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AMEE GUIDE

Health advocacy*

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ABSTRACT

In the medical profession, activities related to ensuring access to care, navigating the system, mobilizing resources, addressing health inequities, influencing health policy and creating system change are known as health advocacy. Foundational concepts in health advocacy include social determinants of health and health inequities. The social determinants of health (i.e. the conditions in which people live and work) account for a significant proportion of an individual's and a population's health outcomes. Health inequities are disparities in health between populations, perpetuated by economic, social, and political forces. Although it is clear that efforts to improve the health of an individual or population must consider "upstream" factors, how this is operationalized in medicine and medical education is controversial. There is a lack of clarity around how health advocacy is delineated, how physicians' scope of responsibility is defined and how teaching and assessment is conceptualized and enacted. Numerous curricular interventions have been described in the literature; however, regardless of the success of isolated interventions, understanding health advocacy instruction, assessment and evaluation will require a broader examination of processes, practices and values throughout medicine and medical education. To support the instruction, assessment and evaluation of health advocacy, a novel framework for health advocacy is introduced. This framework was developed for several purposes: defining and delineating different types and approaches to advocacy, generating a "roadmap" of possible advocacy activities, establishing shared language and meaning to support communication and collaboration across disciplines and providing a tool for the assessment of learners and for the evaluation of teaching and programs. Current approaches to teaching and assessment of health advocacy are outlined, as well as suggestions for future directions and considerations.

Introduction

In the medical profession, activities related to ensuring access to care, navigating the system, mobilizing resources, addressing health inequities, influencing health policy and creating system change are known as health advocacy. As an integral part of the health care system, physicians are uniquely positioned to contribute to the transformation of the system that will ultimately result in improved health systems, health outcomes and reduction of health inequities (Frenk et al. 2010).

Any discussion of health advocacy must start with the social determinants of health and health inequities. Health inequities are inequalities in health between groups of people within countries and between countries that are perpetuated by social and economic conditions, including the distribution of health resources (World Health Organization 2008). Any discussion of social determinants of health, health inequities, or health care access necessarily invokes principles of fairness, the distribution of resources, systems-based practices and public policy—topics that are inherently political. As is discussed later, the incorporation of the political into professional standards for physicians is both controversial and challenging.

As health advocacy becomes more visible within medical education, there is a growing argument that physicians have a duty to participate in activities that contribute to improved health of their individual patients, communities, and populations by identifying and addressing health inequities (Gruen et al. 2004; Farmer et al. 2006). The reemergence of advocacy within the profession has been accompanied by a vigorous debate about the scope of physician responsibility for health advocacy centering on the boundaries of a physician's professional obligations and authority (Dobson et al. 2012). Regardless of the outcome of this debate, teaching our trainees about health advocacy should be an important role of clinical teachers. This paper provides some concrete suggestions for how this might be done.

Health advocacy remains one of the most difficult domains of medicine to teach, learn, assess and evaluate (Frank 2001; Stafford et al. 2010). What is expected of physicians as health advocates ranges widely in its possible activities and applications (Chou et al. 2008; Flynn & Verma 2008; Stafford et al. 2010). How do we define, identify, enact, teach, and assess health advocacy? In this paper we address the definition of health advocacy, highlight some of the controversies related to the teaching of health advocacy, outline strategies for teaching and assessment, and we introduce a framework to better explain the various approaches to health advocacy.

The physician as health advocate

The role of the physician health advocate has been variously defined in the literature and in professional standards

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Practice Points

- To be competent health advocates, physicians must understand the factors that create health inequities and recognize how they impact the lives of their patients
- Although it is clear that efforts to improve health of an individual or population must consider 'upstream' factors, how this is operationalized in medicine and medical education is controversial
- Health advocacy is both a mind-set and a multi-faceted set of skills that includes ensuring access to care, navigating the health care system, mobilizing resources, addressing health inequities, influencing health policy and creating system change
- Numerous curricular interventions have been described but successful integration of health advocacy into medical programs will require a broader examination of processes, practices and values throughout medicine and medical education and will involve education enterprises, organizations and institutions as well as the communities they serve
- There is both an essential cognitive foundation and experiential/workplace learning component to teaching and learning health advocacy
- The UBC Health Advocacy Framework suggests different types, levels and approaches to advocacy resulting in four quadrants of advocacy activities

documents. What many of these definitions share is intentional action by a physician to address social determinants of health and health inequities through his or her professional work. This may be done with individuals, with groups, or by seeking change within a system (Gruen et al. 2004; Hubinette et al. 2014a; Dobson et al. 2015).

A common point of confusion for educators is that the terms health advocacy and health promotion are often misinterpreted. For one, there are dual conceptualizations of health promotion: 'medical' and 'social' health promotion (Seedhouse 1997). 'Medical health promotion' involves efforts to prevent or reduce disease by relying on change in an individual's behavior (smoking cessation, exercise, healthy diet, and so on). 'Social health promotion' involves confronting health inequities by positive developments in the social determinants of the most underprivileged populations (Seedhouse 1997). In clinical settings, health promotion is often used to mean 'medical health promotion' and focuses on individual behavior change or an individual availing themselves of a very focused disease-prevention activity (e.g. screening mammography, immunization, etc.). Further, the notion of health advocacy is often used interchangeably with this conception of health promotion (i.e. medical health promotion) (Hubinette et al. 2014a), which has the effect of both limiting the conception of health advocacy and misrepresenting health promotion. Conceiving health advocacy as simply encouraging patients to change their health behavior or to accept a disease prevention intervention ignores the role that systems play in health outcomes, places the onus on the individual, and assumes that a person has an unlimited ability to make decisions for him or herself. Although medical health promotion undoubtedly plays a role in the health of an individual (for example through screening, immunization, and behavior change), it does not result in systemic change nor does it address the root causes of health inequities. Promoting behavior change in the absence of addressing the social determinants of health assumes a universally high degree of individual choice and does not account for the impact of the environment and social policies on health behaviors or outcomes.

Effective health advocacy and implications for teaching

Many physicians and medical educators agree that the medical profession has a responsibility to voice its collective expertise on the social determinants of health and illness whether or not they, as individual physicians, are personally engaged (Martin & Whitehead 2013). As such, medical education programs around the world have adopted a variety of curricular approaches to address advocacy and its related concepts. Existing curricular interventions to address social determinants of health and health inequities are often centered on knowledge of the social determinants of health; however, understanding the skills and abilities required by effective health advocates may form the basis of more extensive pedagogic strategies. As such, we summarize what is known about effective health advocates with respect to values, skills, abilities etc. and link these to curricular interventions described in the literature. We have organized this review into four broad curricular intervention types and represented these in tabular format (Tables 1–4, all available online as Supplementary Material): admissions, knowledge and skills curriculum, critical thinking, and experiential/workplace learning. Following this, we suggest implications for medical education more broadly.

Evaluating curricular interventions in health advocacy

It is likely that a combination of curricular approaches will promote improved outcomes in medical education efforts around health advocacy (Croft et al. 2012). Despite all of the curricular innovations described in the literature (Tables 1–4, available online as Supplementary Material), only some of these studies report on the efficacy of the interventions in achieving their purpose. The evaluation data is sparse beyond reported gains in knowledge or skill. In other words, very little evidence exists about the effect of curricular innovations on behavioral change (i.e. a physician sustaining health advocacy activities once in practice) and, ultimately, on patient and population health outcomes. Establishing and agreeing on measures of success will be critical components of teaching health advocacy (Croft et al. 2012).

Regardless of how successful any unique curricular intervention might be, isolated interventions alone are likely not enough. The success of health advocacy teaching requires more than cognitive instruction and specific curricular interventions. In addition to students understanding what social determinants are or possible ways of thinking about health advocacy, there are a host of contextual factors that all

students (and faculty) are exposed to and influenced by and affect their conception of what health advocacy is and how they value the role of advocacy in health. Current contextual factors that underlie health advocacy in medical education include: the spectrum of admission processes and policies (Martin & Whitehead 2013), the emphasis on biomedical knowledge over other knowledge (Kuper et al. 2007), and the hidden curriculum that values biomedical care of individual patients in a health care environment over health advocacy actions, both individual and systemic (Martin & Whitehead 2013). Addressing health inequities will require that educational interventions, organizations and institutions (schools of medicine, national bodies, etc.) and communities to act together to create opportunities for meaningful impact on health to address the above contextual factors (National Academies of Sciences Engineering and Medicine 2016).

Current approaches and challenges to assessment of health advocacy

Challenges with the assessment of health advocacy

Research on assessment of health advocacy competencies is comparatively scarce (Oandasan et al. 2001; Jefferies et al. 2007; Bandiera & Lendrum 2008; Sherbino et al. 2013) and scant evidence exists to support criteria for good assessment of these competencies (Norcini et al. 2011). This is troubling, considering the well-known challenges that program directors and clinician educators have voiced related to assessing health advocacy and their associated competencies among their trainees (Frank 2001; Chou et al. 2008). Although the skills and attitudes that are necessary for the health advocate role share "common threads" with other roles, the health advocate may be the most multifaceted of all the roles, which contributes to the difficulty of assessing this role (Flynn & Verma 2008).

In competency-based medical education, there is an increasing emphasis on assessment based on direct observation in the authentic clinical workplace, despite the challenges of heterogeneous settings and varied contexts and heavy reliance on a wide range of dispersed faculty assessors (Holmboe et al. 2010). The actions of advocacy often occur away from the bedside, beyond the direct supervision of supervising physicians. And yet, most of our current tools assume that the attending physician witnesses the encounter (Sherbino et al. 2013). Even in the case where the advocacy actions occur in the clinical environment, we expect clinical teachers to make these inferences based on limited direct observation (Miller 1990) and, perhaps, limited understanding of, or experience with, advocacy themselves (Verma et al. 2005).

Current tools for assessment of health advocacy

Despite the challenges with assessment of the health advocacy knowledge and skills of an individual, there are descriptions in the literature of a range of individual assessment tools. These tools can be divided into written exercises, assessment by clinical preceptors, clinical simulations and multisource feedback (Epstein 2007; Norcini et al. 2011).

Both content- and context-specific, extensive sampling is required to realize an accurate account of learner ability in any setting and this is also true of the assessment of health advocacy (Norcini et al. 2011). Assessment should draw on the perspectives of many, including the learner (Holmboe et al. 2010) as no one assessment method has the ability to encapsulate the information that one needs to make a judgment on an activity as multifaceted as delivery of health care by a physician (Miller 1990).

In addition to clinical assessments by faculty, incorporating health advocacy into case presentations, rounds, and other learning activities (Sherbino et al. 2015) supports reflection and dialog and is crucial to both assessing and valuing health advocacy. Portfolios are capable of capturing learning within authentic contexts and may capture skill development, reflection on values and transformation of perspectives over time. As such, portfolios may prove to be one piece of the answer to assessment of health advocacy and related competencies.

A way forward: using the UBC health advocacy framework

Building on other frameworks (Carlisle 2000; Gruen et al. 2004) and drawing on evidence from the study of physicians in clinical practice engaging in health advocacy (Dobson et al. 2012; Towle 2014; Dobson et al. 2015; Hubinette et al. 2015), we would like to propose a conceptual model of health advocacy in medicine. This health advocacy framework highlights the breadth of health advocacy and the opportunities available to trainees as well as a tool to conceptualize both assessment and evaluation. The UBC Health Advocacy Framework can also be used as a prompt to elucidate institutional values and perspectives on different approaches to and activities within health advocacy.

This model is based on two axes: the horizontal axis represents *who determines the need* for advocacy, whereas the vertical axis represents the *level at which advocacy occurs*. For a more in-depth description of methods, the reader is directed to the AMEE Guide related to this paper (AMEE Guide No 114 found at www.amee.org)

The vertical axis - types and levels of activities

Advocacy activities can be broadly grouped into two types: "agency" and "activism". "Agency" encompasses a variety of activities that involve navigating the system: providing information and education, making connections to community resources, making referrals to non-clinical professionals and helping navigate both the health care and other systems (e.g. supportive housing) when that individual or group would encounter challenges to acting independently. In this sense, the health advocate is an agent working within the constraints of the system to assist with gathering resources for a patient, family, or groups of patients. "Activism" encompasses a variety of activities including raising awareness of an issue, mobilizing resources needed for change, directly making a change or evaluating a change. These activities result in institutional (e.g. practice-level, hospital-level, health care system-level), social, economic, or political change i.e. change that would persist after the efforts of the advocate had ended. Activism includes

Figure 1. Definitions of agency and activism.

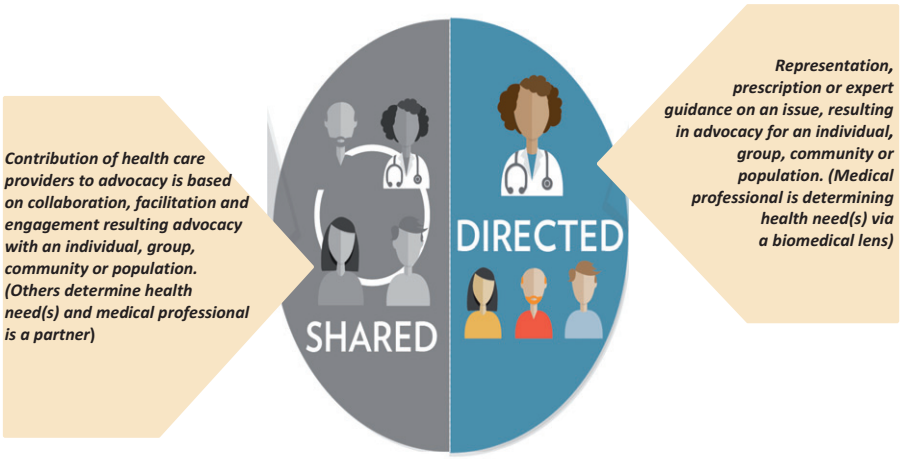

Figure 2. Definitions of shared and directed advocacy.

knowledge translation, community- and population-level as well as system- and policy-level activities (Figure 1).

The horizontal axis - approaches to advocacy

Two distinct approaches to advocacy are represented by the role of the advocate in relationship to the individual, community or population—either "shared" or "directed." With "shared" advocacy, the health needs, strengths, and opportunities for change are determined by the individual, community or population. The contribution of a physician to advocacy is based on collaboration, facilitation and engagement. This results in advocacy *with* an individual, group, community, or population. Physicians must position their biomedical expertise alongside (and not above) patients' interpretations and perspectives (Kleinman & Benson 2006).

With "directed" advocacy, health needs are determined by a physician using their perspective and expertise. This involves representation or expert guidance on an issue, resulting in advocacy *for* an individual, community or population. Of course, a physician should not be encouraged to disempower a patient. While "directed" advocacy takes advantage of the unique perspective of a physician within the healthcare system, it should not involve a paternalistic approach (Figure 2).

The UBC health advocacy framework—bringing the axes together

Advocacy types (agency and activism) and approaches (shared and directed) can be represented along two axes, resulting in four quadrants. Location within a quadrant depends on (a) who determines the need for advocacy (the physician or the patient/community); and (b) the context or "level" in which advocacy takes place. Not all physicians are involved in all four quadrants; whether they should be is subject to debate. Not all quadrants are equally "weighted" in terms of time and energy invested. Activities located within the "directed agency" quadrant are generally currently accepted in medicine as legitimate health advocacy activities while the other quadrants tend to be underrepresented. Figures 3 and 4 represents the health advocacy framework as four quadrants. The following is a description of each quadrant, along with an example.

(Clinical vignettes which illustrate the UBC Health Advocacy Framework in action are found in Boxes 1–3, available online as Supplementary material).

The physician determining the health needs of an individual, family or group of individuals characterizes "directed agency" activities. The physician acts on behalf of that individual (or family or group) to access services and support. Examples of "directed agency" include: calling a radiologist to get an urgent investigation for a patient; ensuring

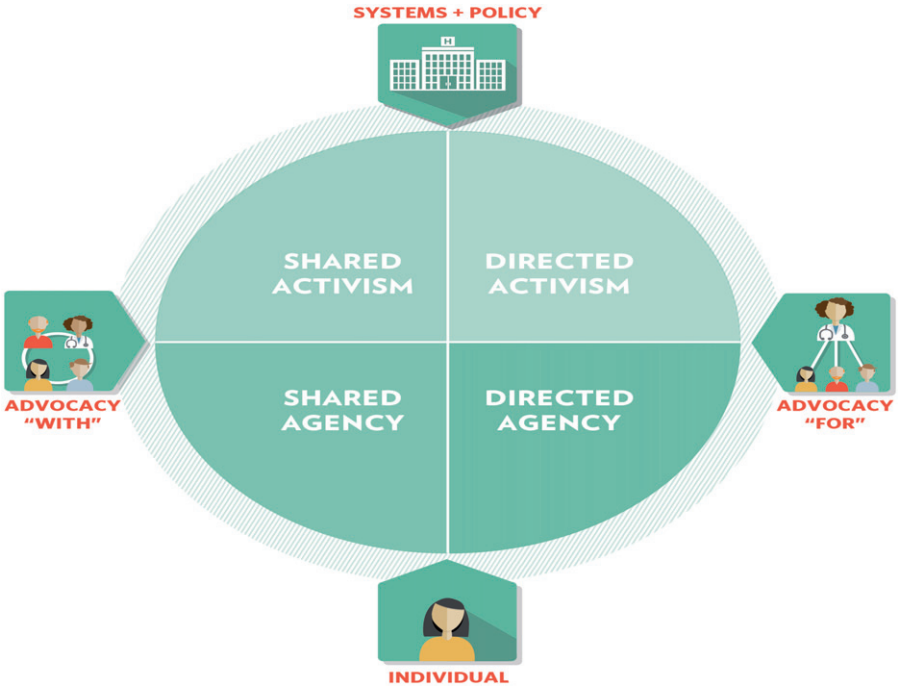

Figure 3. The four quadrants of the UBC Health Advocacy framework.

patients have required health information; making recommendations for screening maneuvers; offering referrals to community agencies and organizations.

The physician determining the strengths, needs and opportunities for change of a community, population, policy or system characterizes "directed activism" activities. The physician works on behalf of, or for, others to reduce health inequities by knowledge translation, community-, population-, system- and policy-level change. Examples include: A physician organization lobbying for legislation that restricts tobacco purchase to those over the age of majority; an emergency physician or neurologist that notices an increase in head injuries and lobbies for changes to bike helmet laws.

An individual or group of individuals determining their own strengths, needs and opportunities for change within a community, population, or system characterizes "shared activism" activities. The physician works in partnership with communities and others to reduce health inequities through knowledge exchange and community-, population-, system-, or policy-level change. Examples include: physicians sitting on the board of a community organization; a physician group which supports a community that is lobbying for changes to policies regarding environmental impact assessment for mining operations.

Individuals or groups determining their own health needs characterize "shared Agency" activities. The physician works in partnership with that individual or group to access services and support. Examples include: A physician who engages with a patient group and helping to facilitate social inclusion and health care knowledge exchange based on the group's identified needs; a physician helping a patient to advocate for their own end-of-life preferences.

Summary

Health advocacy is both a mind-set and a multi-faceted set of skills that includes ensuring access to care, navigating the health care system, mobilizing resources, addressing health inequities, influencing health policy, and creating system change. To be competent health advocates, physicians must understand the factors that create health inequities and recognize how they impact the lives of their patients and populations. Although it is clear that efforts to improve health of an individual or population must consider "upstream" factors, how this is operationalized in medicine and medical education remains controversial.

If medical education answers the call for transformation (Frenk et al. 2010) in order to develop health care professionals with leadership skills, critical thinking abilities, and a systems perspective, then our future health professionals will be equipped as change agents, paving the way for health advocacy and action to reduce health inequities.

Training physicians who are responsive to the needs of patients, communities, and populations requires more than a cursory examination of curricular interventions. It requires an evaluation of the training environment in undergraduate and postgraduate medical education (Martin & Whitehead 2013), a commitment to the social accountability of medical schools to recruit and train the right mix of physicians (Boelen & Woollard 2011), an acknowledgement of the challenges that exist within current health care environments that serve to discourage advocacy (Dobson et al. 2015) and a redistribution of resources and curricular time towards advocacy teaching, learning, and assessment. It is important to be clear about educational goals, to create time and space to integrate health advocacy into training, and to better define our advocacy experiences and represent health advocacy in certification processes (Shah & Brumberg 2014). In order for health advocacy to be sustainable in practice, attention must be paid to the structure of current health care systems (Shah & Brumberg 2014) and the dynamic nature of physicians' roles within these systems (Frenk et al. 2010; Snadden 2013).

Solutions will involve education enterprises, organizations and institutions as well as the communities they serve (Martin & Whitehead 2013; National Academies of Sciences Engineering and Medicine 2016). The UBC Health Advocacy

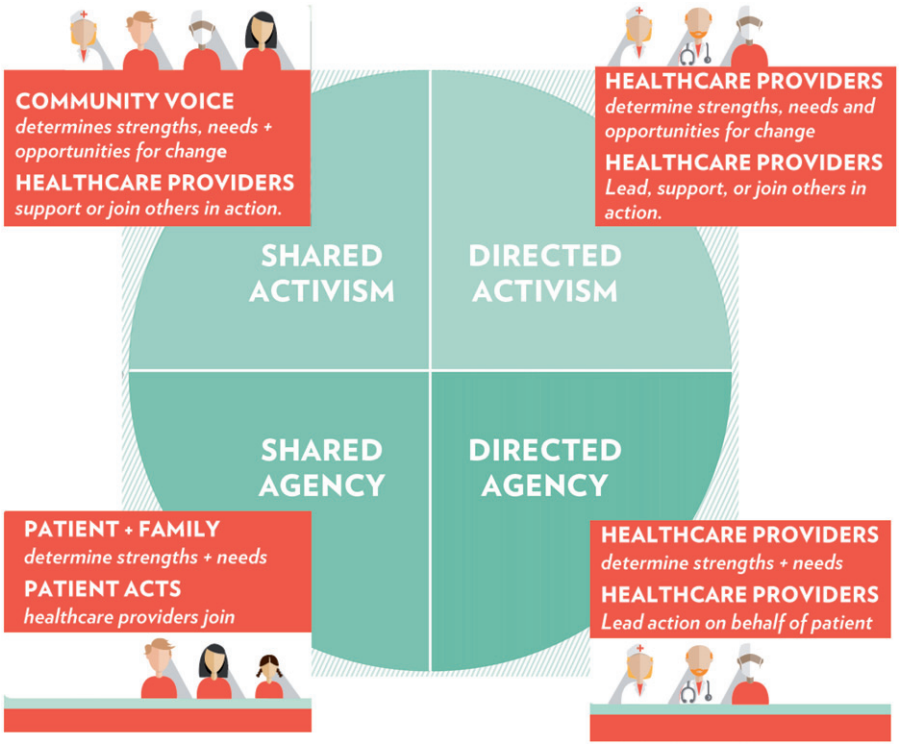

Figure 4. Health advocacy approaches and activities in the UBC Health Advocacy framework.

framework provides a tool that may help learners, educators and programs explore health advocacy more fully.

Limitations and future directions

Any framework has inherent limitations; while allowing elaboration and explication through illuminating and focusing an approach to a topic also excludes material that falls outside of the framework (Bordage 2009). Although it is likely that this framework is applicable to other health professionals and even others outside of health care, it was generated from data collected from physicians and it has not yet been validated by other health professions. Self-advocacy by patients, families, and others is not explicitly highlighted here, as by its nature is not an activity of physicians; in the extreme versions of "shared" advocacy, physician involvement may be limited or insignificant. Finally, the representation of frequency of initiatives and scope of commitment within this framework is not obvious. For example, one physician could fill out forms for numerous patients (i.e. "agency") and only invest a very small amount of time and energy. Another physician could join the board of a community organization once (i.e. "activism") and commit hundreds of hours of time and considerable intellectual property. Future work might attempt to visually represent the frequency of initiatives and scope of involvement. As medicine evolves rapidly during the expansion of both knowledge and access to knowledge by patients, physicians will become less holders of information and more translators of information. It is expected that physicians will increasingly take on a guiding or advocacy role in supporting better health for their patients and communities.

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