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Making a Case for Legal Health Advocacy: A Socio-legal Exploration of the Law as a Tool for Physician Health Advocacy

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1.0 Introduction

In January of 2023, Justice Valente for the Ontario Superior Court of Justice released his decision on the matter of the *Regional Municipality of Waterloo v. Persons Unknown and to be Ascertained, 2023*. The matter regarded a homeless encampment at 100 Victoria St. in Kitchener, a parking lot identified for an as-yet constructed transit hub (Regional Municipality of Waterloo v. Persons Unknown and to be Ascertained, 2023, par 19).

The court ultimately declined to declare that the homeless individuals living in the encampment were in breach of the regional bylaw (Regional Municipality of Waterloo v. Persons Unknown and to be Ascertained, 2023, par 157). The court decided that the bylaw violated s. 7 of the *Charter* in that it deprived the homeless occupants of the encampment of life, liberty and security of the person in a manner not in accordance with the principles of fundamental justice and not saved by s. 1 of the *Charter*. (Regional Municipality of Waterloo v. Persons Unknown and to be Ascertained, 2023, par 158).

The court heavily cited the evidence presented by Dr. Andrea Sereda, a London physician who works with marginalized communities, including the homeless, to elucidate some of the health risks associated with homelessness, the health benefits secondary to shelter found in encampments, and the commensurate risks of eviction from encampments (Regional Municipality of Waterloo v. Persons Unknown and to be Ascertained, 2023, par 54, 55 & 56).

Is Dr. Sereda's testimony an example of legal health advocacy? Where does health advocacy happen and by whom? In 2022 a group of front-line community workers engaged in a hunger strike at London’s City Hall to protest the City’s evictions of homeless encampments despite an unprecedented number of homeless deaths in the community. Is this advocacy? Or is it activism? Is there a difference? This paper will grapple with some of these questions and how they map onto relevant scholarship.

As social activism movements gain increased public attention, so too has interest by medical and legal professionals to engage in what is loosely defined as “health advocacy”. The term advocacy is routinely used within the fields of law, medicine, and social services but can have wildly different meanings depending on the epistemological standpoint and professional association of the user.

Health and mortality disparities secondary to structural factors such as social and economic policies, governance, and societal values and norms have been well established in the literature (CPHO, 2020). These structural forces manifest as differential access to housing, income, and employment (CPHO, 2020). This disparate access to material assets, privilege and power, results in health inequities, including the impact of Covid-19 (CPHO, 2020).

The Covid-19 pandemic made visible the gross disparities in health access and outcomes secondary to the social position of individuals and communities. During the long periods of pandemic restrictions and social isolation, the public’s gaze turned towards these unfair inequities as well as the systemic racism, colonialism, sexism, nationalism, agism and other forms of discrimination and bigotry that manifest itself as illness and death. Consequently, there has been growing public recognition of the social determinants of health, systemic barriers to equitable health access, and deleterious systemic discrimination.

2.0 Research Questions and Thesis

While the differential effects of the pandemic may have turned the public's gaze outward, many health professionals began looking inward at their social and moral responsibility to engage with these issues.

This paper will grapple with the question of whether physicians have a unique moral, ethical or professional responsibility to engage in health advocacy. If so, what are the sources of that obligation, and how is advocacy understood in this context? This paper will examine current literature on the topic of health advocacy and emergent themes therein. These questions will be addressed through a critical examination of the bio-medical, ethical, and legal literature. This paper will also consider how advocacy is situated within medical professional practice standards and whether these obligations sit it tension with scholarship on the topic.

Specifically, this paper will explore emergent themes in the literature including how advocacy is conceptualized, the challenges inherent in defining the term, and the consequent difficulty teaching health advocacy in medical education. This paper will examine how the value of advocacy is represented in the literature, what professional obligations are currently in place, and how these standards intersect with perceptions of professional duty. This paper will also touch on the question of whether physicians are uniquely positioned to engage in health advocacy and whether their influence and social capitol creates a contractual obligation to advance and champion for issues related to the social determinants of health. This paper will also elucidate some of the barriers to engaging in advocacy as identified in the literature. Finally, this paper will also acknowledge scholarship which sits in opposition to the physician's role as health advocate for reasons including scope, competency and political influence.

The second part of this paper will ask in what ways, and to what effect, have physicians used the law as a tool for health advocacy and is working in violation of the law a predeterminant of legal advocacy? Or does violating the law undermine the moral weight of the physician-advocate?

These questions will be addressed through examination of two legal case studies which demonstrate the health professional's engagement in legal advocacy. The identified case studies include R v. Morgentaler (cases where this writer would argue, a physician practiced in direct conflict with the law as a means to advocate for legal change) and Cambie Surgeries Corporation v. BC (a case arguing for privatization of public health care to address surgical wait-times). These case studies have been chosen as diverse representations of the ways in which physicians have engaged in legal health advocacy to advance systemic changes. They also establish a rich foundation on which to grapple with questions about the moral imperative to engage with action that may place the professional in conflict with the law.

2.1 Relevance

The terms health "advocacy", health "activism", and health "justice" are used interchangeably and without a clear consensus of their definitions or differences. Yet, how these concepts are defined and operationalized has implications for how current and future professionals can engage in the practice. Health advocacy, broadly understood, has been most vigorously researched within the fields of public health, medicine, and ethics while legal scholarship has focused primarily on medical-legal collaboration in education and clinical intervention.

Heath care systems are organized by their underlying policies, legislation, professional codes, and funding obligations. Health care professionals who are compelled to engage in health advocacy remain beholden to those very same legal objects. In order to effectively engage in attempts to create more equitable and just systems of health access and provision, professionals must have a clear understanding of what “health advocacy” means, the legal landscape in which it is taking place and how the law itself can be used as a tool to effect health justice.

2.2 Rationale

The rationale for this paper has been conceived in three parts.

Theoretical:

- Explore the Intersection of ethical, professional and legal obligations/opportunities.
- Imbed in existing literature on medical health advocacy education

Political:

- Further current moves to promote health professional engagement in health advocacy/activism.
- Leverage social capital of physicians/health professionals to forward social justice claims

Practical

- Implications for interpretations of professional standards
- Advocacy as tool to mitigate experience of moral distress

3.0 Methodology

3.1 Methods - Literature Search

The literature search for this project was initiated using *Ovid Medline* database with the following search terms and key words: **Physician *or* professional *and* advocacy *or* activism; physician *and* advocacy *and* policy *or* law; ethics *and* advocacy**. The article "**Perspective: Physician Advocacy: What Is It and How Do We Do It?**" by Mark A. Earnest, MD, PhD et al. was identified as a seed article from which the literature search was initiated. The search returned a large number of search results from which n=58 relevant citations were selected for review.

This initial search did not identify many articles which specifically attended to the question of physician engagement in legal advocacy. The search was expanded to include the terms: **Physician *or* professional *and* legal processes *or* legislation *or* legal action *and* advocacy**. This did not uncover many new relevant sources from *Ovid Medicine* or *Westlaw* and therefore the search was continued using *Google Scholar*. Although this uncovered a few more sources there remains a paucity of literature on this topic. While further searches may identity additional resources, I believe the scarcity of literature demonstrates that the intersection of health and legal advocacy is not an area heretofore well researched.

Additional resources were discovered thorough an iterative snowball search of the references of cited sources. This helped to identify additional novel sources and gage when this writer was reaching saturation of relevant literature.

3.2 Analyzing Themes

Sources were manually examined by this writer to identify emergent themes. These themes were organized into a Google Spreadsheet (Appendix A) which allowed the writer to track the recurrence of themes though both the scholarly and professional sources. Some themes were collated at time of writing for the purposes of focusing the content, and limiting the scope of this short paper. Collated themes are colour coded in the coding spreadsheet.

3.3 Limitations

Identification, analysis, and coding of literature cited in this paper was completed manually by this author alone. Given only one person's perspective has created the framework from which conclusions are drawn, there is significant opportunity for error and subjective bias to influence the findings. For example, a different reviewer may have identified additional themes or collated themes in an alternative way. Although every effort has been made by this writer to view the data with fairness, it is unlikely that a truly objective assessment will emerge. That said, this writer admittedly designed this project with a belief that there is opportunity and demand for increased health professional engagement in advocacy. Much of the literature shares a common agreement that advocacy in some shape or form is or ought to be core physician competency, although these lack consensus of how or why that is. Attention has been paid, however, to dissenting voices that argue against the feasibility, correctness, and risks of physician engagement in this activity.

3.4 Theoretical Approaches

This project will employ a critical interdisciplinary approach with the aim to incorporate insights from both legal and non-legal scholarship to address questions that are inherently multi-disciplinary. Interdisciplinary legal research seeks to consider other academic disciplines in order to answer questions such as these (Siems, 2009).

An interdisciplinary methodology can enhance legal literature with "modes of reasoning and discursive techniques found in the political, economic, and social world which are of consequence to the development, implementation and assessment of the law". (Lawlor, 2022). Interdisciplinary methodology used to examine external effectiveness can in turn, measure whether a legal norm is effective in real life. External effectiveness refers to the external consistency of the legal system with the context and culture in which it functions (Schrma, 2011).

Critical Legal Theory posits that the law is necessarily intertwined with social issues, has inherent social biases, supports the interests of those who create the law, and supports a power dynamic which favors the historically privileged while it disadvantages the historically underprivileged (Legal Information Institute, 2022). Further, critical legal theory proposes that the wealthy and powerful use the law as an instrument for oppression to maintain their place in hierarchy but can alternatively be used as a tool to challenge and overturn hierarchical structures of modern society, a perspective particularly salient to this project (Legal Information Institute, 2022).

This paper will also engage with the frameworks of Ethical Principlism (Bauchamp & Childress, 2019) and Feminist Bioethics as tools to explore whether there are ethical obligations for physicians to engage in health advocacy. As a normative ethical framework designed for practical decision making in health care, Principlism is a basic approach designed to address intractable disagreements at the level of normative ethical theory and practical decision-making (Bellefleur, M., 2020).

Feminist bioethics offers a criticism that liberal conceptions of autonomy privilege those most powerful and those with sufficient resources to be unaffected by moral obligations (Wenne, 2020). This is particularly relevant to healthcare as there are significant differences in power between patients and providers and illness can make patients more vulnerable to manipulation and coercion (Sherwin, 2000).

4.0 Background: Literature Review

As outlined earlier, there are several themes which have emerged from the literature on the topic of physician engagement in health advocacy. The first is the lack of consensus in academia and clinical practice of what advocacy means (Bergman, 2005; Bhate & Loh, 2015; Burm et al., 2022; CMPA, 2020; Dobson et al., 2012; Dobson et al., 2015; Earnest et al, 2010; Gruen et al., 2004; Hubinette et al., 2014; LaDonna et al., 2021; Law et al., 2016; Manze et al., 2023). Consequently, multiple authors have offered their own interpretation and conception of the term (Benfer et al., 2012; Bhate and Loh, 2015; Chimonas et al., 2021; Dobson et al. 2012; Dobson et al, 2015; Earnest et al., 2010; Gallagher et al., 2017; Goel et al., 2016; Gruen et al., 2006; Gruen et al., 2004; Horrow et al., 2019; Hubinette et al, 2014; Huddle, 2011; Ince-Coushman, 2017; Kovavh et al., 2019; Kuo et al., 2011; LaDonna et al., 2021; Law et al., 2016; Luft, 2017; Meili et al, 2016; RCPSC, 2023; Wollard et al, 2016). Notably, several authors cited the tension between professional standards like the CanMed Framework (RCPSC, 2023) and the AMA (2001) which centre advocacy as a professional competency, and scholarship that struggles to reach consensus on the meaning of the term (AMA, 2001; CMPA, 2020; Dobson et al., 2012; Earnest et al., 2010; Gallagher et al., 2017; Gottlieb & Johnson, 2011; Gruen et al., 2004; Hatchet et al., 2015; Hubinette et al., 2014; Launer, 2021; Manze et al., 2023; Podolsky & Jones, 2022; RCPSC, 2023; Wiley, 2014; Wollard, 2016).

4.1 Defining Advocacy

Bio-medical and ethical scholarship largely focuses on two categories of health advocacy: Clinical and public. Clinical advocacy is located at the interpersonal level between health professionals and patients and is often understood as professional advocacy to ensure the patient's care needs are met. Public advocacy addresses systemic issues affecting health access, equity, and outcomes. A few authors, highlighted below, have both interpreted and refined these broad categories.

Earnest et al. (2010) argue that despite the general acceptance of advocacy as a physician's professional obligation, the term advocacy within the medical profession remains largely undefined in concept, scope and practice. In their commentary the authors propose a definition of physician advocacy that is understood as actions to promote social, economic, educational, and political changes which mitigate threats to human health and well-being (Earnest et al., 2010).

This piece of writing situates itself within the broader scholarship on the topic of physician advocacy and offers an interesting reconceptualization of the American Medical Association's (AMA) definition of advocacy. Further, the authors notably posit that advocacy is fundamentally a translational activity (Earnest et al., 2010). The activities of the physician advocate, the authors argue, translate interventions from individual patient health to broader public wellness (Earnest et al., 2010).

The authors illustrate the spectrum of physician advocacy using case-studies and physician profiles. Employing this illustrative technique, they are able identify several forms of public advocacy including medical society affiliation, coalition or board leadership, school board advising, public policy advocacy and advising, media consultation, resource allocation management, and legal referrals (Earnest et al., 2010).

Hubinette et al. (2014) explored family physician preceptors' conceptions of health advocacy and of the practical activities they identify as exemplifying the physician's role as health advocate. This aim was embedded in an emerging recognition that eliminating barriers to good health cannot exclude the physician (Hubinette et al., 2014). Physicians, the authors argue, must have a role in shaping the context that impact health outcomes (Hubinette et al., 2014).

The authors identified three discrete but associated ways of conceptualising health advocacy. They concluded that these qualitatively different conceptions of health advocacy effectively illuminate why current ways to define, teach, role model, and assess health advocacy competencies in medical education seem idiosyncratic (Hubinette et al., 2014). The authors consequently suggested development of a broader conceptual framework that could allow medical educators to conceive of novel ways to understand an engage in health advocacy (Hubinette et al., 2014).

Hubinette et al. (2014) propose a three-part conception of health advocacy that includes clinical, paraclinical, and supraclinical advocacy (Fig. 1).

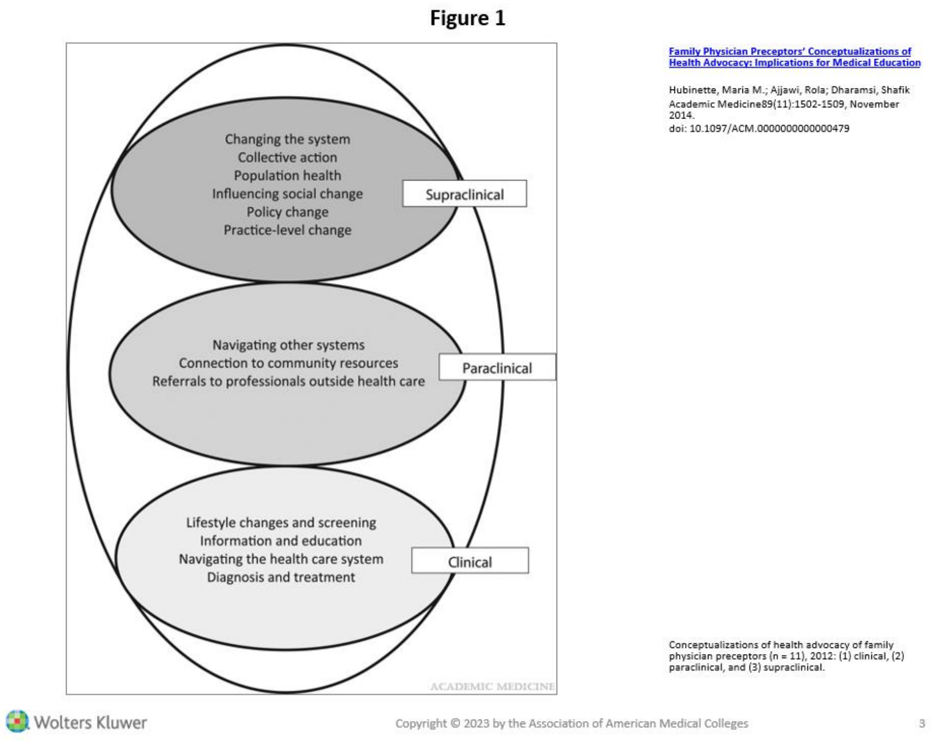

Figure 1

Family Physician Preceptors' Conceptualizations of Health Advocacy: Implications for Medical Education

Hubinette, Maria M.; Ajjawi, Rola; Dharamsi, Shafik
Academic Medicine89(11):1502-1509, November 2014.
doi: 10.1097/ACM.0000000000000479

Conceptualizations of health advocacy of family physician preceptors (n = 11), 2012: (1) clinical, (2) paraclinical, and (3) supraclinical.

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They describe clinical health advocacy as the support of individual patients in addressing health care needs related to the immediate clinical problem within the health care system (Hubinette et al., 2014). Paraclinical advocacy, the authors posit, entails supporting individual patients in addressing needs viewed as peripheral but parallel to the health care system and the immediate clinical problem (Hubinette et al., 2014). This may include activities such as navigating parallel systems like social services, filling out forms for special services, and connecting patients with community resources (Hubinette et al., 2014). Finally, Hubinette et al. (2014) conceptualized supraclinical advocacy as engagement in population-based activities aimed at practice-level and systems-level changes. Health advocacy within this context was focused on addressing the broader social determinants of health and may include activities such as membership in organizations with an advocacy mandate, influencing public policy, and creating change at a system level, such as developing policies regarding health care benefits for refugees (Hubinette et al., 2014).

Sarah Dobson et al. (2012) responded to the formalization of advocacy as a professional activity of physicians with their conception of the “agent/activist” model. They challenge the CanMEDS framework (2023) for having conflated these distinct sub-roles under the rubric of health advocacy and argue that productive conversations about the place of health advocacy are impeded by a lack of clarity about what advocacy is, and how it can be incorporated into daily practice (Dobson et al. 2012).

Their agent/activist health advocate dichotomy can be described as unique activities deserving of equitable attention rather than divergent professional competencies (Dobson et al., 2012). Agency, they argue, involves activities which advance the health of individuals, whereas activism involves advancing the health of populations and communities (Dobson et al., 2012). This distinction can be understood as “working the system” versus “changing the system” (Dobson et al., 2012, pg.1161).

In 2015 Dobson et al. refined their agent/activist conception of the role through a qualitative study that measured the activities and capabilities of health advocates. This study sought to explore how physicians who are known to be activists practice everyday activities of advocacy in order to better understand their skills and abilities, the resources they draw on, and the ways in which they conceptualize their role (Dobson et al., 2015). The study explored the breadth of advocacy engagement described by physicians who practiced these activities in order to identify a set of practices that might be routinely enacted by all physicians (Dobson et al., 2015).

The authors identified five discrete categories of advocacy activities as well as a wide range of abilities and viewpoints that they used across all levels of activity (Dobson et al., 2015). These categories included clinical agency, paraclinical agency, practice quality improvement, activism, and knowledge exchange (Dobson et al., 2015). Further, although the authors found that the activities described at the practice level (clinical agency, paraclinical agency, practice quality improvement) could conceivably be incorporated into the routine professional lives of most physicians, many activities at the systems level (activism and knowledge exchange) might require specific skill development and support (Dobson et al., 2015). The authors noted that while the data allowed for a broader understanding of the range of physician advocacy activities, these findings would necessarily demand refinement of their initial agency-activism framework (Dobson et al., 2015).

In 2006 Gruen et al. published an article which investigated the importance physicians assigned to public roles, described their participation in these activities, and determined the sociodemographic and practice factors contributing to physicians' assessment of their importance and activity. The authors defined "public roles" to mean community participation, political involvement, and collective advocacy (Gruen et al., 2006).

Researchers found that approximately 70% of respondents were defined as civic minded (Gruen et al., 2006). In logistic regression analysis, respondents who were part of an under-represented race or ethnicity, who graduated from a non-US or non-

Canadian medical school, who were women, or who were of an increasing professional age were significantly more likely to be identified as civic minded (Gruen et al., 2006). The authors also found that community participation, political involvement, and collective advocacy were rated as important by more than 90% of respondents (Gruen et al., 2006). Further, a majority rated community participation and collective advocacy as very important. They concluded that public roles are definable concepts that are broadly supported among physicians (Gruen et al., 2006). They found that civic mindedness is primarily associated with sociodemographic factors but civic action, on the other hand, is associated with specialty and practice-based factors (Gruen et al., 2006).

The authors claim that their study offers important evidence for professional leaders, organizations, policy makers, and educators with an interest in promoting physician engagement in public health and health policy (Gruen et al., 2006). The authors also draw attention to the increased value they found physicians assign to issues that directly impact their patient population (Gruen et al., 2006). This is in keeping with this writer's literature review thus far and raises questions about whether physicians ought to be encouraged to assign the same value to social causes more remote from their daily practice.

This paper followed a 2004 article published by Gruen et al. where the authors defined physicians' public advocacy role as advocacy for, and participation in improving the aspects of communities that affect the health of individuals (Gruen et al., 2004). This definition, they argue, focused on communities by considering the attributes that affect the health of individual patients (Gruen et al., 2004). The authors propose a model to capture these issues and to illustrate the possible boundaries between physicians' professional obligations and aspirational goals (Figure 2).

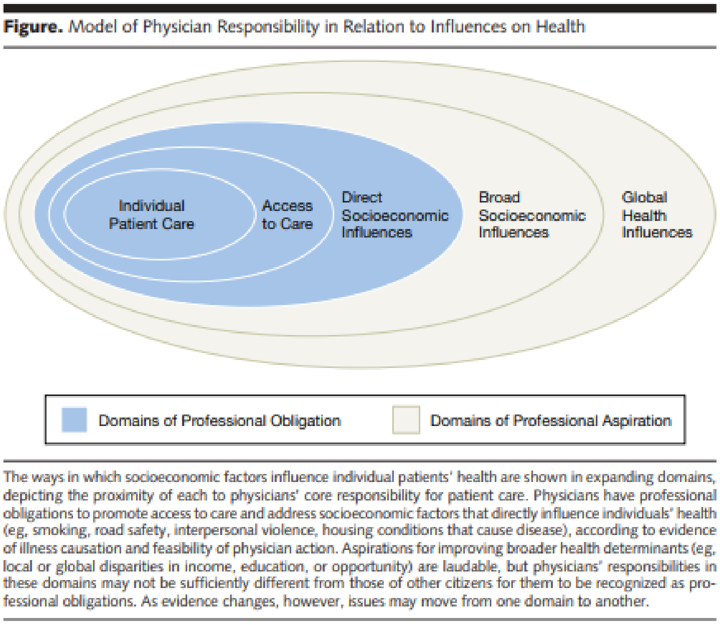

Figure. Model of Physician Responsibility in Relation to Influences on Health

The ways in which socioeconomic factors influence individual patients' health are shown in expanding domains, depicting the proximity of each to physicians' core responsibility for patient care. Physicians have professional obligations to promote access to care and address socioeconomic factors that directly influence individuals' health (eg, smoking, road safety, interpersonal violence, housing conditions that cause disease), according to evidence of illness causation and feasibility of physician action. Aspirations for improving broader health determinants (eg, local or global disparities in income, education, or opportunity) are laudable, but physicians' responsibilities in these domains may not be sufficiently different from those of other citizens for them to be recognized as professional obligations. As evidence changes, however, issues may move from one domain to another.

Gruen, Pearson, S. D., & Brennan, T. A. (2004). Physician-Citizens—Public Roles and Professional Obligations. *JAMA : the Journal of the American Medical Association*, *291*(1), 94–98. https://doi.org/10.1001/jama.291.1.94

At the center of the model, the authors argue, is the physicians' primary responsibility to provide high-quality care to individual patients in their routine clinical practice (Gruen et al., 2004). The model then illustrates concentric circles of physician engagement in activities of advocacy that move from this core responsibility to aspirational physician goals (Gruen et al., 2004). Immediately adjacent to the core responsibility of individual patient care is the connection between health care access and health outcomes (Gruen et al., 2004). Following the access to care domain are subsequent domains of socioeconomic influences on health. These are separated into three areas distinguished by how directly they relate to the health of individual patients and the feasibility and efficacy of physician engagement (Gruen et al., 2004).

The fourth ring of Gruen et al.’s model, represents the domains in which socioeconomic factors are clearly associated with health status, but the evidence of causality of illness in individual patients is less concrete, or the feasibility or efficacy of physician action is less evident (Gruen et al., 2004). In this model, these rings represent the effect of disparities of income, education, housing, and exposure to environmental pollutants on health (Gruen et al., 2004).

Finally, the outermost domain contains socioeconomic influences on health at a global level (Gruen et al., 2004). In these rings the focus shifts to the health effects of the global distribution of resources, knowledge, and opportunity (Gruen et al., 2004). The authors argue that through this framework, it is possible to consider where the boundary should exist between professional obligations and professional aspirations. Specifically, the authors argue that the distinction ought to be based on evidence of causation of illness in individual patients and the feasibility and efficacy of physician action (Gruen et al., 2004) Therefore, instances of demonstrated causality between socioeconomic factors and health (those which fall into the inner 2 domains) should be considered professional responsibilities of physicians, whereas the domains falling into the outer rings are aspirational in nature (Gruen et al., 2004).

4.2 Unique position and Social Capitol

Several authors, (AMA, AHS, & CPSA, 2012; Bhate & Loh, 2015; Banack & Byrne, 2011; Earnest et al., 2010; Gallagher et al., 2017; Goel et al., 2017; Gruen et al., 2006; Gruen et al., 2004; Halliday et al., 2011; Huddle, 2011; Ince-Cushman, 2017; Kovach et al., 2019; LaDonna et al., 2021; Law et al., 2016; Liebe et al., 2022; Liepart et al., 2019; Luft, 2017; Manze et al., 2023; Meili et al., 2016; Palfrey & Chamberlain, 2011; Podolsky & Jones, 2022; RCPSC, 2023; Sud et al., 2011) describe physicians as being uniquely positioned to witness, quantify, and influence the ways in which patients unequally experience health and access to health care. The intimate nature of the doctor-patient relationship allows for physicians to witness the ways health is shaped by the experience of poverty, housing and food insecurity, education, working conditions, lack of social protections, early childhood development, social inclusion, discrimination racism and other social determinants of health. The WHO defines the social determinants of health as:

> “the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems.” WHO, 2023

It is well proven that the social determinants of health have a significant influence on health inequities. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health (WHO, 2023). Several authors in the literature review acknowledge this reality and frame social justice advocacy as a tool to address these health disparities (Benfer et al., 2012; Bhate & Loh, 2015; Banack and Byrne, 2011; Chimonas et al., 2021; Dobson et al., 2012; Earnest et al., 2010; Gallagher et al., 2017; Gold & Schweitzer, 2013; Gottlieb and Johnson, 2011; Gruen et al., 2004; Gruen et al., 2006; Halliday et al., 2011; Hatchett et al., 2015; Kovach et al., 2019; Kuo et al., 2011; Law et al., 2016; Lieb et al., 2022; Launer, 2021; Luft, 2017; Manze et al., 2023; Mieli et al., 2016; Palfrey & Chamberlain, 2011; Sud et al., 2011; Tyler, 2010; Wiley, 2014; Wollard et. Al, 2016).

Some authors take a step past the position that physicians are uniquely positioned to identify and influence the consequences of the social determinants of health. Some argue that physicians are in fact, obligated to engage in advocacy as part of the social contract they have entered as physicians (AMA, AHS & CPSA, 2012; Bhate and Loh, 2015; Banack & Byrne, 2011; Dobson et al., 2012; Earnest et al., 2010; Gallagher et al., 2017; Goel et al, 2016; Gruen et al., 2004; Gruen et al., 2006; Hubinette et al., 2014; Ince-Cushman, 2017; LaDonna et al., 2021; Law et al., 2016; Luft, 2017; Manze et al, 2023; Meili et al., 2016; RCPSC, 2023; Sud et al., 2011; Wollard et al, 2016).

Gruen et al. (2004) write that “In this contract, society grants the medical professions—comprising individuals and their collective associations—special social status and certain privileges such as monopoly use of knowledge, practice autonomy, and the right to self-regulate. In return, the medical profession is expected to promote society's health.” Earnest et al. (2010) draws some equivalency to the expectation in the legal field for lawyers to engage in pro bono work as part of their practice. They centre the unique expertise, social capital, and public trust of physicians as qualities which make this professional group well-situated to engage in public advocacy (Earnest et al., 2010). Banack and Byrne (2011) agree that there is a social contract between society and the medical profession which entrusts the latter with autonomy and self-regulation in exchange for fostering the health of society.

Physicians are, of course, not the only health professionals well suited and well positioned to engage in advocacy. In fact, many individuals and communities encounter barriers accessing a primary care physician. While this writer is uncertain if the physician needs to be positioned as the professional best suited to the role of advocate, it may still benefit the profession to establish a definition of advocacy that is best suited to the physician.

4.3 External Sources of Obligation – Professional Standards

There are several professional organizations that have made policy or practice statements related to health advocacy which have, in turn, been examined in several pieces of the literature (AMA, AHS & CPSA, 2012; AMA, 2001; Bhate & Loh, 2015; Banack & Byrne, 2011; Chimonas et al., 2021; CMPA, 2023; Dobson et al., 2012; Dobson et al., 2015; Earenst et al., 2010; Gallagher et al., 2017; Gottlieb & Johnson, 2011; Gruen et al., 2004; Hubinette et al., 2014; Huddle, 2011; Kovach et al., 2019; Liebe et al., 2022; Launer, 2021; Luft, 2017; Manze et al., 2023; RCPSC, 2023; Schickedanz et al., 2011; Sud et al., 2011; Tyler, 2010; Wollard et al., 2016).

These professional standards include, but are not limited to, the Royal College of Physicians and Surgeons of Canada (2023), the American Medical Association (2001), Alberta Health Services, the Alberta Medical Association and College of Physicians & Surgeons of Alberta (2012), and the American Academy of Family Physicians (Ince-Cushman, 2017).

The Royal College of Physicians and Surgeons of Canada’s CanMED framework (RCPSC, 2023) is frequently cited in the literature as the most comprehensive account of physician health advocacy (Bhate & Loh, 2015; Dobson et al., 2012; Dobson et al., 2015; Hubinette et al., 2014; LaDonna et al., 2021; Law et al., 2016; Luft, 2017). CanMEDS identifies and describes the abilities physicians require to effectively meet the health care needs of the people they serve. “Health Advocate” is therefore one of seven core physician competencies. The RCPSC (2023) argues that as Health Advocates, physicians can contribute their expertise and influence as they work with communities or patient populations to improve health.

Reflecting the concept of social contract found in the literature (Banack & Byrne, 2011; Gallagher et al., 2017; Gruen et al., 2006; Hubinette et al., 2014; Sud et al., 2011; Wollard et al., 2016), the College argues that physicians are accountable to society and have a duty to contribute to efforts to improve the health and well-being of their patients, their communities, and the broader populations they serve (RCPSC, 2023). Further, physicians possess medical knowledge and abilities that provide unique perspectives on health and have privileged access to patients’ accounts of their experience with illness and the health care system (RCPSC, 2023).

The college opinions that the physician's commitment to improving health is not limited to mitigating illness or trauma, but also involves disease prevention, health promotion, and health protection as well as promotion of health equity (RCPSC, 2023). This includes attention to how individuals and populations reach their full health potential without being disadvantaged by factors such as their race, ethnicity, religion, gender, sexual orientation, age, social class, economic status, or level of education (RCPSC, 2023).

The CanMED framework also highlights the unique perspective or special expertise on the determinants of health that physicians can exercise:

> “Physicians recognize their duty and ability to advance safer medical care, the overall health of their patients and the society they serve. Doctors

> identify advocacy activities as important for the individual patient, for populations of patients and for communities. Individual patients need physicians to assist them in navigating the healthcare system and accessing the appropriate health resources in a timely manner. Communities and societies need physicians' special expertise to identify and collaboratively address broad health issues and the determinants of health. At this level, health advocacy involves efforts to change specific practices or policies on behalf of those served. Framed in this multi-level way, health advocacy is an essential and fundamental component of health promotion. (CanMEDS 2005 Physician Competency Framework)."

The college argues that advocacy requires action (RCPSC, 2023). Physicians ought to use their knowledge of the determinants of health to positively influence the health of the patients, communities, and populations they serve (RCPSC, 2023). This is reflective of Guen et al.'s conception of advocacy as a physician's participation in improving the aspects of communities that affect the health of individuals (Gruen et al., 2004). Physicians can, the RCPSC argues, support patients, communities, or populations to call for change, increase awareness about important health issues at the patient, community, or population level, and support or lead the mobilization of resources on small or large scales (RCPSC, 2023). As advocacy occurs within complex systems it requires development of partnerships with other health care professionals, community agencies, administrators, and policymakers (RCPSC, 2023).

Meanwhile, the AMA (2001) states that physicians are bound in their response to these issues by a common heritage of caring for the sick and the suffering. The profession must, it argues, reaffirm its historical commitment to combat natural and man-made assaults on the health and well-being of humankind through coordinated action across geographic and ideological divides (AMA, 2001).

The AMA developed a declaration of professional responsibility which itemizes nine professional commitments. This includes the commitment for physicians to "advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being" (AMA, 2001). Although Dobson et al. (2012) criticized the CanMEDS framework (RCPSC, 2023) for conflating the roles of agent and activist in its conception of physician advocacy, CanMEDS (RCPSC, 2023) seems robust in its conception of health advocacy compared to the broad, dramatic strokes of the AMA (2001).

Fittingly, a Health Quality Council of Alberta (HQCA) study found that a significant percentage of physicians felt that they lacked the resources and skills to advocate effectively for their patients (HQCA, 2012). Subsequently, the Alberta Health Services, the Alberta Medical Association and College of Physicians & Surgeons of Alberta worked together to create a number of resources to assist physician advocacy efforts.

> "Advocacy is an important component of the doctor-patient relationship and physicians should individually and collectively advocate with their patients. Advocacy involves the responsible use of expertise and influence to advance patients health care interests." (AMA, AHS and CPSA, 2012)

The joint committee developed a number of principles to guide advocacy work which confirmed their support for the "license" and "responsibility" of physicians to advocate for health and safe medical care on behalf of their patients, families and their communities without adverse repercussions (AMA, AHS and CPSA, 2012). The principles oblige physicians to do so using proper process and to act in a professional manner in an environment where physicians are appropriately engaged in all decisions that affect their patients and workplace (AMA, AHS and CPSA, 2012). Further the principles included a commitment to a provincial approach with clearly communicated roles and accountabilities to support the physician advocacy role (AMA, AHS and CPSA, 2012).

In their Competency Framework for Family Physicians Across the Continuum, the College of Family Physicians argues that as health advocates, family physicians should work in partnership with patients and communities, contributing their expertise and influence to improve health through an understanding of needs, as agents of change, and the mobilization of resources (Ince-Cushman, 2017). The College goes on to define health advocacy in two ways. First, as the response to an individual patient's needs by advocating with the patient within and beyond the clinical environment, and second, as a resource to their community by advocating with them as active partners for system-level change in a socially accountable manner (Ince-Cushman, 2017).

The Canadian Medical Protective Association (CMPA), a membership-based, not-for-profit organization that provides legal defense, liability protection, and risk-management education for physicians in Canada, notes the challenge created by the lack of consensus on the definition of health advocacy (CMPA, 2020). They argue that numerous definitions and various interpretations of the term have made it difficult to determine what advocacy approaches will be effective and considered professionally appropriate (CMPA, 2020).

Advocacy, they argue, has a long and deep tradition in medicine (CMPA, 2020). This position is reflected in some of the scholarship as well. Several articles have chronicled important acts of advocacy in medical history including the work of Rudolf Virchow, Sir Douglas Black, and Julian Tudor-Hart (Benfer et al., 2012; Bhate & Loh, 2015; Hatchett et al, 2015; Huddle, 2011; Lieb et al., 2022; Launer, 2021; Meili et al., 2016; Palfrey & Chamberlain, 2011; Podolsky and Jones, 2022; Schickedanz et al., 2011).

The CMPA (2020) argues that because of the credibility associated with the medical profession, physicians have historically been called on to speak up on behalf of patients, and to influence policy or program changes. They highlight that during the COVID-19 pandemic, many organizations and authors underscored the principal role physicians played in countering medical misinformation and advocating for vulnerable patients and regulatory or policy changes (CMPA, 2020).

The CMPA notes that while many medical regulatory authorities have indicated it is generally appropriate for doctors to advocate responsibly, advocacy should not interrupt the safe provision of care (CMPA, 2023). They warn against advocacy that promotes misinformation and caution against actions that may increase scrutiny (CMPA, 2020; CMPA, 2023).

While the CMPA argues that advocacy is intrinsic to a physician's role, they caution that uncertainty about its definition can also lead to accusations of overstepping bounds, irresponsibility, or inappropriate behaviours and actions (CMPA, 2020; CMPA, 2023). Similarly, failure to successfully effect change through advocacy can lead to frustration, cynicism, and complacency (CMPA, 2020). Although the CMPA espouses some of the aspirational goals seen from the professional organizations and in literature, there is certainly a more pragmatic and risk-adverse stance apparent in the organization's guidance, as is in keeping with their role.

4.4 Internal Motivations to Engage in Advocacy

While a number of authors have flagged the importance of physician advocacy (AMA, 2001, AMA, AHS, & CPSA, 2012; Benfer et al., 2012; Benfer, 2012; Bhate & Loh, 2015; Chimonas et al., 2021; CMPA, 2023; Earnest et al., 2010; Gallagher et al., 2017; Gruen et al., 2006; Horrow et al., 2019; Hubinette et al., 2014; Ince-Cushman, 2017; Kuo et al., 2011; LaDonna et al., 2021; Liebe et al., 2022; Liepart et al., 2019; RCPSC, 2023), a few studies have specifically focused on *why* physicians feel advocacy is important, *why* they participate in advocacy, how they are motivated to engage in its practice (Burm et al., 2022; Chimonas et al., 2021; Gallagher et al., 2017; Kovach et al., 2019; Gruen et al., 2007; Law et al., 2016).

Chimonas et al. (2021) authored a study which explored the future of physician advocacy through a survey of U.S. medical students. The authors of this study sought to understand medical students' attitudes about civic engagement (Chimonas et al., 2021). This, they argued, would include their interests and future plans around health policy, their ideas about healthcare access and cost accountabilities, their beliefs about different forms of public engagement, as well as their specific issues of interest (Chimonas et al., 2021). They also hoped to identify congruence or lack thereof with professional obligations. The authors hypothesized that the students would identify more interest in advocacy directly related to health and medical care and less support for engagement related to indirect determinants of health (Chimonas et al., 2021).

The study found that most survey participants agreed it was particularly important for physicians to encourage medical organizations to advocate for public health and provide health-related expertise to the community (Chimonas et al., 2021). As hypothesized, issues with indirect connections to health were not found to be as important as advocacy for medical issues (Chimonas et al., 2021).

Interestingly, this study collected demographic information related to political affiliation and consequently found that self-identified liberals and non-whites were likelier than others to value advocacy (Chimonas et al., 2021). Another interesting consideration identified by the authors themselves is that their study was completed prior to the Covid-19 pandemic, a global event which seems to have increased the publics' and health professionals' awareness and commitment to social advocacy (Chimonas et al., 2021). This study has the unique perspective of having been completed prior to the pandemic but published following. Although this writer is unsure there would have been a way to mitigate a relevancy problem that is ultimately the result of unfortunate timing, there remains a disconnect from the context in which it was published.

In a qualitative and evaluative study, Gallagher et al., (2017) aimed to explore doctors' attitudes on values and advocacy. This paper situates its objective within the context of a growing commitment to advocacy and social justice as reflected in several codes of medical ethics around the world (Gallagher et al., 2017).

The authors defined their research question as: "What values matter to doctors in their practices and in their educational experiences?" (Gallagher et al., 2017). The authors report that the paper explores the values and experiences of advocate doctors in order to inform practical and theoretical analysis of both the promotion and facilitation of 'supraclinical advocacy' as an individual professional commitment (Gallagher et al., 2017). “Supraclinical advocacy” is defined by the authors as a group of activities focused on changing practice and changing the system to address the social determinants of health (Gallagher et al., 2017).

The researchers identified two main themes connected to the participants’ involvement in supraclinical advocacy: 1. “It made me”, which described participants’ experiences with medical training and enculturation and how these formed their professional identity, and 2. “Is that all there is?”, which described participants’ perspectives on how medicine shaped their professional rolls (Gallagher et al., 2017). The authors concluded that these findings suggested common approaches to promote and enable advocacy as an individual's professional obligation are not entirely congruent with the experiences and values doctors describe as significant in their development as an advocate (Gallagher et al., 2017).

Gruen et al. (2007) sought to determine the importance physicians assigned to public roles, to describe their participation in these activities, and to identify the sociodemographic and practice factors contributing to physicians’ assessment of their importance and activity. The authors defined “public roles” to mean community participation, political involvement, and collective advocacy (Gruen et al.,2007).

The researchers found that approximately 70% of respondents were defined as civic minded (Gruen et al.,2007). Echoing the findings of Chimonas et al. (2017), respondents who were part of an under-represented race or ethnicity, who graduated from a non-US or non-Canadian medical school, who were women, or who were of an increasing professional age were significantly more likely to be identified as civic minded (Gruen et al.,2007). The authors also found that community participation, political involvement, and collective advocacy were rated as important by more than 90% of respondents (Gruen et al.,2007). Further, a majority rated community participation and collective advocacy as very important (Gruen et al.,2007). They concluded that public roles are definable concepts that are broadly supported among physicians (Gruen et al.,2007). They found that civic mindedness is primarily associated with sociodemographic factors but civic action, on the other hand, is associated with specialty and practice-based factors (Gruen et al.,2007).

In a qualitative study of the experiences and factors that led physicians to be lifelong health advocates, Law et al. (2016), reported two overarching objectives for their project. The primary goal, they reported, was to identify and explore consequential experiences and influences that led physicians to be health advocates (Law et al., 2016).

The authors reported that their phenomenological approach yielded a diverse range of viewpoints among participants. They clustered their findings into three main themes: “1. Who I am and what I do: Identity and development; 2. How I got here: Facilitators to engaging in health advocacy; and 3. How I continue to be a lifelong health advocate” (Law et al., 2016). The authors concluded that many factors, including exposure to social injustice, early life and formative experiences, training, mentors, self-reflection, and collaboration, enable physician health advocates to establish and maintain a commitment to improve the health of both their patients as well as the broader population (Law et al., 2016).

4.5 Advocacy and Medical Education

A number of the reviewed articles (57%) cite the intersection of physician advocacy and medical education as an area in need of both attention and development (Benfer et al., 2012; Bergman, 2005; Bhate, 2015; Burm et al., 2022; Chimonas et al., 2021; Dobson et al., 2012; Dobson et al., 2015; Earnest et al., 2010; Gallagher et al., 2017; Goldfarb, 2019; Gold & Schweitzer, 2013; Gottlieb & Johnson, 2011; Halliday et al., 2011; Hatchett et al., 2015; Hubinette et al.; 2014; Huddle, 2011; Kovach et al., 2019; Kuo, 2011; LaDonna et al., 2021; Law et al., 2016; Luft, 2017; Manze et al., 2023; Palfrey and Chamberlain, 2011; Schickedanz et al., 2011; Sud et al., 2011; Tyler, 2010). Imbedded this analysis is a recognition that the lack of clarity in defining advocacy creates barriers to teaching advocacy as a professional skill.

In the above cited study by Chimonas et al. (2021) which explored medical students' attitudes about civic engagement, the researchers concluded that medical students reported significant interest in advocacy related to health issues consistent with their professional standards. As stated above, associations were drawn between participant attitudes and political affiliation (Chimonas et al., 2021). The authors found that optimization of future physician advocacy could be contingent on relevant learning opportunities and engagement in issues of interest (Chimonas et al., 2021).

Gallagher et al., (2006) concluded that there is an imperative to better understand the moral commitments inherent to advocacy in order to inform future developments in medical education and codes of medical ethics. Law et al. (2016) in turn, hoped to identify opportunities for the development of health advocacy curricula that could prepare physicians to engage in what the authors describe as an "important aspect” of their work. The authors felt these findings could help guide curriculum development related to health advocacy within medical schools.

LaDonna et al. (2021) sought to generate a multi-perspective understanding about the meaning of competence for the health advocacy role. The authors proposed that since advocacy might be inextricable from patient-centred care, engaging patients and physicians in conversations about health advocacy could generate more authentic teaching and a better understanding of the role of advocacy in healthcare (LaDonna et al., 2021). The authors framed this study as a starting point for work generating a multi-perspective understanding about the meaning of competence for the health advocate role (LaDonna et al., 2021).

This study found that advocacy was contingent on a combination of medical and system expertise, a favorable learning and practice environment, as well as personal and professional qualities including experience, status, and political acumen (LaDonna et al., 2021). The authors also found that few participants perceived health advocacy as a fundamental physician role because it is currently characterized as such in medical curriculum (LaDonna et al., 2021). The study found that re-framing advocacy training to include skills like empathy and listening may address misconceptions that health advocacy is primarily a disruptive activity (LaDonna et al., 2021).

In a commentary that appeared in a 2011 issue of Academic Medicine, Thomas Huddle argued that the medical profession “should steadfastly resist” attempts to include advocacy as an essential professional commitment. He argued that advocacy on behalf of social goals, even so uncontentious a goal as the improvement of human health, is inevitably political (Huddle, 2011). He reasoned that civic virtues are situated beyond the professional realm, and the profession of medicine should not require any particular political stance in its members (Huddle, 2011). He further argued that advocacy within academic health centre subverts the activities of research and education and undermines aspirations for objectivity and neutrality (Huddle, 2011).

Huddle (2011) refutes the idea that the medical profession has any special authority or insight into what justice demands or whether economic resources should be allocated to population health rather than other priorities (Huddle, 2011). Physicians, he posits, ought only to demand of themselves that they be good physicians and ought not to make moral virtues a specifically professional burden (Huddle, 2011).

Further, Huddle (2011) argued that physician's unique knowledge of health care needs should not privilege their analysis of those needs in relation to other social demands (Huddle, 2011). Although Huddle also gives a nod to the professions history of advocacy including, again, that of Rudolph Virchow, Huddle argues that for the advocate, truth is only instrumental to their cause. Unlike the scholar steadfastly in pursuit of the truth, the advocate espouses persuasion at the sacrifice of objectivity (Huddle, 2011). The best advocates, Huddle (2011) argues, are rarely the best scholars. Although this echos broader commentary about the validity of interpretive research as compared to its positivistic cousin, Huddle (2011) does perhaps raise a fair point about the competency of physicians alone to address social problems. His argument, however, may only reinforce the dissenting argument that effective advocacy cannot happen in a silo but must involve collaboration across systems.

Reaction to Huddle's commentary was swift and robust (Banack & Byrne, 2011; Gottlieb & Johnson, 2011; Kuo et al., 2011; Palfrey & Chamberlain, 2011; Schickedanz et al, 2011; Sud et al., 2011). Mirroring arguments seen in the literature, respondents cited the privileged knowledge (Sud et al, 2011), need for specific training (Sud et al., 2011; Kuo, 2011; Schnickedanz et al., 2011), clear connection between social conditions and health disparities (Gottlieb & Johnson, 2011; Palfrey & Chamberlain, 2011), physician influence (Halliday, 2011), social contract (Banack, 2011) and the powerful marriage of physician scholarship and advocacy (Halliday, 2011) as foils to Huddles arguments. Gottlieb & Johnson (2011) argue that Huddle's commitment to the physician's apolitical stance is itself a political choice. They argue that:

> Medicine, inexorably linked as it is to money and power, is an inherently political vocation. Its stakes are literally life and death, power and powerlessness. So the choice to remain out of the political debate, however political may be defined, is still a choice. Educating both new and wizened healthcare professionals in the comprehensive armamentarium of advocacy tools available may, in fact, be a less partisan approach than Huddle's absolute anti-advocacy education stance (Gottlieb & Johnson, 2011, pg 1064).

4.6 Resistance to Advocacy as a Competency

Thomas Huddle (2011) is not the only author who has articulated or acknowledged resistance to burgeoning calls for physician advocacy training and participation (Bhate & Loh, 2015; Burm et al., 2022; Banack and Byrne, 2011; Chimonas et al., 2021; Dobson et al., 2015; Earnest et al., 2010; Gallagher et al., 2017; Goldfarb, 2019; Gottlieb & Johnson, 2011; Gruen et al., 2006; Halliday et al., 2011; Hubinette et al., 2014; Huddle, 2011; Kuo et al, 2011; Liebe et al., 2022; Schickedanz et al., 2011).

Dr. Stanley Goldfarb penned a commentary for the Wall Street Journal in 2019 which decried "woke medical schools" and their commitment to social justice. Goldfarb

(2019) argues that social justice is only tangentially related to health care, a bold statement given the wealth of literature elucidating a clear causal connection between the two. He grounds his argument in a claim that this move towards social justice is the result of “a progressive mindset that abhors hierarchy of any kind and the social elitism associated with the medical profession in particular” (Goldfarb, 2019). Although the author here seems to acknowledge the privilege and power afforded the medical profession, unlike other authors we have cited above, Dr. Goldfarb denies any social responsibility commensurate with that elevated social capital.

Rather than a necessary evolution of medical education, Dr. Goldfarb (2019) argues that medical advocacy education happens at the peril of medical training. Doctors, he argues, will become experts in climate change, gun control, social inequity and “other progressive causes”, rather than “basic scientific knowledge (Goldfarb, 2019, pg 2). The author dramatically rings the alarm that “the zeitgeist of sociology and social work have become the driving force in medical education” which mimics the big-government failings of administrator and policy-heavy approaches to governance (Goldfarb, 2019, pg 2).

Dr. Goldfarb’s blunt assessment of medical education leaves little room for the nuanced critiques of its challenges and opportunities. His dismissal of advocacy as a core competency, leaves little reason to consider how health professionals can be better prepared to engage in the practice. While several authors have explored what makes a good physician advocate, and how that skill may be learned, they have arguably grounded their inquiry in the belief that advocacy, is a worthy and necessary pursuit.

4.7 Barriers to Physician Engagement in Health Advocacy

Several authors have explored barriers to physician engagement in advocacy activities (Benfer et al. , 2012; Bhate & Loh, 2015; Burm et al., 2022; Chimonas et al., 2021; Dobson et al., 2012; Dobson et al., 2015, Earnest et al., 2010; Gallagher & Little, 2017; Gruen et al., 2004; Gruen et al., 2006, Hubinette et al., 2014; Lieb et al, 2022; Liepert, 2019; Luft, 2017; Manze et al., 2023).

For example, Kovach et al. (2019) asked how engaged family physicians are in addressing the social determinants of health. The authors situated their study within the context of a move by public health leaders to advocate for clinical and population-based interventions to address social determinants of health (Kovach et al., 2019). The authors noted that the American Academy of Family Physicians (AAFP) has worked to support physicians in addressing these issues but the extent to which physicians are engaged in this work, and the factors for their engagement are unknown (Kovach et al., 2019). Thus, the authors identified three questions to guide their research:

1. To what extent are family physicians engaged in clinical and population-based actions to address the social determinants of health?
2. What are family physicians' perceived barriers to addressing the social determinants of health?
3. What factors are associated with family physicians' level of engagement in clinical in population-based actions to address the social determinants of health?

Of the 434 responses, 81% reported engagement in at least one clinical action, and 43% in a population-based action to address the social determinants of health. Time constraints and staffing issues were the most commonly reported barriers to engagement (Kovach et al., 2019). Additional reported barriers included lack of financial incentives to address the social determinants of health, lack of resources in their local community, lack of education or training, and an inability to provide a solution to the patient’s problem (Kovach et al., 2019). Interestingly, approximately 14% of respondents also cited a lack of evidence to support the social determinants of health as a barrier to their engagement (Kovach et al., 2019).

More experienced physicians were associated with higher levels of clinical engagement and lower median household income was associated with higher levels of population-based engagement (Kovach et al., 2019). Working for a federally qualified health centre was associated with both (Kovach et al., 2019). The authors concluded that their findings suggest some family physicians are engaging in clinical and population-based strategies to address the social determinants of health and this engagement correlates to some specific physician and community characteristics (Kovach et al., 2019).

Leipert e al. (2019) surveyed 1,432 physicians in a single academic system a 21-question survey exploring physician engagement in health policy advocacy. Items on the survey included self-reported health policy advocacy activity, barriers and benefits of health policy activity and participant demographics (Leipert e al., 2019).

The study authors report a demographic breakdown of participants as well as statistics on participant involvement in health policy advocacy, description of types of advocacy, and barriers to participation in health policy advocacy (Leipert e al., 2019). As per their hypothesis they concluded that there is a low overall participation in health policy advocacy by physicians (Leipert e al., 2019). They concluded that barriers identified in their study present an opportunity to improve participation in health policy advocacy (Leipert e al., 2019).

Identified barriers to participation were lack of time and conflicting priorities (Leipert e al., 2019). Although this confirms the hypothesis of the authors, these are large and broad categories, and this writer is doubtful their findings truly present an opportunity to make participation in health policy advocacy feasible as the authors claim (Leipert e al., 2019).

4.8 Intersection of Health Advocacy and the Law

As was mentioned earlier, there is a relative paucity of literature examining how the law intersects with health advocacy (Benfer et al., 2012; Benfer, 2012; Gold & Schweitzer, 2013; Gruen et al., 2004; Gruen et al., 2006; Halliday, et al., 2011; Hatchett et al., 2015; Manze et al., 2023; Palfrey and Chamberlain, 2011; Tyler, 2010; Wiley, 2014). Most of the literature in this area approaches the topic from the perspective of legal/medical education in the classroom and clinic, and opportunities for capacity building and collaborative care therein (Benfer et al., 2012; Benfer, 2012; Halliday, et al., 2011; Hatchett et al., 2015; Manze et al., 2023; Tyler, 2010; Wiley, 2014).

Benfer (2012) examines *The Health Justice Project*, an interdisciplinary advocacy partnership to address the social determinants of health. This paper reports on a program of the Loyola University Chicago School of Law in which JD, MSW, and MPH students, along with medical residents engage in a medical-legal partnership through the *Health Justice Project* law school clinic (Benfer, 2012). The authors describe the aims and activities of the Health Justice Project, a collaborative educational clinic addressing the social determinants of health in Chicago, Illinois. The paper outlines the following objectives for the project: “1. Provide highly effective quality representation to low-income clients in order to resolve the legal needs that underlie, exacerbate, or could result in health disparity; and 2. Provide law students with an intensive, challenging education in the fundamentals of legal practice, systemic advocacy, and interdisciplinary collaboration necessary to becoming effective problem solvers and socially responsible, service-oriented attorneys.” (Benfer, 2012)

The report details the demographic and statistical characteristics of the clients accessing the program (Benfer, 2012). The authors’ report that of the 33,000 Chicagoans served by the clinic each year, 35% of the program's clientele lack health insurance, and 96% are below the United States Federal Poverty Line (Benfer, 2012). The report outlines the ‘IHEAL’ model of intervention which attends to income assistance and insurance, housing and tenant rights, education, advocacy and appeals, and legal referrals (Benfer, 2012). The report also uses case studies to demonstrate how the centre has supported specific clients using this framework through resource counseling, individual advocacy and referral, as well as public policy advocacy (Benfer, 2012).

Although this is a brief report on an educational intervention, it details a novel and exciting program. *The Health Justice Program*, a similar legal program in Toronto, is a collaborative effort of ARCH Disability Law Centre, Aboriginal Legal Services Toronto, HIV & AIDS Legal Clinic of Ontario, and Neighbourhood Legal Services. Although this program aims to support patients who are low-income and have legal problems threatening their health and wellbeing, it does not incorporate the multi-disciplinary collaboration of the Loyola project.

It would likely be helpful to access the original project proposal or program development plan for the *Health Justice Project* to better understand the theoretical and methodological underpinnings of the project. These components have been overshadowed in this article by the authors' focus on practice aims and outcomes of the current project.

Tyler (2010) also reported on her experience engaging in collaborative medical-legal education in the article, *Teaching Social Justice and Health: Professionalism, Ethics, and Problem-Solving in the Medical-Legal Classroom*. This paper details the work of the author to conceptualize and implement a collaborative medical-legal curriculum focused on the intersection between the law and social determinants of health, and the ways doctors and lawyers can partner to address social and health disparities (Tyler, 2010). The author reports that one of the goals of the program was to broaden both law and medical students' appreciation of the role law may play in health, specifically the health of vulnerable individuals and populations (Tyler, 2010).

In order to realise the program's goal of a blended approach to medical-legal education, the author describes the process of curriculum development, and the substantive ways in which health and law intersect (Tyler, 2010). She also reflects on how a failure to protect an individual's legal rights or enforce laws on their behalf may impact health outcomes (Tyler, 2010). The author cites three lessons learned from her experiences. First, she centres the importance of inclusive learning spaces with accessible, relevant learning for all students (Tyler, 2010). Second, she reports that the institutionalization of the course at every university is crucial and can be aided through early reflection on its inclusion in the curriculum (Tyler, 2010). Third, she concludes that complex problems ought to be matched with complex problem-solving skills and practical solutions (Tyler, 2010).

This article offers an interesting practical account of implementation of a medical-legal educational program aimed at addressing social inequality and health disparities (Tyler, 2010). Other articles and studies reviewed in this paper have explored how health advocacy training in medical education could be reconceptualized and its efficacy improved (Tyler, 2010). This article demonstrates a relatively novel pedagogical framework at the intersection of these two professions. This writer would encourage reflection on how other professions and perspectives like public health and social work could also contribute to this curriculum.

In a 2014 article in the Cornell Journal of Law and Public Policy, Wiley explores health law as a vehicle for social justice. The author proposes that health justice offers an alternative to the market competition and patient rights paradigms that dominate health law advocacy, scholarship, and reform, and uses a health justice lens to examine the role of law in reducing health disparities (Wiley, 2014). The objective of the project, the author reports, is to label, describe, and promote the “health justice” movement by considering how health law could be considered instruments of social justice (Wiley, 2014).

The author employs an interdisciplinary theoretical approach to support their proposition (Wiley, 2014). In addition to legal scholarship the author draws on ethics and political philosophy to support their claims (Wiley, 2014). In Part 1, the author explores social justice as a framework to address health disparities and its use in the environmental justice movement, the reproductive justice movement, and the food justice movement (Wiley, 2014). Part 2 of the article describes how a health law toolkit could reduce health disparities by ensuring equitable access to affordable, high quality health care, fostering healthier behaviors, and enabling healthier living conditions (Wiley, 2014). Part 3 of the article draws on the social justice framework proposed in Part 1, as well as recent literature on social justice from the fields of ethics and political philosophy, to assess the health disparity interventions proposed in Part 2 (Wiley, 2014).

The author suggests there are three emergent commitments that stem from use of a health justice framework to reduce health disparities (Wiley, 2014). First, the author argues for commitment to broader inquiry that understands access to healthcare as a social determinant of health deserving of consideration and resources (Wiley, 2014). Second, the author promotes examination into the impact of class, racial, and other forms of social bias, and their impact on the design and implementation of interventions aimed to reduce health disparities (Wiley, 2014). Lastly, the author argues for a commitment to collective action grounded in community engagement and participatory equity (Wiley, 2014). The author draws attention to the tensions within the social justice framework and the health justice movement and argues that these tensions illustrate the power of viewing health law as social justice (Wiley, 2014).

With a critical eye to incongruencies in how the field of health law defines itself, this article effectively draws on scholarship from the fields of environmental, reproductive, and food justice legal scholarship, to propose a conceptualization of the health justice framework as a tool of social justice advancement (Wiley, 2014). The author imbeds this theoretical proposition within prescient academic discourse from the fields of ethics and political philosophy as well as the current health policy landscape in the US (Wiley, 2014). Given that the social determinants of health have been studied in greater depth within the social-science, public health, and bioethical arenas, this nod to interdisciplinary scholarship, seems well suited to the author’s aims.

This paper was written within the context of the American health care system and there are obvious differences between Canada’s single payer system and the private market in the US. There remains, however, philosophical, and ethical parallels that affirm the relevance of this article within the Canadian health law context. In particular, the author calls for a health justice framework that effectively engages with the broader social justice movement. Without this engagement, the author argues that reform efforts will be assessed as an isolated exception to the norm, while the norm itself still stands (Wiley, 2014). Given current moves to depict privatization as a cure for Canadian health care woes, the authors’ position that market-justice reinforces a narrow conception of health care that is dominated by the healthcare industry seem particularly salient.

While there is a scarcity of literature exploring the intersections of health law, social justice and health advocacy, it is possible to conceive of how legal advocacy can fit within some of the conceptions of advocacy offered in the literature. Meili et al. (2016) posit that if the primary goal of physicians is optimal health for their patients, professionals must also consider the greater health of society. Thus, the power of the physician voice must be leveraged to furnish positive political and systemic change (Meili et al., 2016). They propose a conception of social accountability at the macro level which includes activities such as joining and creating advocacy groups, collaborating with other campaigns and organizations to engage in political discourse, engaging in professional organization leadership to influence policy making and funding decisions (Meili et al., 2016).

These suggestions mirror some of those offered by Hubinette et al. (2014) in their vision of supraclinical advocacy. Included in the potential practical application of their theoretical model is the activities of collective or collaborative action, focus on population health, engagement in public policy change and public education, use of influence for social change and improvement of the health care services (Hubinette et al., 2014).

Dobson et al. (2015), similarly lists the actions of the activist to include awareness raising amongst colleagues and administrators, letter writing and lobbying of government, influencing decisions about resource allocation, and founding associations or organisations. Further activities of knowledge exchange at the community and system level include trainee education on the social determinants of health, engaging with community groups, authoring commentaries, engaging with local or national organizations, providing media interviews about health topics, and researching and disseminating scholarship related to health inequities (Dobson et al., 2015).

Finally, Gruen et al. (2004) describe advocacy participation outside of regular practice settings to include activities like raising public awareness of health and social issues through informal and public forums, letter writing, petition signing, lobbying, collective actions to address health issues, encouraging professional medical organizations to act on relevant issues, organizing for political advocacy, voting, participating in a political campaigns, serving on a political interest groups, and attending rallies and protests (Gruen et al., 2004).

Although the examples of medical-legal collaboration noted earlier in this paper focus on advocacy at the clinical/education level, this writer is left wondering how legal health advocacy can map onto the conceptions of system level participation illustrated by Millie, Hubinette, Dobson, and Gruen. These authors have laid a foundation on which an understanding of systems level advocacy, could conceivably incorporate legal participation as a reasonable extension of physician action.

This paper has and will largely focus on the use of physician advocacy to challenge laws and policies seen to be unjust, however it is conceivable that physician legal advocacy could also be activated to champion equitable enforcement of laws (like those enforcing public health standards), engagement with Human Rights Tribunals to support communities experiencing discrimination on the basis of protected grounds, or political lobbying in support of issues like guaranteed income legislation or decriminalization of street drugs.

5.0 Legal Health Advocacy Case Studies

The introduction of this paper cited Dr. Andrea Serada's testimony in the recent Ontario Superior Court decision on *The Region of Waterloo v. Persons Unknown* (2023) and asked the question of whether her testimony could be understood as legal health advocacy. Her testimony demonstrated collaboration with the legal counsel to advance the defendants claims. Dr. Sereda is a highly regarded physician with significant experience treating illness which is the sequelae of homelessness and poverty. Her contributions to the court record highlighted the causal relationship between the social phenomenon of encampment eviction and its devastating health consequences. Although the provision of a legal affidavit has not been studied as a potential tool of physician advocacy, there are evident parallels in both the theoretical aims and practical application of health advocacy as it has been delineated in the literature.

In this section we will examine two additional legal case studies which potentially demonstrate the health professional's engagement in legal advocacy. The identified case studies include R v. Morgentaler (1985, 1988, and 1993), and Cambie Surgeries Corporation v. BC (2022). In the former cases the physician in question made multiple legal appearances after he practiced in direct conflict with the law as a means to advocate for legal and social change, and in the latter a physician and surgical care centre argued for privatization of public health care to address surgical wait-time.

5.1 Dr. Henry Morgentaler

In 1969, Dr. Henry Morgentaler opened an abortion clinic in Montreal in defiance of the *Criminal Code* (CBC, 2009). In 1970 the clinic was raided, and Morgentaler was charged with several offences marking the beginning of a twenty-year legal journey for the women's health physician (CBC, 2009). Through a series of arrests, acquittals, dismissals and appeals, Morgentaler's professional and legal career mapped onto two decades of social transformation and governmental evolution (CBC, 2009; McGill, 2018). Although it is beyond the scope of this paper to outline the entirety of Morgentaler's legal encounters, this paper will briefly summarize three key decisions from 1985, 1988 and 1993 below.

5.2 R. v. Morgentaler, Smoling and Scott, 1985

In 1985 Dr. Leslie Frank Smoling, Dr. Robert Scott, and Dr. Henry Morgentaler were tried for conspiracy to procure a miscarriage contrary to ss. 251(1) and 423(1)(d) of the *Criminal Code* (1985). Dr. Morgentaler believed this legislation was an unjust restriction of women's rights, and publicly advocated that women ought to have "an unfettered right to choose whether or not an abortion is appropriate" in their individual circumstances (R v. Morgentaler, 1988, pg. 31, par b). In addition to this public advocacy, Morgentaler is estimated to have performed over 80,000 terminations during his career, many of which were in violation of the *Criminal Code* (McGill, 2018). The doctors were acquitted but, on a Crown appeal of that acquittal, the physicians sought to argue that s. 251 of the *Criminal Code* (1985) was unconstitutional because it infringed the right to life, liberty and security of the person and the guarantee to fundamental justice under s. 7 of the *Canadian Charter of Rights and Freedoms (1982)* (R. v. Morgentaler, Smoling and Scott, 1985).

The court found s. 251 of the *Criminal Code (1985)* to be constitutional (R. v. Morgentaler, Smoling and Scott, 1985). The guarantee to life, liberty and security of the person in s. 7 of the Charter (1982) was, it found, not limited to protection against arbitrary arrest and detention (R. v. Morgentaler, Smoling and Scott, 1985). The court decided that S. 251(4) of the *Criminal Code (1985)* set out a system for legal abortions where a hospital therapeutic abortion committee has certified that continuation of the pregnancy would place the life or health of the woman at risk (R. v. Morgentaler, Smoling and Scott, 1985). Further, the court found that s. 251 of the *Criminal Code* (1985) would not deprive a woman of her right to terminate pregnancy other than in accordance with the principles of fundamental justice (R. v. Morgentaler, Smoling and Scott, 1985). Finally, the Court of Appeal decision stated that while the courts are not limited to procedural review when applying the principles of fundamental justice and may also review the substance of the legislation, such substantive review should take place only in exceptional cases where there has been a marked departure from the norm of civil or criminal liability resulting in the infringement of liberty or in some other injustice (R. v. Morgentaler, Smoling and Scott, 1985).

An appeal of this decision was allowed by the Supreme Court of Canada on January 28, 1988. This decision will be briefly outlined below.

5.3 R. v. Morgentaler, 1988 CanLII 90 (SCC), [1988] 1 SCR 30, <https://canlii.ca/t/1ftjt>, retrieved on 2023-04-16

In an important and precedent setting decision, the Supreme Court majority held (with three separate reasons) that the appeal should be allowed, and the acquittals restored (R. v. Morgentaler, 1988). The court asked the following constitutional questions:

1. Does section 251 of the *Criminal Code* of Canada infringe or deny the rights and freedoms guaranteed by ss. 2(*a*), 7, 12, 15, 27 and 28 of the *Canadian Charter of Rights and Freedoms*?

2. If section 251 of the *Criminal Code* of Canada infringes or denies the rights and freedoms guaranteed by ss. 2(*a*), 7, 12, 15, 27 and 28 of the *Canadian Charter of Rights and Freedoms*, is s. 251 justified by s. 1 of the *Canadian Charter of Rights and Freedoms* and therefore not inconsistent with the *Constitution Act, 1982*?

3. Is section 251 of the *Criminal Code* of Canada *ultra vires* the Parliament of Canada?

4. Does section 251 of the *Criminal Code* of Canada violate s. 96 of the *Constitution Act, 1867*?

5. Does section 251 of the *Criminal Code* of Canada unlawfully delegate federal criminal power to provincial Ministers of Health or Therapeutic Abortion Committees, and in doing so, has the Federal Government abdicated its authority in this area?

6. Do sections 605 and 610(3) of the *Criminal Code* of Canada infringe or deny the rights and freedoms guaranteed by ss. 7, 11(*d*), 11(*f*), 11(*h*) and 24(1) of the *Canadian Charter of Rights and Freedoms*?

> 7. If sections 605 and 610(3) of the *Criminal Code* of Canada infringe or deny the rights and freedoms guaranteed by ss. 7, 11(*d*) 11(*f*), 11(*h*) and 24(1) of the *Canadian Charter of Rights and Freedoms*, are ss. 605 and 610(3) justified by s. 1 of the *Canadian Charter of Rights and Freedoms* and therefore not inconsistent with the *Constitution Act, 1982*? (R. v. Morgentaler, 1988, pg 31-32)

The first constitutional question was answered in the affirmative in regard to s. 7 and the second in the negative in regard to s. 7 (R. v. Morgentaler, 1988, pg 32, par e). The third, fourth and fifth constitutional questions were answered in the negative (R. v. Morgentaler, 1988, pg 32, par e). The sixth constitutional question was answered in the negative with respect to s. 605 of the *Criminal Code* (1985) and was not answered in regard to s. 610(3) (R. v. Morgentaler, 1988, pg. 32, par. f). The seventh constitutional question was not answered (R. v. Morgentaler, 1988, pg. 32, par f).

The majority opinion consisted of three distinctive reasons as defined by different judges. All three of the majority assessments agreed that the conditions outlined in *Criminal Code* Section 251 (1985) were unlawful (R. v. Morgentaler, 1988). All three-majority judgments shared a common agreement that the procedural conditions breached the section 7 right of “security to the person” (McGill, 2018). Justice Wilson also believed the abortion law breached section 2 of the *Charter (1982)* and the individual's right to freedom of conscience (McGill, 2018).

Section 7 of the *Charter* (1982) also featured heavily in the 1988 ruling in *R v. Morgentaler* in support of a woman’s substantive right to bodily integrity. The decision recognized a breach of the *Charter* (1982) right to security of the person due to bodily interference, delay, and the psychological harm caused by section 251 of the *Criminal Code* (R. v. Morgentaler, 1988, pg. 33, par a). The majority decision found this infringement represented a failure to comply with the principals of fundamental justice (R. v. Morgentaler, 1988, pg. 33, par b).

In the years leading up to the Supreme Court appeal, Henry Morgentaler was charged with violating section 251 (Criminal Code, 1985) on multiple occasions. Although acquitted several times by juries he was sentenced to prison for refusing to follow law that he felt was an unjust insult to women's autonomy (McGill Blog, 2018, par. 3). By publicly defying the law and refusing to move the issue away from the public gaze, this writer would argue that Dr. Morgentaler galvanized a movement which ultimately led to a Supreme Court ruling celebrated by reproductive rights activists.

5.4 R. v. Morgentaler, 1993

The 1988 Supreme Court decision meant that abortion was no longer regulated by criminal law. It was no longer an offence to obtain or perform an abortion in a clinic such as those run by Dr. Morgentaler (R. v. Morgentaler, 1993). A year later, in January 1989, it was rumoured in Nova Scotia that the Dr. Morgentaler intended to establish a free-standing abortion clinic in Halifax, an intention the he publicly acknowledged (R. v. Morgentaler, 1993).

In March 1989, the Nova Scotia government approved regulations prohibiting the performance of an abortion anywhere other than in a place approved as a hospital as well as a regulation denying medical services insurance coverage for abortions performed outside a hospital (R. v. Morgentaler, 1993). These actions were established to ostensibly prevent the establishment of free-standing abortion clinics in Halifax.

Despite these actions, Dr. Morgentaler opened his clinic and was later charged with 14 counts of violating the *Medical Services Act* (R. v. Morgentaler, 1993). Initially, the clinic only provided counselling and referrals to Dr. Morgentaler's Montreal clinic (R. v. Morgentaler, 1993), however, on October 26, 1989, Dr. Morgentaler defied the Nova Scotia legislation by performing seven abortions (R. v. Morgentaler, 1993). He announced that he had done so at a press conference later that day (R. v. Morgentaler, 1993). Several days later he performed seven more abortions and was consequently charged with 14 counts of unlawfully performing a designated medical service, namely an abortion, other than in a hospital approved as such under the *Hospitals Act*, contrary to s. 6 of the *Medical Services Act* (R. v. Morgentaler, 1993).

Dr. Morgentaler publicly announced his intention to continue his activities in contravention of the *Ac*t, and on November 6,1989 the government of Nova Scotia obtained an interim injunction under s. 7 of the Act to restrain him from further violations of the Act (preforming abortions) pending the resolution of the charges and the constitutional challenge in court (R. v. Morgentaler, 1993).

Dr. Morgentaler did not dispute that he had performed the abortions as alleged. He argued, instead, that the Act and the regulation were inconsistent with the Constitution Act (1982) and consequently of no force or effect, on the grounds that they violated women's *Charter* (1982) rights to security of the person and equality and that they were an unlawful intrusion of the federal Parliament's exclusive criminal law jurisdiction (R. v. Morgentaler, 1993). He also argued that the regulation was an abuse of discretion by the provincial cabinet and therefore in excess of its jurisdiction (R. v. Morgentaler, 1993).

The trial judge held that the legislation was outside the province’s jurisdiction because it was “in pith and substance” criminal law and acquitted the physician (R. v. Morgentaler, 1993). This decision was upheld by the Court of Appeal (R. v.

Morgentaler, 1993). The court found that the legislation had an effect virtually indistinguishable from that of the now invalid abortion provision of the *Criminal Code (1985)*, and this overlap of legal effects could support the inference that the legislation was designed to serve a criminal law purpose (R. v. Morgentaler, 1993).

The R v. Morgentaler (1998) ruling supports the concept of distributive justice through its recognition of the burden afforded to women who cannot access the resource of hospital-provided abortion with the same ease of women of different privilege (R v. Morgentaler, 1988, pg. 33, par. d). This ethical claim was reflected in Dr. Morgentaler’s practice of clinic-based abortions which flouted the criminal restriction of abortion to hospital setting (McGill Blog, 2018). Where distributive justice claims fail however, lies in the continued challenge that women (particularly rural, northern and Maritime women) face in accessing therapeutic abortions as governed by provincial health regulations (Marshall & McLaren, 2013).

Regardless of a person’s stance on reproductive health, this writer argues that substantive justice and the social conception of autonomy was influenced by Dr. Morgentaler’s actions. In turn, the law has influenced the public perception of these same acts and subsequent actions to follow. Had Henry Morgentaler not continued to perform therapeutic abortions while simultaneously being charged for the same and advocating for change, then the public sentiment and its impact on the efficacy of the Criminal Code may not have shifted in advance of, and in keeping with the Supreme Court ruling on the criminality of preforming abortions. The wheels of justice may have slowly turned in the same direction, but these acts arguably created a climate of compassion, urgency, and accountability to which the courts have (as least in part) responded.

How then, do Dr. Morgentaler's legal actions map onto academic conceptions of legal advocacy? By the measure of some of the frameworks described above, collective action, letter writing, and public engagement alone can meet the requirement of public or system-level advocacy. These are actions that Dr. Morgentaler also participated in; however, his actions were arguably more effective as they happened concurrently with his breach of the criminal code. Is breach of law or policy a necessary component of effective health advocacy? Or does a breach of the law invalidate advocates moral claim? Donald Berwick (2020) references the work of philosopher Immanuel Kant and the “moral law within” when considering the moral determinants of health. He writes that all nations (short of dictatorships) form a moral accord as the basis of a just society yet the moral force of professional leadership can be influential when grounded and mobilized (Berwick, 2020).

Perhaps the actions of Dr. Morgentaler can be framed as those which belong on the far end of Gruen et al’s (2004) spectrum of physician responsibility and aspiration. However, by their own account, that distinction ought to be based on evidence of causation of illness in individual patients and the feasibility and efficacy of physician action (Gruen et al., 2004). Pregnancy can be a life-threatening condition for many reasons and Dr. Morgentaler’s actions proved to be quite effective. However violation of a criminal law may be outside the boundaries of what many would consider feasible.

Is a specific moral perspective the pre-requisite of constructive health advocacy? This question will be particularly salient when considering the next example of *Cambie*

Surgeries Corporation v. BC (Attorney General) who arguably used the pretext of social advocacy to disguise their motivation of financial gain. Although much of the literature examines physician advocacy as a means to address the social determinants of health and promote social justice, does advocacy that falls outside of these virtuous moral aims still count as advocacy? Further, how can these moral claims be measured and by whom?

While many physicians and health professionals spoke publicly in support of health inequities and population health during the Covid-19 pandemic, a cohort of professionals spoke out in criticism of public health protection measures. Theirs was an opinion that was arguably not backed up by scientific evidence but was still espoused by a not-insignificant portion of the population.

5.6 Cambie Surgeries Corporation v. British Columbia (Attorney General), 2022

The appellants in this case — including Cambie Surgeries Corporation, Dr. Day and the Specialist Referral Clinic Inc. — challenged the prohibition on private billing by enrolled BC physicians (Palmer, 2023).

The appellants alleged that the limits on charging patients privately, in accordance with the *Canada Health Act* (1985) and the *BC Medicare Protection Act* (1996), infringe patients' rights to life, liberty, and security of the person under Section 7 of the *Canadian Charter of Rights and Freedoms* (Palmer, 2023). They contended that certain provisions of the *Medicare Protection Act* (1996) were unconstitutional because they effectively prevented patients in British Columbia from accessing private medical treatment that would otherwise be available to them when the public system cannot provide timely access to necessary care (Cambie Surgeries Corporation v. British

Columbia (Attorney General), 2022). They claimed the impugned provisions breached patients' rights to life, liberty, and security of the person under s. 7 of the *Charter* (1982) and were not saved by s. 1 (Cambie Surgeries Corporation v. British Columbia (Attorney General), 2022). Further, the appellants alleged multiple errors of fact and law in relation to both the s. 7 and s. 1 analysis of the initial trial (Cambie Surgeries Corporation v. British Columbia (Attorney General), 2022).

The appellants argued that since the publicly funded system causes some patients in some jurisdictions to wait for some medically necessary services, patients should have the right to obtain such services more quickly by paying privately, either out-of-pocket or through private insurance (Palmer, 2023).They promoted a system of "dual practice" in which physicians can be paid from both public and private funds, including through private duplicative health insurance covering the same medically required hospital and physician care covered under MSP (Palmer, 2023).

Beyond this, the plaintiffs also argued that even physicians still enrolled in MSP should be allowed to "extra bill" patients — through out-of-pocket payment and private insurance — who do not wish to wait their turn for publicly-funded care (Palmer, 2023). Essentially, the plaintiffs sought to overturn three key provisions of the *BC Medicare Protection Act* (1996): the prohibition on private duplicative insurance, the limits on extra billing, and the ban on dual practice (Palmer, 2023).

In a decision that will have far-reaching implications across the Canadian health care landscape, The BC Court of Appeal dismissed the appeal. Chief Justice Bauman and Justice Harris did so on the basis that although the impugned provisions deprive some patients of their rights to life and security of the person, they do so in accordance with principles of fundamental justice (Cambie Surgeries Corporation v. British Columbia (Attorney General), 2022). Although unnecessary to decide the case under s. 1, they agreed with Justice Fenlon that, even if the provisions breach s. 7, they are saved by s. 1 (Cambie Surgeries Corporation v. British Columbia (Attorney General), 2022).

Justice Fenlon, in concurring reasons, also dismissed the appeal. She found that the provisions do deprive some patients of their rights to life and security of the person in a manner that is not in accordance with the principles of fundamental justice and the deprivations are grossly disproportionate (Cambie Surgeries Corporation v. British Columbia (Attorney General), 2022). However, in her opinion, the s. 7 breach is justified under s. 1 of the Charter (Cambie Surgeries Corporation v. British Columbia (Attorney General), 2022).

Meili et al. (2016) argue that physician advocacy can be undermined when the public perceives that advocacy is undertaken to advance a physician’s own interests or financial gain. They caution that that this can be viewed as a “self-serving” advocacy role and that advocacy of this kind “must be tied to the to the desire to design renumeration in ways that incentivize the best practice for patients” (Meili, 2016, pg 786). Although Dr. Day and Cambie Surgeries may have presented their legal action as an altruistic endeavor to improve patient outcomes, they also stood to benefit from substantial financial gain as a result.

Does this mean that the legal action of Dr. Day and Cambie Surgeries is not advocacy? It is true that our current health-system is bending under the burden of restricted resources and ever-growing wait-times. On its face, the evidence presented by the appellant in trial offers a potential means to address health care delivery issues. That said, claims that privatization will improve the current system ignore “evidence that private healthcare will harm the public system by, for example, creating or exacerbating inequity, increasing demand for services and increasing overall costs, and reducing the capacity of the public system as medical manpower is lured to the private tier” (Flood, pg 223).

This writer is reminded, when considering the issue of the legitimacy of physician advocacy, of the domains of physician responsibility outlined by Gruen et al. (2006). As we discussed earlier, the domains are distinguished by how directly various socioeconomic factors influence patient health and the feasibility and efficacy of physician advocacy (Gruen et al., 2006). In the case of Cambie Surgeries, the appellant attempted to illustrate a causal relationship between extended wait-times and patient best interests, but neglected the potential harms to many patients that would result from a change in the legislation. Further, they privileged an argument from which they would financially benefit over that which affords some measure of equitable access to those who would be shut out of a private pay or two-tier system.

Returning to the question of whether the legal action taken by Dr. Day and Cambie Surgeries qualifies as advocacy, this paper will argue no. Although there is a prima facie claim to health access in the appellants application to the court, the claimants willfully disregarded how their claim would harm the most disenfranchised and vulnerable of their population. The claimants chose a solution that would both benefit themselves and harm others. They did not meet the burden of proof that their aim is to mitigate the impact of the social determinants of health, a key component seen across many definitions of health advocacy.

6.0 Conclusions

Authors have detailed the long history of physician advocacy for illness that reflects the social, political, environmental, and economic conditions in which people live (Benfer et al., 2012; Bhate & Loh, 2015; Hatchett et al, 2015; Huddle, 2011; Lieb et al., 2022; Launer, 2021; Meili et al., 2016; Palfrey & Chamberlain, 2011; Podolsky and Jones, 2022; Schickedanz et al., 2011). Starting with Rudolf Vichow who pioneered advocacy for political reform, food safety, and sewer systems, and tracking the important contributions of health professionals through the centuries (Podolsky and Jones, 2022). It takes very little imagination to understand how individuals who are intimately aware of individual, community, and population health are uniquely positioned to bear witness to the effects of poverty, exclusion, insecure housing, and limited education. Vichow is quoted to have stated “physicians are attorneys of the poor, and social problems fall to a large extent within their jurisdiction” (as cited in Podolsky and Jones, 2022).

Given this tacit knowledge, it seems reasonable to expect that physicians will leverage their social capital and privilege to benefit those communities they serve, and from whom they are granted elevated social status, financial security, and the ability to self-regulate.

This paper has offered several interpretations of advocacy which this writer will categorize broadly as clinical and public advocacy and detailed the ways in which these ideas can be operationalized. Gruen et al. (2006) define the physicians' public role to be "advocacy for and participation in improving the aspects of communities that affect the health of individuals" (pg 2467). Earnest et al. (2010) identify advocacy as "action by a physician to promote those social, economic, educational, and political changes that ameliorate the suffering and threats to human health and well-being that he or she identifies through his or her professional work and expertise" (pg 63). Chimonas et al. (2021) write that "in recent decades physician advocacy, particularly regarding social determinants of health and just distribution of resources, has been embraced as a core component of professionalism" (pg 1). Indeed, this paper has highlighted how these ideals have tracked onto professional standards such as the CanMED framework (RCPSC, 2023) and AMA (2001) Code of Medical ethics. As John Launer (2021) writes "doctors who believe that medicine and politics are entirely separate will be seen as fundamentally out of touch with medicine or politics, or both" (pg 611).

Despite this, there remains some resistance to these ideas, inconstancy invoking a core agreement of what advocacy means, and therefore difficulty teaching and operationalizing the skill. However, although there remain differences in the details of how advocacy is defined, there are common commitments to the broad strokes of what it has, and could, address. The inequity and inequalities of the human experience are played out on human bodies. Those who witness, diagnose and benefit from the provision of treatment ought to engage in efforts to address its underlying cause.

This research has helped to synthesize the existing and sometimes conflicting interdisciplinary literature that seeks to define and operationalize health advocacy and examine the concept of legal health advocacy within that framework. This could have implications for health advocacy education and interdisciplinary collaboration and engender a professional commitment to the practice of health advocacy for health professionals.

We have seen examples of medical-legal advocacy that happens at the level of clinical intervention and collaborative education and have detailed how academics conceptualize public medical advocacy. This itemization of the practice of advocacy furnishes some ideas of how these practices can include legal advocacy. Finally, we have considered two examples of how physicians have used the courts to set transformative legal precedents.

Robert Lifton, who studied German doctors complicit in the crimes of the Holocaust wrote that “as citizens, and especially as professionals, we need to bear witness to malignant normality and expose it… that inevitably includes entering into social and political struggles against expressions of malignant normality” (as cited in Launer, 2021, pg 611). The law is a blunt instrument but a powerful tool. When wielded by those of significant power and privilege there emerges an opportunity for social change for the “good” however we may define it.

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