed to systematic change and because participants included them within their examples of activism, I referred to these activities as “quiet activism.” Quiet activism included activities such as research, removing barriers for individuals from equity-seeking groups to speak publicly at various events, and background support for campaigns, such as phone banking and supplying food for campaigners.

The second organizing theme, *Not an expectation, but an obligation for some*, was divided into two sub-themes, the first of which was, *Loud and undervalued activism cannot be an expected duty of the profession*. While physicians acknowledged the importance of activism, this sub-theme discussed the barriers physicians face that make activism an unrealistic expectation for all physicians to undertake. One of the major barriers was the view that activism is not valued by government or society. They felt this was evidenced by the fact that those physicians who engage in the most activism, such as family doctors, are viewed as the least prestigious within the medical specialty hierarchy. Furthermore, since most physicians are compensated using the fee-for-service model, and since there is no fee code for activism, those who engage in activism experience a disproportionate level of unpaid work. Participants acknowledged the monetary privilege that most physicians receive, but felt these factors contributed to the view that activism work is not valued. This also led to the other barrier of time. Since activism work had to be done during non-working hours for non-salaried physicians, activism work took away from other responsibilities and obligations, such as family, hobbies, and non-medical pursuits.

Other barriers were reported by the physician-activists; however, these were discussed by fewer participants and to a lesser extent. Many of the barriers discussed by participants, such as a lack of time, fear of punishment, isolating colleagues or patients by engaging in controversial issues, burnout, a lack of resources, and medical students coming from backgrounds of privilege were consistent with previous literature on the topic (Abrama et al., 2022; Bhate & Loh, 2015; Earnest et al., 2010; Fried et al., 2019; Griffiths et al., 2021; Liebe et al., 2022; Neumann et al., 2011; Stafford et al., 2010). Although my review of the literature on the barriers of advocacy and activism was not exhaustive, it appears that participants in this study felt that the lack of value assigned to activism by government was a more pressing concern than the previous literature implies. Another barrier that was not prominent in the previous literature but was commonly mentioned by participants was personality. When physicians defined activism to include only loud

activism activities, participants felt that there were only some temperaments that were emendable to activism.

The second sub-theme, *The obligation of medicine extends beyond the traditional role of the physician, as taught by role models and mentors*, described why these physicians felt the calling to be engaged in activism. Participants explained that as a physician, they felt a moral calling to do more than just treat the physical ailments of the patient in front of them. Participants provided stories that demonstrated why the social inequities that patients experience must be addressed if their illnesses were to be properly treated. Role models and mentors inspired participants to become involved in activism by either instilling the moral norm to help others or by demonstrating that change was possible despite barriers. This is consistent with some of the previous literature that also discusses the importance of role models and mentors for advocacy education (Earnest et al., 2010; Griffiths et al., 2021; Luft, 2017).

In summary, physicians in this study all viewed activism, which could be loud or quiet, as an obligation they must personally fulfill. They recognized that there are currently barriers that make it unfeasible to demand that all physicians must engage in activism. However, they personally felt the reasons that justified the need for activism were compelling enough to continue to engage in the efforts for positive change, despite any personal setbacks they face from these barriers. Overall, although activism can not be mandated now, physicians believed that it was an ideal that should be strived towards.

For the sake of the following argument, I ask the reader to momentarily set aside these barriers. In this hypothetical reality, where activism is valued by government and there is protected time for physicians to engage in activism, I contend that there are two necessary steps that need to be taken, both of which include the UBC-HAF. Recall the definitions outlined in this framework, which have been extensively discussed in this thesis. This framework defines advocacy as an umbrella term that encompasses both agency and activism activities, where agency activities are those in which the physician helps patients navigate pre-existing healthcare and community systems, and activism activities are those whose goal is to make systemic-level change within and outside the healthcare system (Hubinette et al., 2017).

Based on the views of the participants in this study, my first contention is that the language of the UBC-HAF that differentiates between advocacy, agency, and activism is a relevant and important distinction that needs to be implemented in policy documents, and most importantly,

into the CanMEDS framework. I provide an example of how the terms agency and activism can be incorporated into the current key-competencies of the health advocate role. I argue that this will better define what is expected of physicians and will result in improvements in medical school curriculum. My second contention, is that the definition of activism within the UBC-HAF, needs to more explicitly state that activism is inclusive to all activities that contribute to positive change, and thus is not dependant on scale or the degree to which the action occurs within the public domain. I argue that the broadening of this definition will make activism feel more inclusive to both learners and educators and these two changes will result in more physicians who identify as activists.

Previous literature has established that there is great confusion regarding what is expected of physicians under the CanMEDS health advocate role (Dobson et al., 2012; Earnest et al., 2010; Vance et al., 2019). As was discussed in the literature review, when the language of the UBC-HAF is used to frame the current CanMEDS key-competencies in the health advocate role, this document already clearly states that physicians are required to be activists. A simple change in these definitions to include the language of the UBC-HAF would clarify these roles, as demonstrated here:

1. Respond to an individual patient's health needs by *acting as an agent* with the patient within and beyond the clinical environment.
2. Respond to the needs of the communities and populations they serve by *engaging in activism* with them for system level change in a socially accountable manner.

In these slightly re-written competency definitions, by removing the ambiguous term of advocacy, the first definition now clearly articulates that physicians are expected to use their influence to help patients access services they need within the clinical environment and in the community. The re-written second key-competency clarifies that the other role of the physician is to engage in activities that affect change that benefit patients. This more explicitly outlines the two activities that are expected of physicians, under the umbrella term of being a health advocate.

These clarified key-competency definitions would remove the previous confusion that has plagued the profession. This change would thus require Canadian medical schools to reassess their curriculum that targets health advocacy to ensure students are prepared to meet these objectives. Currently, the health advocate meta-competency is cited as being the hardest of the CanMEDS competencies to teach and assess, with instructors feeling unprepared to take on this role because

of the confusion regarding what needs to be trained, and thus resulting in an inconsistent curriculum across the country (Canadian Federation of Medical Students' Government Affairs and Advocacy Committee, n.d.; LaDonna et al., 2020; LaDonna et al., 2023; Poulton & Rose, 2015). When the UBC-HAF language is applied to previous research on the current state of advocacy training, it appears agency is being taught more effectively than activism. For example, recall the study by Vance et al. (2019), who found that while 59% of residents felt confident advocating for the health and well-being of individual patients, only 13% felt confident in their ability to advocate for changes in health policy. One can thus surmise that medical trainees have received more adequate training for agency compared to activism. Future research will need to further assess whether agency is being adequately trained. However, this demonstrates the implication that clarified key-competency definitions would assist in the assessment of medical curriculums to find gaps and then target the areas that are lacking. Based on the results from Vance et al. (2019), it is likely that improvements will be needed in the areas that should be training the skills for activism.

The second action requires a shift in understanding of what types of activities fall under activism. It is imperative that physicians and learners adjust their view of activism to include the quiet activism that is consistent with the views of the physician-activists in this study, and the work of feminist scholars. Thus, those within healthcare need to be exposed to the broader definition of activism, in which all activities that contribute to positive change, regardless of scale or publicity, are seen as activism. The mode in which this shift in perspective can be accomplished needs to be investigated in future research. However, I maintain that this needs to be perpetuated at least within one or more of the CanMEDS materials, such as descriptions in its enabling competencies, within the Milestones Guide, or within the Teaching and Assessment Tools Guide. Inclusion within CanMEDS materials would implore medical schools to include it within their curriculums.

Currently, instructors of health advocacy are encouraged to use the aforementioned CanMEDS Teaching and Assessment Tools Guide, which includes methods of teaching and assessing the health advocate meta-competency (Takahshi et al., 2015). One of the authors of the UBC-HAF, Dr. Maria Hubinette, was a co-author of the Tool Guide, which was released prior to the publication of the UBC-HAF. This section of the Tool Guide thus uses the terms agency and activism. However, this document states that learners can feel overwhelmed with the idea of the health advocate role because they view incorporating "activism into regular, everyday practice [as] daunting" (p. 224). They thus imply that the more palatable and less intimidating concepts of

advocacy as agency should be focused on in education. This highlights why including the terms agency and activism within the key competencies is not enough. It is imperative that both learners and instructors adopt this more inclusive, and thus less intimidating view of activism so that the skills for activism are taught during medical education.

The adoption of this broader understanding of activism would make it significantly less daunting because it opens a wider breadth of possible ways physicians can be engaged as activists. It follows then that this view would allow for more ways activism could be integrated into training. For example, participants in this study observed that research is already heavily emphasised in medical school and residency curriculum; and as discussed, research can be a form of quiet activism when the research is a precursor to or has the goal of making positive change. Therefore, one way participants suggested that activism be incorporated into the curriculum is allowing and encouraging students to direct their research projects towards topics that require change. Thus, this more inclusive definition of activism can be creatively incorporated into the current curriculum, without facing the commonly cited barrier of their not being enough time to teach advocacy and activism during medical education (Goldfarb, 2022; Griffiths et al., 2021; Stafford et al., 2010). Furthermore, because this definition is more inclusive, it is likely that some practicing physicians would readily identify with the newly defined activist title. As discussed by Poulton and Rose (2015), one of the major barriers to teaching advocacy in general is a lack of role model physicians in practice. If more physicians identified as activists, they may feel more confident to act as mentors to the next generation of physician-activists and in doing so, would also perpetuate a norm within the culture of medicine that activism is expected, important, and valued.

I have argued that the terms agency and activism, taken from the UBC-HAF need to be incorporated, most importantly, into the CanMEDS framework. I have based this on the views of the participants in this study, who agree that ideally, all physicians should be engaging in activism to invoke improvements in patient outcomes and redress social injustices. I further argued that the term activism needs to be reimagined to include those activities that promote change, but that do not necessarily jump to mind when one thinks about activism. This is based on the responses of the participants, who clearly demonstrated that quiet activism is integral to improvements at all levels of society. Taken together, the implications of these changes would ultimately increase the number of physicians who engage in and identify as activists.

However, to conclude, let us recall the reality that we momentarily set aside, in which barriers exist that impede many physicians' ability to engage in activism. If activism is to be included within the expected duties of medical doctors, as physicians in this study agree is a goal the profession should be striving towards, a shift in values by government, society, and medical institutions is integral. In the current system, where activism is not valued, most physicians who feel compelled to engage in activism must do so outside of their designated work hours. It is simply not reasonable, in any profession, to demand that the members of its workforce volunteer their time to meet the minimum expectations of their job. Whether a shift in values is possible, and how it could be accomplished needs to be investigated in future research efforts. However, since the CanMEDS framework already implies that activism is a responsibility of the profession regardless of these barriers, the 2025 CanMEDS framework should clarify these key competencies using the UBC-HAF in the interests of reducing confusion around the role. Furthermore, CanMEDS materials should adopt the inclusive definition of activism presented by the participants in this study, as this would improve medical education and increase the number of physicians who are interested in activism. Until this is accomplished, as well as changes in the value placed on activism, the necessary burden of activism will continue to rest heavily on the shoulders of those few physicians who already understand activism's worth.

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Appendix 1: Recruitment Materials
Appendix 1a: Recruitment Poster

PARTICIPANTS NEEDED

LOOKING FOR PHYSICIAN ACTIVISTS

- Must be currently practicing in any specialty as a fellow or attending in the Maritime provinces
- Must self identify as being involved in activism advocacy (defined as those activities whose goal is systemic level change)

The purpose of this study is to investigate the perspectives of physicians who are involved in activism to clarify practice guidelines and to better teach and assess the CanMEDS health advocate role to medical trainees



YOUR PARTICIPATION INVOLVES:

1.0-1.5 hour interview on
Microsoft Teams

DOES THIS SOUND LIKE YOU?

Please email
Alexandra.Bromley@msvu.ca or
 call [REDACTED]



Appendix 1: Recruitment Materials

Appendix 1b: Recruitment Letter



Participant Recruitment Letter

Study title: *Activism: Does it fall within the roles and responsibilities of all physicians?*

Dear Physician-Advocate,

My name is Alexandra Bromley, and I am a master's student at Mount Saint Vincent University working under the supervision of Dr. Jennifer Brady, who is the director of the School of Nutrition and Dietetics at Acadia University. As part of my master's degree, I am conducting research on physicians' perspectives and attitudes towards their role as health advocates as outlined by the CanMEDS framework. I am currently recruiting participants for this study.

I am particularly interested in the perspectives of those physicians who engage in activism. Activism can take many different forms including, but not limited to, supporting or providing input on social justice issues on social media platforms, sitting on a community board, lobbying to elected officials, or engaging in protests. If you take part in activism activities, and this engagement is an important element of your professional identity, then you are likely an excellent candidate for this study!

If you decide to volunteer in this study, your participation will consist of a one-on-one semi-structured interview and a short demographic survey. This interview will take 60-90 minutes and will be conducted online using Microsoft Teams at a date and time that is convenient for you. With your permission, an audio-recording will be taken of the interview to ensure accurate transcription for analysis.

The results of this research will be used in the writing of my thesis, as well as for scholarly publication and presentations. This research will be added to a growing body of knowledge to inform medical education and to help clarify the health advocate role in future CanMEDS frameworks and other physician guidelines.

This study has been reviewed and has received ethics clearance from Mount Saint Vincent University and Acadia University's Research Ethics Boards.

If you are interested in participating or would like additional information about this study, please do not hesitate to contact me by email at Alexandra.Bromley@MSVU.ca or by phone at XXX-XXX-XXXX. You may also contact my supervisor by email at Jennifer.Brady@AcadiaU.ca or by phone at XXX-XXX-XXXX. Thank you for your interest in this project.

Yours sincerely,

Alexandra Bromley

Appendix 2: Data Collection Materials

Appendix 2a: Interview Schedule

Preamble

- I want you to know that I have not started the recording on Microsoft Teams and the external audio-recorder. I want to remind you that once the recording begins, you may ask for the recording to be turned off at any time. You may also refuse to answer any questions and we can end this interview at any time for any reason without any repercussions.
- Before we begin the interview, do you have any questions?
- May I have your consent to begin the interview and to start the recording?

Engagement in Activism

1. Tell me what activism in medicine means to you?
 - Possible probes:
 - a. How would you define activism in medicine?
 - b. What is the difference, if at all, between advocacy and activism?
2. Tell me about how you engage in activism as a physician?
 - Possible probes:
 - a. What activities and topics do you engage in?
 - b. From your experience, is the level and type of activism you engage in common to other physicians?
3. How did you come to be engaged in activism as a physician?
 - Possible probes:
 - a. What, if any, experiences or learning brought you to be involved in activism?
 - b. How was the education and training you received to become a physician important to becoming involved in activism in your profession?
 - c. How were other experiences outside of your education and training important to becoming involved in activism in your profession?
4. Thinking back to when you first engaged in activism as a physician, did you feel that your education and training prepared you to do so? Why or why not?
 - Possible probes:
 - a. Were there any specific educational experiences that were particularly helpful/unhelpful in preparing you?
 - b. Were there any specific educational experiences that you wish you received to better prepare you?

Perspective and Attitude Toward Physician's Roles as Activists

5. What roles, responsibilities, or obligations, if any, do physicians have to engage in activism?
 - Possible probes:

- a. Should all physicians have a role or responsibility to engage in activism? Are there any specialties or types of physicians who should/should not be expected to take on the role of an activist?
 - b. What issues do you think physicians have played an important role in as activists, if any at all?
 - c. Are there any activism topics or activities that are not appropriate for physicians to engage in?
6. What do you think about the education and training of new physicians with respect to the knowledge and skills related to activism?
 - Possible probes:
 - a. How, if at all, should knowledge and skills related to activism in medical practice be taught in medical education and training?
 - b. When and how should this education and training take place?
7. What supports, if any, do you believe are important to facilitating physician's engagement in activism?
 - Possible probes:
 - a. What supports already exist?
 - b. What supports do not currently exist would you like to see created to support physicians' engagement in activism?
 - c. What barriers, if any, exist to physicians engaging in activism?

Code of Ethics and Professionalism Relationship to Social Justice Activism

The Canadian Medical Association in the Code of Ethics and Professionalism (2018) states that there are seven commitments of the medical profession. The third of these is a commitment to justice. They define this commitment to justice as “[promoting] the well-being of communities and populations by striving to improve health outcomes and access to care, reduce health inequities and disparities in care, and promote social accountability.”

8. Can you tell me what this definition means to you?
 - Possible probes:
 - a. How is this commitment to justice as stated by the CMA related to your engagement in activism?
 - b. Do you feel that you were prepared with the knowledge, skills, and confidence to uphold this commitment to justice?
 - c. Do you believe this commitment is a reasonable request to make of all physicians?

Conclusion

9. Keeping in mind that this research is focused on the professional roles and responsibilities of physicians as activists, is there anything else that I have not asked you about that you would like to share?

Before we part, I want to remind you that you may withdraw your interview from this research study at anytime up until 30 days following today, which is the point where the data will have already been analyzed. You may withdraw for any reason without repercussions from the research team or the associated universities. To do so, or if you have any other questions or concerns, you can contact me directly, or my supervisor, Dr. Brady. If you have any concerns and do not want to speak with someone that is directly related to the research, you can contact the Research Ethics Board Coordinator at MSVU or the Chair of the Research Ethics Board at Acadia University. The contact information for all of these people can be found on the information sheet and consent form you have been provided with.

Appendix 2: Data Collection Materials

Appendix 2b: Data Form



Data Form for Physician Participants

Study title: *Activism: Does it fall within the roles and responsibilities of all physicians?*

Participant ID: To be filled out by researcher

Age: Click to add age

Racial/Ethnic Identity: Click to add racial/ethnic identity

Gender: ☐ Female ☐ Male ☐ Other. Specify (optional): Click to add gender (optional)

Medical specialty: Click to add specialty

Location of undergraduate medical training: Click to add school, city and country of undergraduate medical training

Year of medical school graduation: Click to add year of graduation

Location of residency training: Click to add school, city, and country of residency training

Location of fellowship training (if applicable): Click to add school, city, country of fellowship training

Location of current practice: Click to add city and province of current practice

Facility/Practice type of current practice (i.e., clinic, hospital, etc.): Click to add facility/practice type



Letter of Information for Participants

Study title: *Activism: Does it fall within the roles and responsibilities of all physicians?*

Investigators:

Ms. Alexandra Bromley, Principal Investigator, MSc Candidate

- Email: Alexandra.Bromley@MSVU.ca
- Phone: XXX-XXX-XXXX

Dr. Jennifer Brady, Supervisor

- Email: Jennifer.Brady@AcadiaU.ca
- Phone: XXX-XXX-XXXX

Introduction:

Physician's roles and responsibilities in activism are contested within the medical community. However, very few studies have explored the experiences and perceptions of physicians who engage in activism. This research study explores the experiences and attitudes of physicians who engage in activism. For this study, activism is defined as those activities whose goals are systemic level change. Findings from this study aim to help clarify the key competencies of the health advocate role for the 2025 and future CanMEDS frameworks and shed light on how medical trainees can be prepared to take on this role.

Procedure:

Should you agree to participate in this study, a semi-structured interview over Microsoft Teams will be scheduled with Alexandra Bromley at a date and time that is convenient for you. The interview is expected to take 60-90 minutes where you will be asked about your understandings of, attitudes towards, and engagement in activism within the medical profession. The interview will be audio- and video-recorded using Microsoft Teams, as well as a handheld audio recorder. A meeting link will be sent via email to you 24 hours prior to the scheduled interview time. The audio-recording of the interview will be transcribed verbatim by only Alexandra Bromley. No one besides Alexandra Bromley will be transcribing your interview. The transcripts from all participants will be thematically analyzed. Following the interview, a short data form will be emailed to you that you will be asked to fill out. Questions on this form ask about demographic and medical training. This information from the data form will be used to provide general context about the participants.

Confidentiality & Protecting Your Personal Information

All information gathered during this research study will be held in the strictest confidence and stored on Alexandra Bromley's secure password protected personal computer and Microsoft OneDrive account. Any identifying information collected from you during the study will only be viewed by Alexandra Bromley and her thesis supervisor, Jennifer Brady. Direct quotes from your interview transcript will be used in dissemination materials (i.e. scholarly publications, summary reports, conference or seminar presentations, Alexandra Bromley's thesis) created to report on this research. However, you will be referred to with a pseudonym and identifying information (i.e. name, year and institution of graduation, former and current employers) will be removed from quotes used in dissemination materials.

During the interview an audio-visual recording will be taken on Microsoft Teams. This file will be converted to an audio-only file immediately following the interview. The original file containing visual information will be permanently deleted. Once the Microsoft Teams recording has been checked to ensure that it has been securely saved, the backup recording on the external audio-recorder will be permanently deleted. The audio-only file of your interview will be deleted following the completion of this study. The transcript of the interview and your data form will be stored

on Alexandra Bromley's MSVU OneDrive account for five years after completion of the study. After this time these documents will also be permanently deleted.

Participation, Withdrawal & Participant Rights:

Participation in this study is completely voluntary. You may skip any questions you do not wish to answer. You may withdraw your data from the study up to 30 days after your interview without any repercussions. You also have the right to have the recording equipment turned off at any time during the interview. If you do not want any visual recording taken of you, you have the right to turn off your camera on Microsoft Teams.

If you decide to withdraw from the study, all study data and information collected about you up until that point will be destroyed and permanently deleted and no additional information will be requested. If you decide following the interview that you would like to withdraw from the study, you can request to have your data deleted up until the time that the data is analyzed. Following data analysis, you will no longer have the option to withdraw from the study, as this will impact the integrity of the research.

You have the right to review and copy your personal information collected in this study. If you request a copy of your transcript, one will be sent to you by email. You have the right to request corrections to any information inaccurately recorded.

Potential Risks:

All data obtained from the study will be held in the strictest confidence. However, any data sent electronically or stored online may be accessed by domestic or foreign authorities if legally required. Your employer may also have legal access to any information that you send using employer-owned equipment.

Potential Benefits:

There are no direct benefits to participants related to participating in this research and no compensation is provided from this study. However, participants may expect some benefit of participating in a one-on-one interview that is associated with the focused time and attention to reflecting on their professional experiences as physicians who engage in activism. Participants may also experience benefit from having the opportunity to express their opinions which could potentially be used to improve medical education and clarify future editions of the CanMEDS framework.

Research Results:

The results of this study are intended to be published in scientific literature and may be presented at conferences or seminars. If you wish, a summary of the study results can be provided to you when they are ready. If you would like to receive this summary, please indicate this on the consent form and provide an email address where they can be sent.

Funding & Conflicts of Interest:

This study has received funding from the Social Sciences and Humanities Research Council in the form of the Canadian Graduate Scholarship and from Research Nova Scotia in the form of the Scotia Scholar Award. These organizations are not involved in the design of the study or the analysis of the data. There are no real, potential, or perceived conflicts of interest to declare on the part of the researchers, their institutions, or those funding the research.

Questions & Further Information:

If you have any questions about the scholarly or scientific aspects of the research, or you would like any other further information regarding the research project, please contact Ms. Alexandra Bromley or Dr. Jennifer Brady.

This research study has been approved and has received ethical clearance from both Mount Saint Vincent University and Acadia University. If you have questions or concerns about how this study is being conducted and wish to speak with someone who is not directly involved in the research, you may contact the Mount Saint Vincent University Research Ethics Coordinator, Brenda Gagné by email at Brenda.Gagne@MSVU.ca or by phone at (902) 457-6350 or the Chair of the Research Ethics Board at Acadia University, Dr. Stephen Maitzen by email at Stephen.Maitzen@AcadiaU.ca or by phone at (902) 585-1407.



Consent Form for Physician Participants

Study title: *Activism: Does it fall within the roles and responsibilities of all physicians?*

TO BE FILLED OUT BY PARTICIPANT:

I acknowledge that I have had time to review the Letter of Information and the Consent form, and I have had the opportunity to ask questions and they have been answered to my satisfaction. By signing this document, I _____ am acknowledging my agreement to the following:

- I understand that I am consenting to participate in an interview that will last approximately 60 to 90 minutes in length. The interview will take place at a date and time that is convenient for me, via Microsoft Teams. I understand that during the interview I will be asked about my understanding of, attitudes towards, and engagement in activism in medical practice. I am also consenting to filling out a short data form that will ask me about my demographic and medical training.
- I understand that the interviews will be audio and visual recorded on Microsoft teams and an additional audio recording will be taken with an external audio recorder for backup purposes. Since the video recording from Microsoft Teams is not needed for data analysis, the audio-visual file will be converted to an audio file only, immediately following the interview and the original file with the visual content will be permanently deleted. If I wish, I can turn my camera off on Microsoft Teams if I do not want any visual recording taken of me.
- I understand that the audio files will be transcribed verbatim by Alexandra Bromley. No one besides Alexandra Bromley will transcribe the interviews. The audio files will be permanently deleted following transcription and data analysis. I understand that the transcript and data form will be stored for 5 years following the completion of the study. These documents will be stored in the institutional OneDrive network. These documents will only be available to the research team.
- I understand that my participation in this interview is completely voluntary. I am aware that this means that I may decline to answer any question(s) and I may end my participation at any time without any repercussions. During the interview, I may request that the recording on Microsoft Teams and external audio recorder to be turned off. I may also withdraw my participation from the study at any time and can request to have all recordings, transcripts, and my data form collected up to that point removed from the research and destroyed up to 30 days following the interview.
- I understand that, despite my identity and personal information being known to the researchers, I will not be identified in any reports, papers, thesis, research articles, presentations, or any other communications about the research. I understand that direct quotes from my transcript may be used in these communications, however, no identifying information will be included. My identity will also be kept private from other participants in the study.
- If I would like a copy of the research findings one will be made available to me.
- I understand that the MSVU University Research Ethics Board (REB) and the Acadia REB has reviewed and approved this research study.
- If I have any concerns or complaints about my participation in this research and want to speak to someone other than the primary investigator (Alexandra Bromley), I may contact her supervisor, Dr. Jennifer Brady. If I want to contact someone who is not directly involved with the current study, I can contact the Research

Ethics Coordinator at Mount Saint Vincent University, Brenda Gagné at (902) 457-6350, Brenda.Gagne@msvu.ca or the Chair of the Research Ethics Board at Acadia University, Dr. Stephen Maitzen at (902) 585-1407, Stephen.Maitzen@AcadiaU.ca.

- I have read and understood the Information Sheet and the Consent Form describing the purpose of this research and what is being asked of me as a participant. I have also been provided with a copy of each if I want to reference it in the future.
- I understand that by signing this consent form, I have not waived my rights to legal recourse in the event of research-related harm.
- I consent to participate in the research project titled, *Activism: Does it fall within the roles and responsibilities of all physicians?*

Signature:

Date:

Would you like a summary of the results when they are available? ☐ Yes ☐ No

If you would like to receive a copy of the results when they are available, please provide an email address:

Email (optional):

TO BE FILLED OUT BY INTERVIEWER

Participant ID:

I have reviewed the Information Sheet, the corresponding Consent Form, and the nature of the consent process with the participant. I judge that they understand the risks of participating, that participation is entirely voluntary, and that they understand they may withdraw from the study at anytime without repercussions up until the point of data analysis.

Name: Alexandra Bromley

Signature:

Position: Primary Investigator

Date: