



Expanding the advocacy lens: using photo-elicitation to capture patients' and physicians' perspectives about health advocacy

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Received: 24 January 2022 / Accepted: 3 September 2022 / Published online: 10 October 2022
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Abstract

Health advocacy (HA) remains a difficult competency to train and assess, in part because practicing physicians and learners carry uncertainty about what HA means and we are missing patients' perspectives about the role HA plays in their care. Visual methods are useful tools for exploring nebulous topics in health professions education; using these participatory approaches with physicians and patients might counteract the identified training challenges around HA and more importantly, remedy the exclusion of patient perspectives. In this paper we share the verbal and visual reflections of patients and physicians regarding their conceptualizations of, and engagement in 'everyday' advocacy. In doing so, we reveal some of HA's hidden dimensions and what their images uncovered about the role of advocacy in patient care. Constructivist grounded theory guided data collection and analysis. Data was collected through semi-structured interviews and photo-elicitation, a visual research method that uses participant generated photographs to elicit participants knowledge and experiences around a particular topic. We invited patients living with chronic health conditions ($n=10$) and physicians from diverse medical and surgical specialties ($n=14$) to self-select photographs representing their experiences navigating HA in their personal and professional lives. Both groups found taking photographs useful for revealing the nuanced and circumstantial factors that either enabled or challenged their engagement in HA. While patients' photos highlighted their embodiment of HA, physicians' photos depicted HA as something quite elusive or as a complicated and daunting task. Photo-elicitation was a powerful tool in eliciting a diversity of perspectives that exist around the HA role and the work advocates perform; training programs might consider using visuals to augment teaching for this challenging competency.

Keywords Health advocacy · Health professions education · Patients · Physicians · Qualitative · Visual methods

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Introduction

Advocacy by patients and physicians plays an important role in medicine, particularly in recent years where the healthcare system faces growing health challenges. Many patients rely on health advocacy (HA) to assist them in accessing and maneuvering a health care system fraught with inefficiencies and inequalities (Hubinette et al., 2022; Koopman et al., 2021). Similarly, physicians engage in HA at many levels utilizing different strategies, from expediting the diagnostic process for an individual patient to using social media to bring public attention to worsening social determinants of health (Hubinette et al., 2014, 2021). Regardless, HA is an example of a skill that many practicing physicians and by extension, their learners find puzzling. (Endres et al., 2022; Hubinette et al., 2017; McDonald et al., 2019). Despite being identified as a core component of influential physician competency frameworks (Accreditation Council for Graduate Medical Education, 1999; Royal College of Physicians & Surgeons of Canada, 2015) the breadth of advocacy activities is such that it remains an elusive role for both practicing physicians and learners to identify and interweave meaningfully into clinical care (Hubinette et al., 2017, 2021; McDonald et al., 2019; Poulton & Rose, 2015; Stafford et al., 2010; Verma et al., 2005; Wright et al., 2005). Even in medical specialties and sub-specialties where HA education is both prioritized as a critical aspect of patient care and curricular interventions have been implemented, there is little evidence supporting the efficacy of these initiatives (Gordon et al., 2020; Howell et al., 2019; Hubinette et al., 2017). Consequently, practicing physicians and learners are left struggling to attain a clear understanding of what HA means and how it should be enacted, leaving those seeking to bolster HA education wondering how to do this better.

Perhaps more concerning, patients' perspectives about what HA means to them and the role HA plays in their care remains conspicuously absent from most medical education research on how advocacy skills might be more effectively exhibited during clinical interactions. Patient engagement in health professions education is not a new phenomenon; substantial research around patients as meaningful contributors to medical education has been carried out with tangible implications for clinical practice (Bleakley & Bligh, 2008; Gordon et al., 2020; Rowland et al., 2019; Towle & Godolphin, 2013; Towle et al., 2010). Yet, even with the multiplicity of roles patients play in educational development, delivery, and evaluation (Cheng & Towle, 2017; Jha et al., 2010; Kline et al., 2020; Roebottom et al., 2018), combined with greater calls to integrate more rigorous social medicine curricula across the education continuum (Hubinette et al., 2022; MacLeod & Frank, 2010; Westerhaus et al., 2015), meaningful patient involvement in undergraduate and postgraduate medical training remains woefully limited.

Clearly, fresh approaches to understanding and training HA are required. Both clarifying what HA means to physicians and fostering meaningful inclusion of patients' voices into medical education using creative research elicitation strategies may be a valuable place to begin. Visual methods are gaining traction across a wide range of disciplines such as sociology, education, and health professions education as powerful tools for capturing the unique, multi-layered experiences of individuals (Cleland & MacLeod, 2021; Mannay, 2010; Pain, 2012; Paradis & Leake, 2016), and we recently used photo-elicitation to explore patients' and physicians' conceptualizations of competence for the HA role (LaDonna et al., 2021). Patients' and physicians' photographs stimulated insightful conversations about their perceptions of HA and their roles as advocates. We were particularly struck by the ways patients and physicians used photos to capture the complexities of the HA role that oftentimes are overlooked or go unexpressed in medical training and practice.

Here, we distinguish both *how* patients' and physicians' engagement in photo-elicitation enabled them to instill a clearer perspective of HA, and *what* their images reveal about the role of advocacy in patient care. Our goal is to consider the potential benefits of using innovative techniques to unpack and convey diverse sets of expertise and perspectives around HA in ways that words alone cannot.

Methods

We used photo elicitation (Harper, 2002) in combination with constructivist grounded theory (CGT) (Charmaz, 2014) to better understand how patients and physicians conceptualize and enact 'everyday' HA. A central tenet to CGT is the incorporation of multiple participant perspectives to identify and conceptually explain a social process or behaviour (e.g., health advocacy) as it unfolds over time. A further key principle in CGT is how data collection and analysis occur simultaneously rather than sequentially through a method of 'constant comparison' (Charmaz, 2014), with the intention of constructing a rich theoretical account of the phenomenon under study.

Data collection

Recruitment of patient and physician participants occurred via email invitations and posters hung up across one Canadian medical school and affiliated acute-care teaching hospitals, with those interested in participating contacting SB and KL for further study information. We felt combining patients' expertise with physicians' clinical knowledge and familiarity with practice workflow was necessary to generate a holistic understanding about HA. In total, 10 individuals living with a chronic health condition and 14 physicians from diverse medical and surgical specialties with varying years in practice provided written informed consent to take part in this study (Table 1). Data was collected over two research visits using photo elicitation (Harper, 2002), a technique in which participants are asked to create or assemble a photographic record showcasing their experiential knowledge in relation to a particular topic, in this case, their perceptions of, and everyday experiences engaging in, HA. We were drawn to this elicitation method for its strength in promoting participant agency and stimulating exploratory dialogue within the participant–researcher relationship (Frith & Harcourt, 2007; Harrison, 2002; Richard & Lahman, 2015).

During the first research visit, SB explained to participants the purpose of the study and rationale for using photographs to capture their understanding and experiences of health advocacy. During this time, SB engaged participants in a brief conversation about what HA means to them and their perceptions about what health advocates do. Following this, SB asked participants to take pictures about how they define and engage in HA throughout their daily lives and professional work. Participation in the photo-taking component of the study was optional and instructions were not overly directive, meaning that we neither defined advocacy for participants, nor limited considerations of advocacy to a specific health condition or activity. At this time, we also reviewed with participants the ethical considerations of using the photo-elicitation technique (Bugos et al., 2014). All participants were informed on how their photographs would be used or shared in the dissemination phase of the project. In instances where participants wished to take or include a photograph of another person or group of people, written consent from each individual in the photograph was required. Participants had anywhere from 3 to 6 weeks to take

Table 1 Participant demographics table

Patient participants			Physician participants		
Patient ID	Diagnosis	Sex	Physician ID	Specialty	Sex
1	Mental Health	F	1	Respirology	F
2	Breast Cancer	F	2	Neurology	F
3	Multiple Comorbidities	F	3	Anesthesia	F
4	Breast Cancer	F	4	Gerontology	F
5	High-risk pregnancy	F	5	Endocrinology	M
6	Muscular Dystrophy	M	6	Neurology	M
7	Type 1 Diabetes	M	7	Pediatrics	M
8	Multiple Comorbidities	M	8	Emergency Medicine	F
9	Addison's disease	F	9	Psychiatry	M
10	Multiple Comorbidities	F	10	Psychiatry	F
			11	Oncology	M
			12	Family Medicine	F
			13	Neurosurgery	M
			14	Pediatrics	F

pictures. Participants then returned for a second research visit where they were asked by SB to describe each of their photographs (e.g., “Tell me why you took this photograph? How does this picture illustrate HA?”) and included probing questions aimed at encouraging participants to elaborate on their initial perceptions of advocacy and to describe their approaches to advocacy in their clinical work or related to their health condition. All interviews were audio-recorded and transcribed verbatim.

Data analysis

Analysis in CGT follows a three-phase analytic process: *initial*, *focused*, and *theoretical* coding (Charmaz, 2014). During *initial coding*, SB and KL reviewed line-by-line the first two transcripts from each participant group and developed gerunds (action words ending in “-ing”) or relied on participants’ words (in vivo codes) to encapsulate the experiences, activities and actions described by participants, including those that yielded moments of insight or discovery. At this stage we remained close to the data, paying attention to what participants said, how they described their engagement in HA, focusing on instances when the social processes and behaviours of patients and physicians seemed to align and when they appeared in disharmony. We then assessed the most frequently occurring initial codes and moved to the second phase, *focused coding*, where we consolidated our collection of the most compelling initial codes into a code book which were then applied to the next 3–4 transcripts. The full research team met monthly throughout the data analysis phase to discuss preliminary findings, appraise the analytic level of our chosen codes, and to finalize the coding structure which was then used to refine the codebook used to recode the entire dataset (*theoretical coding*). Particular aspects of our analysis undertaken as part of the original study have previously been published (LaDonna et al., 2021). The findings reported here offer a different perspective, attending specifically to how participants utilized their resulting photographs and narratives to convey and, in many cases, enhance their understanding about HA. Throughout the analytical process, the team focused on how

participants used photographs to indicate the complexities of the HA role, including the unspoken tensions that underlie this competency.

In addition to augmenting the trustworthiness of the study, our regular team meetings afforded us the opportunity to collectively engage in reflexivity, an ongoing process that invites researchers to consciously examine and reflect upon their attitudes, underlying assumptions, and positionality in relation to the research participants and context under study (Barrett et al., 2020). Our team was made up PhD trained medical education researchers with complementary yet distinct areas of expertise. SB frequently relies on multiple narrative texts (visual, spoken, written) to explore people's experiences around a particular perspective or phenomenon and her emerging program of research falls largely under the umbrella of social accountability. KAL regularly uses visual methods to generate understanding about the complexities of clinical training and care, and she has established a program of research aimed partly at strategizing the meaningful inclusion of patient voice in health professions education. SC is a qualitative researcher who uses visual methods to understand how clinicians collectively adapt to unexpected and challenging situations. CJW is both an education researcher and a physician who regularly interacts with complex patients and is responsible for teaching and assessing trainees within the clinical learning environment.

Given the iterative nature of this study, we could not determine sample size a priori. Instead, we concentrated on maintaining openness to divergent and unanticipated findings that perhaps were inconsistent with, or unexplored in previous medical education research about HA. Data collection ceased when we determined we had sufficient data to develop a robust understanding of the process under study (Nelson, 2017). Ongoing written records or 'memos' were maintained throughout each stage of the research process. Birks et al. (2008) describes memos as being "a snap-shot of thought processes at a given stage of the research that facilitates an understanding of what perspectives were held and why decisions were made" (p. 71). For us, the form and structure of our memos evolved depending on study phase. Early on, they served as more of a formal record, where the focus was on describing and documenting important details around our study process. They later took on a more conversational tone, serving as a space for us to 'think aloud' with one another and alongside our data sources to further reflect upon areas of alignment and discordance within participants stories, and—as analysis continued—to trace, compare, and categorize data. Ethics approval to conduct this study was obtained from Western University.

Results

In total, 212 photographs were presented to us by physicians and patient participants, with individual participants sharing anywhere between 0 and 31 photographs. Participants shared with us a variety of photographs, including stock images, screen shots, original images taken for the purpose of this study, and pre-existing photographs from their personal collection. Some photographs were staged to either re-enact past engagement in health advocacy, or to metaphorically depict what it means to be a health advocate. We begin this section by detailing how patients visually documented their understanding of HA and follow with how physicians used photographs to depict their professional experiences engaging in HA. We then elaborate on how both participant groups used visuals to depict what we have labelled the 'hidden dimensions' of HA work, specifically, where they perceived their engagement in advocacy was unseen, overlooked, or met with resistance.

Each participant quote has been assigned a unique identifier based on the participant group and the corresponding interview. For example, P3, I2 signifies Patient 3, Interview 2 whereas MD 4, I1 indicates Physician 4, Interview 1.

Patients' engagement in advocacy: learning to live well with chronic illness

Patients captured images and told stories about their illness experience that evidenced the importance of advocacy in their lives. Patients spoke candidly about their illness and its impact to convey the centrality of advocacy in “taking ownership” (P8, I2) of, and coping with, chronic illness. As one patient remarked, “You’ve got to really take a whole lot into your own hands. That’s how you advocate for yourself” (P3, I1). Most often, engagement in healthy habits and routines, outdoor green spaces and the private space of the home featured prominently in patients’ image-taking (Figs. 1 and 2).

Fig. 1 Patient photograph of smoothie bowls. Shared with permission from Patient 1



Fig. 2 Patient photograph of recreational trail. Shared with permission from Patient 8



Fig. 3 Patient photograph of their personal library. Shared with permission from Patient 1



Patients embraced the opportunity to document and discuss their experiences of being chronically ill, often sharing powerful images and anecdotes of experiences that tended to be invisible to healthcare providers during routine clinical encounters. This was because for many patients, advocacy primarily meant a commitment to proactive self-care. Multiple patients shared photographs of education resources or images of them initiating patient advocacy activities and lifestyle changes they believed positively influenced the course of their illness. For example, one patient participant staged a photo of their personal library, which included a collection of resources that were described as offering invaluable advice and support in learning to live with chronic illness:

This is my little reading corner at home, of all kinds of self-help books and things that have gotten me through the last few years...you have to do research, I really think...Because, you're the person that knows your body best...I find the more I educate myself, the easier it is for my doctor to come up with a solution for me. (P1, I2) (Fig. 3)

Identifying resources to which they could turn to for information and support was highly valued by patients: "it's just really affirming to see someone else tell stories that capture some of the challenges that you are facing" (P4, I1). Patients recognized that physicians cannot "be a superhero all the time" (P1, I1) and in response, saw advocacy as their responsibility, maintaining a commitment to learn—and keep learning—all they could about their illness or condition.

Physicians' engagement in health advocacy: traversing complicated terrain

Unlike patients who were readily able to identify the importance of advocacy in their care journey, some physicians recurrently acknowledged the challenge of taking photos representing their involvement in and understanding of HA. As one emergency physician commented, "I didn't think about calling [a patient] a dentist and getting the [patient] colostomy bags as advocacy. That's just looking after people...I had to think, 'what the heck am I ever going to take a picture of?'" (MD8, I2).

Participating in the photo-elicitation method appeared to encourage some physician participants to engage in deep reflection around the HA role. As one physician participant revealed, "[the process of collecting photos] helped me think about advocacy perhaps more

Fig. 4 Physician photograph metaphorically illustrating the challenges of health advocacy. Shared with permission from MD 4



as a journey than a destination” (MD7, I2). For others, their engagement in photo-taking appeared to prompt a change of consciousness, leading them to reassess the place of HA within the healthcare system:

This is my metal reindeer who has been lying on its side and its head is buried in snow. I think we have had our head in the sand for so long about what healthcare is. It’s not just about curing disease, but it’s about health promotion, recognizing risk (MD 4, I2) (Fig. 4).

It seemed for physician participants that taking photos served as an avenue for them to communicate their evolving understanding of what HA is as well as actively process and label their engagement in HA within the broader health care system.

Who identifies as an advocate?

Patient participants came into the study with a firm understanding of their role as advocates, using visual images to chronicle their engagement in self-advocacy. For those physicians who expressed some uncertainty with regard to their role as an advocate, the use of visuals enabled them to recognize, often for the first time, how advocacy features in their clinical practice:

I’ve never described myself as that [health advocate], but I think others would probably describe me as that. Now talking to you, I would think, yeah, likely I am. I guess I never saw myself as an advocate. I just saw myself as doing what I thought was right. (MD10, I1)

Photos additionally stimulated dialogue around the ‘ideal’ advocate, revealing why most physicians in our study were reluctant to self-identify as a health advocate. For instance, some physician participants shared stock images of iconic advocates like Oprah Winfrey and Mother Teresa. In these circumstances, visuals reinforced for some participants that advocacy requires often going above and beyond the scope of practice, requiring a level of eminence, competence, resources, and devotion they did not feel they necessarily

possessed. We observed this sense of bewilderment during interviews whereby participants engaged with the term health advocate reluctantly, identifying as a “below the radar health advocate” (MD6, I1) or using terms such as a “systems level thinker, a budding or emerging social innovator” (MD10, I2), and “counsellor” (MD11, I1) to describe their engagement in advocacy work. Patients and physicians did, however, align on a critical point: advocacy is not widely perceived as an intrinsic physician role. Patients were more likely to identify family, friends, and other healthcare professionals as influential advocates:

At one point I was on basically a drug, an injection that put me in a fake menopausal state, which comes with a lot of side-effects doing...and the support for that was minimal. It was basically like, okay, this is going to happen to you...hopefully you can deal with it okay, we'll see you next time for your next appointment...I can't call my doctor and talk to them about it. I have to call my other support systems, my other advocates. I have to call my mom on the phone and say, this is awful, I don't feel well...I have to manage it myself...They're not there every single step of the way. (P1, I1)

Similarly, physicians described advocacy efforts being largely carried out by a patient's primary caregiver or their colleagues—case managers, social workers, nurses, and other allied health professionals:

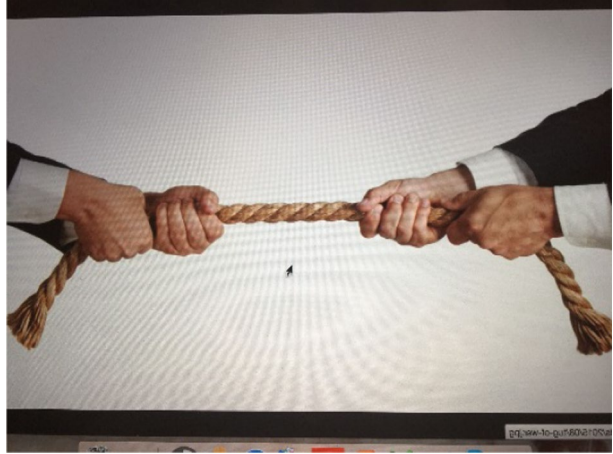
My nurse is a much stronger health advocate than I am...she goes to bat for stuff. If the PICC line can't be inserted next week, she'll start calling people and saying we need to get this done...She makes a fuss on behalf of the patients. I don't make a fuss on behalf of the patients, except if it really is problematic. (MD11, I1)

Physician participants who perceived they played a role in advocacy recognized that it requires “working with a team, and not just blazing your own trail” (MD9, I1) because “you can't do it all on your own. You can't take it all on yourself” (MD14, I1). Interestingly, the role of patients in advocacy was an area of discord; although the vast majority of patients' photographs captured their engagement in HA work, physician participants rarely mentioned—or took pictures capturing—patients as part of this team. More often, physicians' photos and subsequent stories conveyed HA as something they needed to do for, rather than with, patients. Regardless, both participant groups recognized that cultivating a community of advocates, both inside and outside the health care system was necessary, and that physician advocacy alone was helpful but insufficient.

Making visible the hidden dimensions of health advocacy work

While patients and physicians entered our study with different understanding and goals related to HA, the use of visuals prompted both groups to delve deeply into the depth and complexity of their HA experiences. What soon became apparent was how each participant group used visuals to document and make visible the inconspicuous dimensions of HA that were either easy to overlook during a clinical encounter or appeared trivial in comparison to more public forms of advocacy such as community service or political involvement. In other words, participant photos revealed the candor of their advocacy work—for better or worse. For example, it was not uncommon for physicians, particularly those who readily self-identified as advocates, to share visual metaphors depicting the tension between being a caretaker for patients and a gatekeeper of hospital resources:

Fig. 5 Physician photograph depicting the struggle of advocacy work in healthcare. Shared with permission from MD 13



The tug of war idea was around how sometimes it feels that there are diametrically opposed goals that physicians have to manage.... You want to be the best advocate, but also the best caregiver for your patient. You want to make sure that you're doing everything you can to give them an accurate diagnosis and timely treatment, and at the same time, you're a steward of the health system.... how do you balance those things? (MD13, I2) (Fig. 5)

For physician participants, assuming the advocate role for a patient often meant “dis-advocating for someone else” (MD11, I2). Physicians regularly used visuals to depict the tensions advocacy work creates, acknowledging that reconciling these tensions was a constant pursuit. Many patient participant photos also revealed their advocacy efforts as incredibly tension-filled and “draining at a time when you don’t have extra energy” (P4 I1) albeit in a slightly different manner. Interestingly, even before being enrolled in our study, patients were incorporating visuals into their clinical interactions to address personal concerns with their health care team and negotiate the trajectory of their care. For example, patient participant 2 shared with us a photograph they had taken documenting the accumulated bruising experienced early on in their cancer treatment as a result of receiving frequent IVs. By showing their physician the photo seen here (Fig. 6), they were able to advocate for a chemo port whereby medications could be delivered directly into the port rather than a vein.

Yet, with advocacy comes the risk of being considered a nuisance and for some patients, their photos lead to conversations about the potential repercussions of their advocacy efforts. They sought to be heard and understood by their health care providers, but often their concerns were ignored or met with a terse reply—as evidenced by this example:

When my oncologist gave me the results of my liver biopsy and said, you have stage four breast cancer and we need to start chemotherapy ... There are a lot of questions that come to your mind, but none of them ... it’s hard to formulate them. I think I said, are there any complementary therapies that I should consider? Complementary therapies, to me, means things that go along with medicine, not alternative therapies. I think he said no before I finished the question. And so, I was like, okay, I cannot talk to you about this. (P4, I1)

Fig. 6 Patient photograph exemplifying the use of visuals during a clinical encounter with their physician. Shared with permission by Patient 2



Most patient participants had similar stories, using their photographs to help us gain insight into their personal experience of illness. Participants noted how their interactions within the healthcare system were at times frustrating, but nonetheless they had to be measured in their response because “if you get upset or angry, they will not deal with you” (P3, II).

The photo-elicitation method appeared to help elucidate the complex and, in some cases, invisible processes of how patients and physicians understand and engage in HA. It also revealed tensions, documenting not only patients’ experiences of peripheralization in medical care but also the invisible HA work both patients and physicians regularly engage in.

Discussion

Combining visual tools with interview methods has proven illuminative when seeking a more nuanced understanding of nebulous topics in health professions education such as complexity (LaDonna et al., 2018; Molinaro et al., 2021) or to engage with the experiences of people living with chronic conditions in ways that promote individual agency and lessen the risk of disempowerment (LaDonna & Venance, 2015). Furthermore, research using visual imagery has been shown to be a valuable reflective learning tool for those directly participating in the creative process (Brand et al., 2016; Wald et al., 2010). Recognizing its potential, we set out to understand what the photo-elicitation technique (Harper, 2002) might help us better understand about HA. We invited patients and physicians to take photographs representing their perceptions, interactions, and daily experiences navigating HA in their personal and professional lives with the hopes of generating a better understanding of this poorly understood, yet critically important aspect of care.

Engagement in the photo-elicitation method allowed for more in-depth understanding of both patients’ and physicians’ perspectives around HA, and in turn, demystified the reality of their advocacy work. It seemed to additionally give participants the freedom to

explore their experiences in their own unique way, evoking in most participants a heightened awareness of what HA means and how it unfolds within and outside the clinical environment. Both participant groups recognized the value of HA. However, the use of visuals made obvious the fundamental differences in how patients and physicians articulate and assume the HA role, widening our knowledge of what constitutes and impedes advocacy work as well as providing insight into why HA training lags behind that of other competencies (Bhate & Loh, 2015; Endres et al., 2022; Hubinette et al., 2022).

For physicians, the photo-elicitation method appeared to help some clarify their role as an advocate—an aspect of their practice they had not previously classified as part of their professional identity. For others, using visuals was helpful in elucidating, and perhaps dispelling, widely held notions that HA is not an intrinsic physician role, despite being codified in frameworks as an essential physician skill (Accreditation Council for Graduate Medical Education, 1999; Royal College of Physicians & Surgeons of Canada, 2015). Consequently, many physicians shied away from identifying as, or engaging in HA because they perceived it requiring skills and stature that took them outside their comfort zone. In contrast, patients' photos depicted advocacy as an essential feature of the labor of living with chronic illness (Koopman et al., 2021). Most patients saw advocacy as everyday self-care but used it defensively when they feared falling through the cracks. Even before engaging in this study, patient participants were deliberate in their use of visuals, using them strategically as both a communication tool and as a persuasive device to capture the attention of health care providers. This notion that patients feel they must serve as their own advocate has been discussed in the chronic disease literature as well as the cancer survivorship literature (Benham-Hutchins et al., 2017; Hagan & Donovan, 2013; Hagan & Medberry, 2016). However, to date, patient experiences of self-advocacy have largely been overlooked in medical education and practice. The sharing of photographs, then, appeared a useful strategy for both groups: physicians cultivated an enlightened perspective around this important competency and how it fits within their professional work while patients came to realize just how much time and energy they invest into managing their health and wellbeing.

Our study findings raise questions and possibilities for more meaningfully embedding patient centeredness into teaching (and by extension, practice). Medicine and medical education are still very much entrenched within a biomedical orientation, and despite espousing a philosophy of patient centeredness, these directives remain overshadowed by curriculum and practice approaches that prioritize physicians' clinical expertise versus patients' lived expertise. The HA competency epitomizes why medicine and medical education needs to rely on different ways of knowing beyond the biomedical. In our study's context, the photo-elicitation method challenged both participant groups to think differently about HA amidst an ever-changing and challenging healthcare climate and consider the affordances of how the visual medium might be used as a way of being heard, and therefore having one's experiences recognized.

Given how successful the photo-elicitation method was in exploring and advancing our participants understandings of the HA role, we propose that visual approaches might be as useful in the clinical learning environment as they are for research exploration (Molinaro et al., 2021). Our study findings revealed patients using visuals to advocate for themselves in clinical settings, a finding we are unsure would have surfaced had we not used visual methods. Similarly, the invitation to take photographs appeared to open the door to conversations with physicians that otherwise may not have taken place. Incorporating the use of visuals into health professions education has shown tremendous promise in enhancing empathy and reflection (Brand et al., 2016; McBain et al., 2015; Rutherford et al., 2018)

and tolerance for ambiguity (Bentwich & Gilbey, 2017; Brand & McMurray, 2009). Given the growing interest, visual approaches may additionally be useful for exploring and advancing understanding around the HA role. We can imagine for example, our study findings eliciting constructive dialogue and self-reflection around the concept and practice of patient-centred care or being drawn on to develop a HA education initiative where patients train learners and faculty how to 'see' real world examples of advocacy. Visual storytelling could be embedded into teaching (Molinaro et al., 2021) to illustrate not only patients' clinical experiences, but the work patients are doing (often when their energy is limited), and the implications when this work is either discredited or overlooked. Such learning activities may additionally make visible the structural factors constraining and influencing clinical interactions between patients and healthcare providers (Hubinette et al., 2022; Metzl & Hansen, 2014). These efforts have the potential to reconcile some of the misconceptions that persist around HA and may be personally and professionally transformative in enabling learners to see HA as a shared effort with, rather than for, patients.

Limitations

The images and narratives shared in this article are representative of a single sample of patients and physicians in one Canadian city. Since participants self-selected to take part in study activities, findings reflect patients and physicians who hold distinct views on HA. This is a strength rather than a limitation of qualitative research which seeks to generate a rich understanding by purposefully sampling those who can demonstrate through thick description the significance and complexity underpinning a social process. Generalizing our study findings was not the aim of this research; rather, our intention was to explore individuals' perceptions of HA and the unique dynamics underpinning their engagement. Nevertheless, we expect these findings are transferable to other settings and situations and may inspire training programs to critically reflect on some of the tensions inhibiting active teaching of, and fulsome engagement in, HA.

Conclusion

There remains considerable ambiguity around what HA means and how it should be taught and assessed, in part because many practicing physicians and learners are unsure about how to competently enact the HA role and patients' perspectives around HA are largely absent from the conversation. In this study, we demonstrate the application and usefulness of photo-elicitation to illuminate the complexities and hidden dimensions of advocacy from the perspective of both patients and physicians. By doing so, we have generated findings that enable common ground between patients and physicians to be established, while additionally revising the discourse of HA to capture both groups' understandings of, and unique insights into HA, including the clever, calculated tactics they employ to 'show' their expertise and call attention to their unique circumstances.

In our study's context, reliance on photo-elicitation was a powerful tool in eliciting a diversity of perspectives that exist around the health advocate role, including where efforts fall short. Recognizing that the conversation that unfolds around photographs is

as important as the photographs themselves, training programs might consider expansion beyond traditional biomedical approaches to medical training and care and invest greater attention into how visuals could be used as pedagogical tools to improve how this ‘difficult’ competency taught and deliberated.

Supplementary Information The online version contains supplementary material available at <https://doi.org/10.1007/s10459-022-10162-2>.

Funding This research was funded by the Royal College/Associated Medical Services CanMEDS Research Development Grant.

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