EDUCATION

Teaching and Assessing Advocacy in Canadian Physiotherapy Programmes

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ABSTRACT

Purpose: Advocacy is an essential component of physiotherapy (PT) practice. As a result, universities are expected to teach and assess advocacy-related competencies in their curriculum. The purpose of this study was to explore current educational practices for teaching and assessing advocacy in Canadian PT programmes, barriers to teaching and assessment, and solutions for enhancing educational practices. ***Method:*** We used a convergent parallel mixed-methods design. Teachers and coordinators from Canadian PT programmes completed an online survey, and clinical supervisors participated in telephone interviews. We performed descriptive statistics and thematic analyses. ***Results:*** Advocacy-related competencies were widely covered in the academic curriculum of the 13 PT programmes represented by our participants, but not all competencies were assessed equally. Barriers to teaching and assessment of advocacy included the lack of role clarity, relevant teaching and assessment strategies, time, and opportunity to practice the role in the curriculum. Students' personal experience and motivation also had an impact. ***Conclusion:*** Essential steps toward enhancing educational practices are to clarify the definition of *advocacy,* guide PT educators in explicitly and concretely teaching and assessing advocacy, develop a staged approach to covering advocacy throughout the curriculum, and normalize advocacy as a PT domain.

Key Words: patient advocacy; competency-based education; professional competence; professional role; leadership.

RÉSUMÉ

Objectif : le rôle de défenseur est un aspect essentiel de la pratique de la physiothérapie. Les programmes universitaires de physiothérapie ont ainsi le mandat d'enseigner et d'évaluer les compétences associées à ce rôle dans leur cursus. La présente étude visait à explorer les pratiques pédagogiques actuelles pour enseigner et évaluer le rôle de défenseur dans les programmes canadiens de physiothérapie, de même que les obstacles à l'enseignement et à l'évaluation et les solutions pour optimiser les pratiques pédagogiques. ***Méthodologie :*** les chercheurs ont utilisé un devis convergent mixte en groupes parallèles. Les professeurs et coordonnateurs des programmes de physiothérapie canadiens ont rempli un sondage en ligne, et des superviseurs de stage ont participé à des entrevues téléphoniques. Les chercheurs ont effectué des statistiques descriptives et des analyses thématiques. ***Résultats :*** les compétences relatives au rôle de défenseur étaient largement couvertes dans le cursus des 13 programmes de physiothérapie représentés par les participants, mais n'étaient pas toutes évaluées de manière égale. Les barrières à l'enseignement et à l'évaluation du rôle de défenseur incluaient le manque de clarté du rôle, le manque de stratégies d'enseignement et d'évaluation pertinentes, ainsi que le manque de temps et d'occasions d'exercer ce rôle dans le cursus. L'expérience personnelle et la motivation des étudiants avaient également une incidence. ***Conclusion :*** les étapes essentielles pour améliorer les pratiques pédagogiques consistent à préciser la définition du rôle de *défenseur*, à orienter les éducateurs en physiothérapie pour qu'ils enseignent et évaluent explicitement et concrètement le rôle de défenseur, à développer une approche transversale et progressive pour couvrir ce rôle au travers de leur cursus et à reconnaitre le rôle de défenseur comme un aspect important de la pratique de la physiothérapie.

Mots-clés : compétence professionnelle; défense des patients; formation fondée sur les compétences; leadership; rôle professionnel

Advocacy, defined as responsibly using physiotherapy (PT) knowledge and expertise to promote the health and well-being of individual patients, communities, populations, and the profession,[1] is an essential component of PT practice. It is becoming increasingly important as health services are rationalized and re-formed, resulting in limited access to PT services across Canada.[2–3] Competent PT advocates could use their knowledge and expertise to help address national health concerns, such as the aging population and the opioid crisis. Physiotherapists, for example, have an important role to play with regard to the opioid crisis by educating patients, health professionals, and the public about alternative forms of pain management and by advocating for increased access to inter-professional (IP) multimodal pain management programmes. Thus, physiotherapists need to be educated

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to become competent advocates. Despite the importance of advocacy and the inclusion of this role in the Essential Competency Profile (ECP),[1] little is known about how best to prepare future clinicians to embrace and enact their role as advocates.

The PT literature has, for the most part, explored the skills and traits required to be an effective advocate, such as possessing strong IP skills and being humble and persevering.[4] Research has also identified strategies such as working with marginalized populations and participating in IP activities as contributing to the development of advocacy in PT education.[5–6] Other health professions, such as medicine, have explored barriers to teaching and assessing advocacy. These barriers include the lack of a distinct curriculum, unclear assessment parameters, insufficient dedicated time in the curriculum, and educators' limited understanding of the role.[7–8] Although some of these barriers may also exist in PT, PT's curriculum and scope of practice differ from those of medicine. Moreover, because advocacy is reported to be a complex role to teach and assess,[9] more PT-specific research is needed to advance understanding of these issues.

The overarching aim of this study was to describe the current educational practices for teaching and assessing advocacy in Canadian PT programmes. More specifically, the study objectives were to (1) describe what advocacy-related content is being taught and assessed, (2) describe how advocacy is being taught and assessed, (3) explore the barriers to teaching and assessing advocacy, and (4) explore solutions for enhancing educational practices.

CONTEXT OF THIS STUDY

One of the members of our research team (JB), a graduate student from the University of Sherbrooke, conducted this study. We conceptualized the study's methodology in Fall 2016 and collected data in Fall 2018. This study, therefore, used the third-generation ECP (2009) as a frame of reference for defining advocacy. In December 2017, the National Physiotherapy Advisory Group (NPAG) released its latest version of the ECP, in which *advocacy* is now known as *leadership,* defined as "physiotherapists envision and advocate for a health system that enhances the wellbeing of society."[10(p. 15)] Although the term has changed to *leadership,* advocating for patients, communities, populations, and the profession remains a central component of this important role.

METHODS

Our Research Centre's Ethics Board approved the study, and participants provided electronic consent.

Study design

The study had a convergent parallel mixed-methods design. We collected quantitative and qualitative data from three groups concurrently, analyzed the data separately per group, and then combined the results to present an overview of the current educational practices and the potential barriers and solutions to teaching and assessing advocacy in Canadian PT programmes.[11]

Participants and recruitment

We collected data from three groups of educators involved in the academic or clinical curriculum – that is, academic courses or clinical placements.

Group 1 included PT faculty members teaching mandatory courses with advocacy learning objectives. After receiving approval from the Canadian Council of Physiotherapy University Programs, we contacted programme directors from the 15 Canadian PT programmes to assist us with recruitment. A total of 14 directors forwarded the survey to their faculty; the estimated size of this group is unknown.

Group 2 included academic coordinators of clinical education responsible for clinical placements in each PT programme. We individually invited all the coordinators (n = 15) to participate in the study because their contact information was publicly available online.

Group 3 included clinical supervisors who self-identified as having a good understanding of advocacy and had recent experience in supervising student placements. We recruited supervisors using a snowball sampling method through the coordinators and our research team's professional contacts. In addition, the Canadian Physiotherapy Association posted an invitation in their national rounds e-newsletter.

Instruments and data collection

We developed three data collection instruments and piloted them with members of our research laboratory, who either have advocacy experience or are involved in our PT programme. We then revised the instruments on the basis of their feedback. We programmed two online surveys using REDCap (Research Electronic Data Capture, Vanderbilt University, Nashville, TN): one for faculty, composed of seven open-ended questions and four closed-ended questions (see online Appendix 1), and one for coordinators, composed of eight open-ended questions and four closed-ended questions (see online Appendix 2). Participants self-administered the surveys. We then exported the data to Microsoft Excel 2018 (Microsoft Corporation, Redmond, WA) for analysis. We developed a semi-structured interview guide for supervisors (see online Appendix 3). Instruments were available in French and English, and each was structured around our study's four objectives. One bilingual member of the research team conducted each 1-hour interview and transcribed the audio recordings verbatim.

To respond to our first objective, to describe what content is being taught and assessed, the faculty survey explored which advocacy-related competencies are covered in academic courses, using closed-ended questions

based on the ECP's definition of advocacy.[1] Supervisor interviews explored which advocacy-related activities students are exposed to during their clinical placements.

To respond to our second objective, to describe how advocacy is being taught and assessed, the faculty survey explored which formats are used in academic courses. The coordinator survey explored how students are officially assessed after their clinical placements, and the supervisor interviews explored which teaching and assessment strategies are used during student clinical placements.

To respond to our third and fourth objectives, to explore the barriers to and solutions for teaching and assessing advocacy, all instruments gathered qualitative data from the participants using the same open-ended questions. Each instrument prompted the participants to consider various factors when answering these questions, including personal, institutional, professional, and other factors.

Data analysis

We analyzed data separately for each group and structured the analysis around our study's four objectives. We used descriptive statistics (i.e., frequencies) for the survey's closed-ended questions. For the survey's open-ended items and the interviews transcribed verbatim, we analyzed the data using Braun and Clark's six-step process, which included familiarizing ourselves with the data, generating codes, searching for and reviewing emerging themes, and refining the themes.[12] Each step was performed by two members of our research team (JB and CC) and discussed until consensus was met. We then sent a summarized report of the results to participants for validation.

The results are presented in three sections: (1) advocacy-related content, (2) teaching and assessment strategies, and (3) barriers to and solutions for teaching and assessing advocacy. In the first two sections, we separated the results into two subsections, the academic curriculum and the clinical curriculum, because the advocacy-related content and the teaching and assessment strategies differed between the two educational settings. For the third section, we made no distinctions based on educational setting because similar barriers and solutions emerged.

RESULTS

Participants

Each participant was affiliated with 1 of the 15 Canadian PT programmes. We recruited at least one participant per programme who belonged to one of the three groups described next.

Physiotherapy faculty members

A total of 20 faculty, responding for one or multiple courses from their programme, completed the faculty survey. A total of 13 PT programmes were represented, with 1–3 participants per programme. We aggregated the data from each PT programme (n = 13) to present an overview of which advocacy-related competencies are taught and assessed (see Table 1) and which teaching and assessment strategies were used (see Table 2) at the PT programme level.

Academic coordinators of clinical education

Eleven of the 15 coordinators responded to the coordinator survey, for a 73% response rate.

Clinical supervisors

Eight supervisors affiliated with four PT programmes participated in the semi-structured telephone interviews. They had a wide range of experience in practice (4–21 y), practice settings (e.g., acute care, rehabilitation, private practice, student-led clinics), client populations (neurology, orthopaedics, chronic pain), geographical locations (urban, rural, international), and extra-clinical experience (management, teaching, research).

Content taught and assessed

Academic curriculum

Table 1 presents aggregated data from the faculty surveys, identifying the frequency of programmes that include at least one course that teaches and assesses each of the advocacy-related ECP competencies.

Clinical curriculum

Supervisors reported that most of the clinical opportunities for students to practise advocacy fell into the following categories: identifying a need for advocacy when working with patients, educating and empowering patients, participating in patient rounds, discharge planning and IP liaising, communication, and collaboration. Opportunities for community, population, and professional advocacy were said to be less frequent:

> I think that we reinforce to students the need to advocate on an individual basis. I don't feel that students get the opportunity to do it at a bigger level for communities and populations (Supervisor 4).

Teaching and assessment strategies

Academic curriculum

Table 2 presents aggregated data from the faculty surveys, identifying the frequency of programmes that use, in at least one of their courses, the formats for teaching and assessing advocacy found in the table.

Clinical curriculum

Of the 11 coordinators, 10 (91%) reported officially assessing students' performance on the basis of the ranking and comments found in the placement reports. Six coordinators (55%) offered pre-placement training to supervisors on how to assess advocacy by reviewing performance

Table 1 Advocacy-Related Competencies Taught and Assessed in Canadian Physiotherapy Programmes ($N = 13$)

Competency*	*n* (%) of programmes	
	Taught ≥ 1 course per programme	Assessed ≥ 1 course per programme
Collaborates with clients and other health care providers to understand, identify, and promote the health and PT needs and concerns of		
Patients	12 (92)	10 (77)
Populations	11 (85)	7 (54)
Speaks out on health issues identified by clients	8 (62)	9 (69)
Together with other health care providers, empowers clients to speak on their own behalf	8 (62)	8 (62)
Understands the limits and opportunities in the practice setting to address health issues	9 (69)	7 (54)
Works collaboratively to develop strategies to optimize client care	12 (92)	8 (62)
Identifies the determinants of health of		
Patients	11 (85)	9 (69)
Populations	10 (77)	7 (54)
Understands factors that act as barriers to accessing services and resources	12 (92)	7 (54)
Describes the role of the PT profession in advocating for health and safety	8 (62)	8 (62)
Uses opportunities to communicate the role and benefits of PT to enhance the health of		
Patients	11 (85)	8 (62)
Communities	11 (85)	7 (54)

* Enabling competencies for the advocate role are from the *Essential Competency Profile for Physiotherapists in Canada*.[1]
PT = physiotherapy.

criteria. None, however, discussed how to teach advocacy to students during clinical placements.

Supervisors described various strategies used to teach students about advocacy during clinical placements, which fell into one of the following three themes: role modelling, providing information, and facilitating.

Role modelling was said to be the point of entry, introducing students to advocacy. It included having students observe, attempting to inspire students, and providing feedback.

> Initially it's a lot of observing, and I try to really point out those moments [when] we are advocating for our profession or for our patients. For students who don't pick up on it, I talk about it a bit more concretely and try to stimulate their curiosity. (Supervisor 8)

Providing information was seen when supervisors shared knowledge with students:

> Students come in with variable knowledge of what they can advocate for. Sometimes what you're doing is just teaching them about the system and what resources are out there. (Supervisor 3)

Facilitating was seen when supervisors prompted their students' critical thinking skills:

> Sometimes it takes a bit of prompting for students to think "big picture" and realize what determinants of health are affecting a person's experience. First, I want them to tell me what they've noticed and what they think are the issues. Then I might give them a clue [about] where to go next. (Supervisor 5)

As for assessment, all the supervisors expressed difficulty objectively assessing their students using their programme's placement report.

> There [are] a lot of those points where, some of them check off, but some of them are a little too non-achievable within a student placement. (Supervisor 6)

Therefore, some supervisors said that they relied on their gut feeling to grade their students' performance, whereas others based their assessment on their students' ability to identify when advocacy was needed and their willingness to act and follow through.

Barriers and solutions

We identified five main themes on the barriers and solutions to teaching and assessing advocacy.

Theme 1: clarity of role

Participants considered the ECP's definition of advocacy to be vague and unclear and, as such, difficult to teach and assess.

> The role of advocate is perhaps not clearly understood or envisaged by many members of the clinical community. (Coordinator 11)

Table 2 Teaching and Assessment Strategies Used in Canadian Physiotherapy Programmes ($N = 13$)

Strategy	*n* (%) of programmes
Teaching	
Lectures	13 (100)
Case studies	11 (85)
Simulations	10 (77)
Readings	9 (69)
Workshops	9 (69)
Patient interactions	8 (62)
Debates	7 (54)
Community projects	6 (46)
Patient testimonies	6 (46)
Movies	4 (31)
Volunteer work	1 (8)
Other teaching strategies	1 (8)
Assessment	
Case presentations	9 (69)
Essays	9 (69)
Exams	8 (62)
Self-assessments	7 (54)
Objective structured clinical examinations	6 (46)
Oral presentations	6 (46)
Observation of patient encounters	4 (31)
Portfolio	4 (31)
Debriefing	3 (23)
Internship reports	2 (15)
Other assessment strategies	2 (15)
Standardized tools	0 (0)

They considered this lack of clarity to be a major barrier to advocacy training because an educator's perception and understanding of the role will directly influence how and what they teach in terms of PT advocacy. To overcome this barrier, participants from all groups recommended simply clarifying the definition.

> I think it would just be better defined with a few concrete examples given for each competency. I don't think it's a lack of teaching, I just think it's a lack of a strong definition so that everyone is on the same page. (Supervisor 6)

Theme 2: educators' ability to teach and assess advocacy

Faculty expressed difficulty with teaching advocacy because of a lack of knowledge either of relevant content to cover or of effective strategies to use in a classroom setting.

> In the classroom, it feels unreal or contrived, and not an authentic experience. (Faculty 10)

Similarly, supervisors struggled to teach advocacy to students who were not naturally inclined to defend their patients' interests.

> Some people just don't get it, I don't know how to help them. How do you teach them other than by demonstrating? (Supervisor 8)

Participants generally expressed that assessing advocacy was quite challenging for them. Faculty described the difficulty of assessing advocacy in a fair, clinically relevant, and time-effective manner, whereas supervisors expressed uncertainty regarding what PT programmes expected their students to be able to demonstrate in terms of advocacy.

> It is quite open to interpretation. I don't think there have been such guidelines, this is what a good advocate should look like, this is what a poor advocate would look like. (Supervisor 6)

Coordinators echoed this, stating that supervisors tended to provide fewer comments in the advocacy section of their placement reports; this limited their ability to assess students' performance.

To overcome these difficulties, faculty suggested that facilitating networking opportunities for faculty and supervisors across Canada to share their expertise and experiences in this area would be beneficial. Some faculty also found that PT programmes should incorporate more clinically relevant activities in the curriculum (e.g., IP case studies) and facilitate learning opportunities in community settings. As for supervisors, they recommended that PT programmes offer them some guidance on how to explicitly teach and assess advocacy.

> It's just being a bit more explicit about what clinicians do in their day-to-day practice, but probably don't label it as such, and I think that they don't recognize that they have a duty to foster it in their students. (Supervisor 4)

Theme 3: student factor

Factors related to students' requisite knowledge, attitudes, and skills emerged as barriers to teaching advocacy. Faculty and supervisors expressed the view that students were often unwilling to engage in advocacy.

> It's such an abstract concept, they just don't understand what it really is or the importance of it, they see advocacy as just "not physio." (Supervisor 8)

Supervisors commented that students struggled with advocacy because of their limited life experience and, moreover, that students from privileged backgrounds often required extra prompting to understand how health determinants influenced their patients' experience. They also said that students often lacked basic communication and IP skills, both of which were necessary to advocate for their patients. In addition, students did not know how to go about effecting change on a larger scale.

> Often times they see issues that are happening, like patients telling them about how their disability is affecting their life. They want to do something about it, but don't necessarily know what to do or how to do it. (Supervisor 2)

To prepare students for their placements, supervisors suggested that the academic curriculum focus on building concrete advocacy skills.

> Touching on interprofessional communication in more depth, to know the scopes of other professionals and to know when we need to be insistent upon something. (Supervisor 7)

To address students' difficulty understanding systemic issues, a coordinator recommended that the academic curriculum include an enhanced focus on navigating the health care system and how PT can contribute to population health. Similarly, a supervisor suggested introducing students to frameworks to help them address advocacy issues. Finally, left unanswered was the question of how to nurture a student's sense of social responsibility. One supervisor even wondered whether PT programmes should, in fact, include certain soft skills as criteria for admission into PT programmes and questioned whether advocacy could even be taught.

Theme 4: organizational factors

Certain organizational factors appeared to limit students' exposure to advocacy, mainly the lack of dedicated time in the academic and clinical curriculum.

> Students have a significant amount of information to learn in a condensed amount of time, so it is always a balance to find the right mix/emphasis. (Coordinator 4)

Participants expressed uncertainty regarding the appropriate time in the curriculum to address advocacy because advocacy was typically broadly covered in foundational PT courses.

> Some competencies may be more relevant as students progress toward the end of the programme. Of course, the ideal setting to apply and demonstrate advocacy competencies is in clinical placements. (Faculty 5)

However, supervisors and coordinators recognized that it was difficult for students to learn about advocacy while they were building their clinical skills. Also, opportunities to advocate arising during student placement vary; certain placements facilitated the development of advocacy more than did others. Settings with a strong focus on patient-centered care, located in under-resourced areas, or in which students interacted with vulnerable patients offered more opportunities to practise advocacy.

To overcome these barriers, participants recommended that programmes gradually cover advocacy throughout the entire curriculum, by integrating and synthesizing the materials from course to course (i.e., staged programming) and mandating that all faculty be involved in teaching this content.

> Cover the competencies for the advocate role across many courses, and embed learning objectives within a variety of clinical reasoning, clinical skills, professionalism, case-based, etc. courses. The intent is for students to learn about these competencies and their different applications. (Faculty 5)

In addition, to ensure that students developed advocacy competencies in the clinical curriculum, a coordinator highlighted the importance of students undertaking placements in a variety of environments and with patients from across the lifespan.

Theme 5: curricular priorities

PT's curricular priority has traditionally focused on developing the expert role at the expense of other roles, including advocacy. A supervisor suggested that the root causes of this were physiotherapists' failure to recognize themselves as advocates and the influence of PT's governing bodies.

> If we look at colleges, their mandate is to protect the public, so the easiest way to do that is to make sure that clinicians have extremely strong clinical skills. It starts there, then trickles down, as universities tailor their programmes [to] the requirements of the regulatory bodies. (Supervisor 2)

The participants called on PT associations and PT programmes to normalize advocacy as a PT domain, as part of developing professionals' roles and responsibilities, and to recognize physiotherapists for their advocacy work. Other recommendations were to include advocacy on PT examinations and to have PT colleges mandate their members to reflect on advocacy in their registration process.

DISCUSSION

This study aimed to provide an overview of the current practices for teaching and assessing advocacy across PT programmes in Canada and to identify the barriers and possible solutions to enhancing educational practices. The findings suggest that although advocacy-related competencies are generally covered in Canadian PT programmes, this coverage might not be optimal, and opportunities for students to practice advocacy might be limited. One of the main barriers to teaching and assessing advocacy was the lack of clarity about what advocacy in PT is. These results echoed findings in medical education, which have reported that advocacy was one of the more challenging roles to define, explicitly teach, role model, and assess in medical education.[8–9] Consequently, Canadian PT students may graduate with varying perspectives on what advocacy truly entails.

Our findings indicate that clarifying the ECP's definition of advocacy is an essential step in enhancing educational practices. Although the necessity of clarifying the role has been noted elsewhere in the medical literature,[7,8,13] the strategies proposed have differed. Our participants recommended simply adding concrete examples to the ECP's existing definition of advocacy, whereas other studies in medical education have suggested fully

reconceptualizing the advocate role to highlight its breadth.[13] Indeed, considering the many aspects of advocacy in PT, greater clarification may be required for physiotherapists and PT educators alike so that they can fully understand its scope and be able to effectively address advocacy issues for, and with, individual patients, communities, populations, and the profession. Once the role is clarified, it may be more feasible to develop relevant content and effective educational strategies to build students' advocacy knowledge and skills.

Our participants also highlighted the need for guidance to assist them in teaching and assessing advocacy in an authentic and time-effective manner. Faculty suggested the benefit of networking among Canadian PT programmes, thus sharing PT educators' expertise and experiences. Supervisors expressed a need for PT programmes to clarify their expectations and come up with explicit strategies for teaching and assessing advocacy. These solutions have also emerged in the medical literature, which has suggested that courses and evaluation strategies should be shared across faculties because all are facing the same challenges.[8] PT programmes could model themselves on existing tools, such as the advocacy e-book developed to help medical residency supervisors seize teachable moments in daily practice.[14] Such a guide could enhance PT supervisors' ability to teach advocacy, regardless of how conducive their setting may be to advocacy.

Our findings suggest that PT educators struggle to engage reluctant students in embracing their role as advocates. One of our participants recommended including advocacy on examinations as an external motivator, which echoes findings in medical education.[8] However, there is a need to dig deeper into how to foster a sense of social responsibility in students to inspire them to become true advocates. Other opportunities for nurturing students' attitudes toward advocacy may be worth exploring, such as exposing them to vulnerable populations. In fact, having PT students work with under-served populations has already proved to help increase their insight into the social factors affecting health and stir up their emotions in the face of health inequities.[5] These findings echo the opinions of some of our participants, who suggested that placements in under-resourced areas or with vulnerable populations offered more opportunities for students to practice advocacy. In addition, other studies have noted that IP activities are a valuable way for students to develop their professional identity and realize the importance of advocating for their profession.[6]

To overcome the time constraints of PT programmes and to enhance students' understanding of the breadth of their advocacy role, our participants suggested gradually covering advocacy throughout the entire curriculum. This recommendation is consistent with the medical literature, which recommends thoughtful planning and graded educational activities to expose students to the various aspects of advocacy, from individual to higher-level interventions.[15]

Finally, our participants encouraged PT associations and programmes to become involved in changing the PT culture, by normalizing advocacy as a PT domain for both clinicians and students. In fact, by effectively teaching advocacy to PT students, the PT culture may eventually change as graduating physiotherapists embrace their role as advocates.

IMPLICATION FOR PRACTICE

Since the end of our study, NPAG released the latest version of the ECP, in which *advocacy* has been replaced by *leadership*.[10] In an effort to clarify the role, the level of proficiency that students should demonstrate for each competency has been identified.[10] However, the need remains to plan a staged approach to covering the many aspects of advocacy and guide PT educators in effectively teaching and assessing this important role. Next steps could include encouraging NPAG to reach consensus with the help of PT advocacy experts as to what is essential in teaching advocacy, helping PT programmes map their curricular approach, and elaborating feasible teaching and assessment strategies. Also, further research could explore new graduates' perspectives on how advocacy was taught at their school and how it is influencing their work experience after graduation.

Finally, because the results of this study suggest that students lack the opportunity to concretely build their advocacy skills, PT programmes could integrate educational activities into the academic curriculum to gradually develop students' advocacy skills. Students could begin to learn about various strategies to effectively advocate for patients in the health care system. To enhance student learning, educational activities should require students to synthesize and apply the content and to develop their critical thinking skills. This would prepare them to identify and seize opportunities for advocating for their patients during clinical placements. Once individual-level advocacy skills have been addressed, students could then learn about system-level advocacy. To motivate students and enhance their understanding of these more complex approaches, it would be beneficial for them to identify a current issue they feel strongly about, then analyze and plan an advocacy strategy for it.

Our study had two limitations. First, there was a sampling bias, whereby our participants might highly value advocacy as a role, compared with other educators. However, because the participants were chiefly responsible for teaching and assessing advocacy in their programmes, they are representative of the target population. Moreover, our participants worked alongside students in the academic and clinical curriculum and could provide complementary perspectives. Second, our data collection instruments documented the frequency of the competencies

taught and assessed, as opposed to describing the content. However, the qualitative data gathered in our three groups highlighted the opinions of experienced PT educators, thereby allowing us to bring out the nuances in the quantitative data. We are therefore confident that this study correctly portrays the existing barriers that need to be reflected on to enhance educational practices regarding the advocate role.

CONCLUSION

Our study aimed to describe current educational practices for teaching and assessing advocacy in Canadian PT programmes, identify the barriers to teaching and assessing advocacy, and explore solutions for enhancing these educational practices. We gathered rich data from the three main groups of PT educators working alongside PT students in both the academic and the clinical curriculum, providing valuable insight. The main recommendations were to clarify the ECP's definition of *advocacy;* identify relevant advocacy-related knowledge and skills to be covered in PT programmes; guide PT educators in explicitly and concretely teaching and assessing advocacy; explore opportunities for nurturing students' sense of social responsibility; develop a staged approach for covering advocacy throughout the curriculum; and strive to change the PT culture by normalizing advocacy as a PT domain. In pursuing these recommendations, PT programmes could aim to standardize educational practices; this would ensure that students become effective advocates once they enter practice.

KEY MESSAGES

What is already known on this topic

Advocacy is essential for physiotherapy (PT) practice, yet little is known about how to teach and assess its associated competencies in PT education. Moreover, in medical education, an area that has been the focus of much research on this topic, advocacy is said to be one of the most challenging roles to define, explicitly teach, role model, and assess.

What this study adds

This study highlighted the barriers that limit the optimal coverage of advocacy in PT education and elicited solutions from the perspective of PT educators for enhancing educational practices. These solutions included clarifying the definition of *advocacy,* identifying relevant content, recommending effective educational strategies, and developing a staged approach for covering the role throughout the entire curriculum, thus normalizing advocacy as a PT domain.

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