EDUCATION FOR HEALTH

ORIGINAL RESEARCH PAPER

Inspiring Health Advocacy in Family Medicine: A Qualitative Study

L Mu, F Shroff, S Dharamsi

The University of British Columbia, Vancouver, BC, Canada

Published: *April 2011*

Mu L, Shroff F, Dharamsi S

Inspiring Health Advocacy in Family Medicine: A Qualitative Study
***Education for Health*, Volume 24, Issue 1, 2011**

Available from: http://www.educationforhealth.net/

ABSTRACT

Context: The Canadian Medical Education Directions for Specialists identifies health advocacy as an essential role for physicians. Health advocacy is also an integral part of the principles of family medicine. It relates to the physician's responsibility to identify and respond appropriately to the social determinants of health and the healthcare needs of vulnerable and marginalized populations. The competencies related to health advocacy are regarded by medical educators as difficult to integrate into residency training.

Objectives: This qualitative study investigates what family medicine residents, educators and physicians perceive inspires them to engage in health advocacy, and explores how best to incorporate related competencies into medical training.

Methods: In-depth, semi-structured interviews conducted with a purposive sample of four family medicine residents, three physicians and two educators who self-identified or were identified by peers as health advocates. Interviews were recorded, transcribed and analyzed using framework analysis. Transcripts were made available to the participants to ensure transcript accuracy.

Findings: Early exposure to social injustice, parental influences, role modeling and internal motivators were seen as important inspirations for health advocacy.

Conclusion: Creating an enabling and nurturing environment prior to and during residency training may be necessary to sustain the motivation to engage in health advocacy. Findings from this study suggest possibilities for a resident-guided participatory curriculum development process around health advocacy. Recommendations for promoting health advocacy in postgraduate

training include effective integration of health advocacy in the curriculum by providing protected time and resources, providing experiential learning opportunities and fostering a community of practice for physician health advocates.

Keywords: CanMEDS roles, health advocacy, medical education, pedagogy, qualitative research, social responsibility

Introduction

For decades, physicians and medical institutions have been called upon to take a more active role in health promotion and disease prevention. While most physicians recognize the importance of working on population health issues, many are not undertaking activities in this arena[1-9]. As a result, medical schools have been advised to ensure greater social accountability by directing their education, research and service activities towards addressing the priority health concerns of the community, region and/or nation they have a mandate to serve[10-12].

The Canadian Medical Education Directions for Specialists (CanMEDS) framework of essential physician competencies includes health advocacy (HA) as a key component[13]. The health advocate role requires physicians to use their expertise and influence as health advocates for advancing the well-being of individual patients, communities and populations. Health advocacy is also an integral part of the four principles of family medicine as articulated by Rosser[14]. As skilled clinicians, family physicians are called upon to serve as a resource to their communities. They are required to adapt to the primary healthcare needs of the population, in response to the mounting evidence that a strong primary healthcare system improves the health of populations[15-21].

Yet, ten years after the formal adoption of the health advocate role into Canada's postgraduate educational objectives, the exact nature of this role remains nebulous and little is known about how to teach and evaluate related competencies[22,23]. A variety of pedagogical frameworks and approaches have been proposed and piloted, including service-based learning[24,25], positive role modeling and reflective learning[26,27], research-based health activism, and partnering with community organizations[3,28-31]. Although some researchers have attempted to understand how best to engage physicians in reducing health disparities and increasing their responsiveness[25,32,33], little is known about what motivates family medicine residents and physicians to participate in health advocacy.

This study examines what inspires family medicine residents and physicians to engage in health advocacy and explores how to meaningfully incorporate the CanMEDS health advocate competencies into residency training.

Studying what 'inspires' individuals may provide one way to understand the uncertainties surrounding health advocacy and its integration into medical training. Inspiration as a concept is well established in the social psychology literature. Thrash and Elliot[34] explain that inspiration involves a *trigger* (person or idea) and a *target* (behavior, or personal goal). They propose that inspiration as a concept may be understood and operationalized through 1) trigger-oriented questions related to sources of inspiration, and 2) target-oriented questions that seek answers around the purposes possibly served by inspiration. This exploratory study sought to develop a better understanding of what triggers family medicine physicians, educators and residents to participate in health advocacy related activities, and for what purposes.

Methods

Guided by principles of interpretive and hermeneutical frameworks[35], we conducted semi-structured, in-depth interviews with a purposive sample of four family medicine residents, two educators and three physicians, all associated with a single department of family medicine in an urban center. These individuals self-identified or were identified by their peers as health advocates. We conducted a total of nine interviews; each interview lasted between 60-90 minutes, and was recorded and transcribed verbatim. Each participant was given an opportunity to review the transcribed interview for clarification and accuracy[36]. LM, a medical resident at the time, conducted seven of the interviews following training provided by the co-authors, both of whom have extensive experience teaching and conducting qualitative research. FS conducted one of the interviews, as part of the training process for LM.

Interviewees were asked to reflect upon their motivations for engaging in health advocacy, the influence of their residency experiences upon their advocacy work, and how residency training could be improved for those aspiring to do HA. Taken together, multiple perspectives provided a form of data triangulation as well as a richer, more varied picture of the interaction between residency training and health advocacy. We applied the *Framework Analysis*[37] process (familiarization; identifying a thematic framework; indexing; charting; mapping and interpretation) to develop themes based on the research questions and related interview narratives. Following a period of detailed study of the transcripts, we coded all transcripts and categorized codes under main ideas, producing a chart of key themes. We added and modified themes using an iterative process until we found significant similarities within each theme.

Findings

The participants' reported that their conceptions of health advocacy were *triggered* by heightened levels of empathy, sensitivity and compassion for patients from marginalized groups. Health advocacy activities were seen to include working with community groups that support vulnerable populations, advocacy-oriented research, being active in medical associations, making financial donations and political lobbying for positive social change. These activities generally *targeted* social and environmental determinants of health, as well as factors that affected access to healthcare services.

For participants, there was a clear distinction between individual health advocacy and advocacy at a community or systemic level. Individual advocacy was conceptualized largely in terms of helping individual patients gain access to healthcare or social services and assisting them in negotiating the healthcare system. Participants viewed empowering and working with communities and with others who have expertise in health advocacy as very important.

We have organized our findings thematically, with representative quotes and phrases under each theme as examples that highlight the participants' perspectives and attitudes toward health advocacy.

Inspiring and Motivating Factors

Internal motivators were important for all participants. These fell into three broad areas: the recognition of a '*need*' to effect positive social change and a corresponding desire to be socially responsive; professional and personal satisfaction; and the feeling of '*engaging in a greater cause.*' Family values, parental influence, role models and early exposure to social inequity were seen as

important motivating factors. Hence, there was an innate interest in engaging in health advocacy that could not otherwise be accounted for by previous experiences. As a result, some residents reported a motivation to actively seek opportunities to engage in health advocacy within medicine.

> *Once I was in medicine, my first year of medical school, I was looking [for] how I can contribute as much as possible, with this career, to marginalized populations.*

The importance of witnessing health challenges, within their close circle of family or friends and among socioeconomically disadvantaged groups, emerged frequently in discussions and seemed to leave a strong impression. Participants who had educational or work experience outside of medicine realized that these factors contributed to their broader perspective on health and health advocacy. Although formative experiences were an underlying influence for all participants, the residents reported pivotal experiences from their medical training which reinforced their interests in health advocacy. These included working with highly-motivated peers and meeting physician mentors, usually through involvement in a health advocacy project. One resident describes her experience of a formal global health program in undergraduate medicine:

> *…There was a program that we were encouraged to apply for that had us volunteering in this inner city health clinic… [it] gave us the opportunity to live in a northern First Nations community.… [Another] experience was living for a summer in rural Mozambique… I was excited about that program and applied and in that found another sort of community of people who were interested in working in marginalized communities but also working on changing health status and improving health in those communities. And that became a very formative part of my medical education so far.*

Integrating Health Advocacy in Postgraduate Education

Participants held mixed feelings about integrating health advocacy into residency training. One of the physicians we interviewed viewed residency training as a time for acquiring clinical skills and questioned the effectiveness of focusing on health advocacy during this time.

> *[R]esidency is a time when the focus is on developing competency at clinical practice…learning [about advocacy] may therefore not be optimal or even as good as it is in medical school when students are less stressed with the day-to-day aspects of providing individual patient care.*

Other participants felt that health advocacy training should be integrated into postgraduate medical training right from the outset. There was also a sense among the faculty that, *'we do too much sheltering of residents':*

> *Too much of, 'you need to focus on just learning the clinical stuff.' Residents need to know about how life works as a doctor. Understanding how [physicians] fit into the larger picture of what is going on that is creating this environment where [we] work is absolutely crucial.*

Overall, the participants agreed that integrating HA as part of the formal curriculum can help future physicians develop the knowledge and skills for improving population health and enhancing social accountability. There was general agreement that

sensitization to the social context of patients' lives should be integrated early into undergraduate and postgraduate curricula. One of the physicians pointed out:

> *It's essential that you get exposed when you're a resident, that you're actually incorporating it as part of your practice from the beginning…*

Residents also emphasized the need to create time and flexibility within the postgraduate curriculum for health advocacy activities. This seemed to stem, in part, from their own frustrations with trying to engage in health advocacy during their training. Suggestions included health advocacy-oriented research, specific advocacy electives, longitudinal residency structures which give residents control over their own schedules, and part-time residencies. One resident described using research to legitimize health advocacy.

> *… Ultimately in my career I saw that as a niche - research is something that is valued by the healthcare community and by funding agencies - I could actually use that in its role as an advocacy tool.*

Finding ways to make health advocacy valued in the medical system was thought to be a key factor. For instance, physicians mentioned the importance of training residents in a non fee-for-service environment, so that taking more time to provide care for a patient would not result in loss of income.

Enabling and Impeding Factors for Health Advocacy in Residency

Participants reported that HA in residency tended to be opportunistic in nature. Residents attempted frequently to negotiate their HA interests into their training. Some found that the research project requirement served as an opportunity to give expression to their health advocacy interests. Although participants reported being supported in principle to conduct HA projects, such support did not translate into practical accommodations which would have made the projects more fruitful and satisfactory. One physician said of her resident project:

> *[It was] extremely well supported. I should say that there was lots of support, 'Go get it! We think it's great what you're doing.' [Yet],there wasn't a lot of financial support, there wasn't a lot of time given... But certainly everyone I talked to about the project thought it was a great idea.*

The main barriers reported by participants were time constraints, lack of control over schedules, lack of formal curriculum in health advocacy and lack of mentors. Participants emphasized problems with a culture of entitlement within medicine – they acknowledged that physicians are generally privileged members of society and may have difficulty relating to marginalized people prompting a view that there is a sense that professional obligation to health advocacy does not extend beyond clinical medicine. In essence, health advocacy was seen as less valued due to its '*para-clinical'* nature.

> *…We get so much teaching on clinical issues and very little about how you can advocate about these issues in a broader context and I think that's a reflection on the fact that there are obviously accreditation requirements and their focus in medicine is clinical always.*

Culture of Medicine

Several participants alluded to the need for attention to non-academic aspects of the curriculum. In particular, the attitudes and behaviors of clinical preceptors towards patients and learners were seen to be an important influence on the behaviors of trainees. A safe, respectful teaching environment for learners was stressed, as was the need for modeling of health advocacy behaviors and activities.

> *My opinion is that residency is more about acculturation than just pure translation of knowledge from people around you. You're not just absorbing knowledge; you are absorbing a way of being, a way of doing things and a way of thinking. And that just comes from being in this milieu, in this environment. And so the environment actually then has to pass on those values.*

Meaningful Learning through Experience

Participants recommended both didactic teaching methods and experiential learning techniques to support learning about HA. However, some felt that learning through experience would have a more meaningful impact on learners' perceptions and attitudes. Some participants recommended a basic level of exposure to health advocacy issues for all learners at the undergraduate and postgraduate levels. Participants suggested that formalized involvement in a HA project by partnering with community organizations could present a fruitful opportunity for experiential and participatory learning. The key features of such a program would be a meaningful and sustainable integration into the curriculum, support from faculty in terms of mentorship and resources and longitudinal involvement that would span both undergraduate and postgraduate training.

> *I think that we can add better exposure to experience, not just experiential like, 'here go do an elective and see what it's like.' There's a value to experiential learning for sure, but participating at every level of the experience is probably the way the learning occurs, not just 'plunk you in at the implementation phase' you know and 'just absorb something, whatever you learn will come out of it.'*

Participants cautioned against framing additional curricular content as '*mandatory*' as residents may react against activities which seem like an additional imposition.

Community of Practice and Mentorship

A strong theme throughout the interviews was the importance of connection to like-minded peers. This was particularly important for resident participants. Being part of a group of motivated peers provided inspiration to engage in health advocacy, motivation to continue despite challenges, and was also seen as one of the greatest rewards of health advocacy work.

> *I think largely it's the community and the people around those things. Whatever one gets involved and passionate about, if there's people to share that with that becomes very very important, …you realize how important those friendships, connections are, and I realized that a group of people that I worked with, I protested with, or you know tried to change things with, often came up against big roadblocks with, those are hugely bonding experiences and that's really become my community and that sustains me a lot… if we spent more time thinking about that idea of community around activism or…*

around health advocacy that we could find some ways to encourage and create that a little bit more, at least facilitate the process.

Participants mentioned that being part of a residency site which focused on marginalized populations increased the likelihood of meeting like-minded peers and mentors, and of having relevant clinical experiences.

The residents [at my residency site] had all a kind of similar set of experiences, were equally motivated to be involved in addressing inequities in health. So it kind of draws a lot of like-minded people.. [leading to] peer mentorship, talking to colleagues about their experiences and reinforcing each other and being involved in some collective initiatives... so there were certainly experiences in the residency… that encouraged me.

I also think that we need to have some way… where you can come together… some place where you could have that growing of ideas, that happens when people who are excited about a topic start spilling over. Instead of people working individually in the martyr role… we need to be able to band together in systematic ways to have impact on government and society in general.

The residents also voiced a desire to see a formalized mentoring program:

It would be wonderful to have an established 'advocacy mentorship program' which would allow students to connect with mentors through group networking activities and one-on-one meetings.

Discussion

The physicians, educators and residents we interviewed in this study believed that early exposure to social inequity, family values, role models and other similar experiences influenced their desire to '*make a difference*.' These findings appear to be consistent with existing literature about physicians' motivations for engaging in health advocacy. Other researchers have also found that many of these experiences take place during the formative years or emphasized influences from pre-clinical educational, work, or life experiences[27,32,33]. This suggests that among the range of important factors that influence thoughtful, compassionate and community responsive physicians are their experiences prior to entering medical school.

Our study also suggests that facilitated experiences during medical training may help to reinforce the desire to engage in health advocacy. For instance, some of our participants indicated that they actively sought outlets for health advocacy during medical training. While some of the participants had engaged in faculty-supported advocacy initiatives in medical school, there appeared to be a dearth of formalized opportunities during residency. Although residency was recognized as a stressful time for trainees and there is immense pressure to master clinical competencies, there was general agreement among participants that health advocacy training ought to be better integrated into postgraduate curricula.

Opportunities to participate in faculty supported, community partnered, longitudinal health advocacy projects appear to enable residents to make a meaningful contribution to the healthcare needs of vulnerable populations[30]. A formalized mentorship program that matches residents with physician health advocates in their training site may help to develop a community of practice for health

advocate trainees and physicians. Our study also echoes other researchers' findings that advocacy activities should not be viewed simply as 'charity work' or an 'add-on' to core clinical activities, because this provides less incentive for physicians to exercise their role as health advocates[22]. For HA to be integrated into curricula in a meaningful and effective manner, it ought to be genuinely acknowledged, allocated resources and allotted protected time. Moreover, a charity model of HA is not likely to result in sustainable improvements in health status.

Limitations

Qualitative methods are useful for exposing how people think about a particular phenomenon by analyzing the language they use to describe or explain their beliefs, reasoning, experiences and values. Although qualitative studies are not conducted to be generalizable, the relevance of our findings may be transferable to other similar contexts. Since our interview participants were all from an urban academic teaching center, the results of our study are most applicable to similar contexts. The inclusion of residents, physicians and educators provided multiple perspectives, drawing upon a range of experiences spanning both time and geography. However, given the small sample size we cannot support claims of having achieved theoretical saturation. Similar studies across a range of programs in different residency programs would provide a broader perspective of the various factors that enable or limit approaches to HA.

Conclusions

This study builds upon the limited but growing literature on what inspires and motivates physicians to engage in health advocacy. In order for HA to become a standard part of medical curricula, meaningful and sustainable approaches are required. There should be efforts to overcome the tension between an exclusive focus on clinical medicine and efforts that respond to the broader determinants of health. Possible ways to promote meaningful engagement in HA activities were identified from our study. These included a greater awareness of the social determinants of health, providing experiential learning opportunities throughout medical training, community partnerships and fostering a community of practice for physician health advocates.

Acknowledgements

This project was partly funded by a grant to Dr. Shafik Dharamsi from the Royal College of Physicians and Surgeons of Canada on a larger study on the health advocate role in medicine. We would like to also acknowledge the Providence Healthcare Department of Family Medicine for their support of this residency project. We are grateful to all of our participants for their time and invaluable insights. In addition, we would like to acknowledge J. Pipitone for his assistance with the interview transcription. Please direct all correspondence to Dr. Shafik Dharamsi (shafik.dharamsi@familymed.ubc.ca).

References

1. Brill JR, Ohly S, Stearns MA. Training community-responsive physicians. *Academic Medicine*. 2002; 77(7):747.

2. Gruen RL, Pearson SD, Brennan TA. Physician-citizens-public roles and professional obligations. *Journal of the American Medical Association*. 2004; 291(1):94-98.

3. Gruen RL, Campbell EG, Blumenthal D. Public roles of US physicians: community participation, political involvement, and collective advocacy. *Journal of the American Medical Association*. 2006; 296(20):2467-2475.

4. Furler J, Harris E, Harris M, Naccarella L, Young D, Snowdon T. Health inequalities, physician citizens and professional medical associations: an Australian case study. *BMC Medicine*. 2007; 5:23.

5. Oandasan I, Malik R, Water I, Lambert-Lanning. Being community-responsive physicians. Doing the right thing. *Canadian Family Physician*. 2004; 50(7):1004-1010.

6. Parboosigh J. Medical schools' social contract: more than just education and research. *Canadian Medical Association Journal*. 2003; 168(7):852-853.

7. Rourke J. Social accountability in theory and practice. *Annals of Family Medicine*. 2006; 4(1):S45-48.

8. Rubenstein HL, Franklin ED, Zarro VJ. Opportunities and challenges in educating community-responsive physicians. *American Journal of Preventive Medicine*. 1997; 13(2):104-108.

9. Verma S. Honouring the Social Contract: Medical schools take social responsibility seriously. *University of Toronto Bulletin.* November 14, 2005; 16-17.

10. Woollard RF. Caring for a common future: medical schools' social accountability. *Medical Education*. 2006; 40(4):301-313.

11. Gregg J, Solotaroff R, Amann T, Michael Y, Bowen J. Health and disease in context: a community-based social medicine curriculum. *Academic Medicine*. 2008; 83(1):14-19.

12. Boelen C, Woollard B. Social accountability and accreditation: a new frontier for educational institutions. *Medical Education*. 2009; 43(9):887-894.

13. Frank JR, Danoff D. The CanMEDS initiative: implementing an outcomes-based framework of physician competencies. *Medical Teacher*. 2007; 29(7):642-647.

14. Rosser W. Sustaining the 4 principles of family medicine in Canada. *Canadian Family Physician*. 2006; 52(10):1191-2, 1196-1197.

15. Starfield B. Primary care and health: a cross-national comparison. *Journal of the American Medical Association*. 1991; 266(16):2268-2271.

16. Starfield B, Lemke KW, Bernhardt T, Foldes SS, Forrest CB, Weiner JP. Comorbidity: implications for the importance of primary care in 'case' management. *Annals of Family Medicine*. 2003; 1(1):8-14.

17. Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within Organization for Economic Cooperation and Development (OECD) countries, 1970-1998. *Health Services Research*. 2003; 38(3):831-865.

18. Gruen RL. Evidence-based advocacy: the public roles of health care professionals. *The Medical Journal of Australia*. 2008; 188(12):684-685.

19. Marmot M. Social determinants of health inequalities. *The Lancet*. 2005; 365(9464):1099-1104.

20. Illich I. Medical Nemisis 1974. *Journal of Epidemiology and Community Health*. 2003; 57(12):919-922.

21. Filc D. The medical text: between biomedicine and hegemony. *Social Science and Medicine*. 2004; 59(6):1275-1285.

22. Verma S, Flynn L, Seguin R. Faculty's and residents' perceptions of teaching and evaluating the role of health advocate: a study at one Canadian university. *Academic Medicine*. 2005; 80(1):103-108.

23. Leveridge M, Beiko D, Wilson JW, Siemens DR. Health advocacy training in urology: a Canadian survey on attitudes and experience in residency. *Canadian Urological Association Journal*. 2007; 1(4):363-369.

24. Dharamsi S, Espinoza N, Cramer C, Amin M, Bainbridge L, Poole G. Nurturing social responsibility through community service-learning: Lessons learned from a pilot project. *Medical Teacher*. 2010; 32:905-911.

25. Dharamsi S, Richards M, Louie D, Murray D, Berland A, Whitefield M, Scott I. Enhancing medical students' conceptions of the CanMEDS Health Advocate Role through international service-learning and critical reflection: A phenomenological study. *Medical Teacher*. 2010; 32(12):977-982.

26. Chretien K, Goldman E, Faselis C. The reflective writing class blog: using technology to promote reflection and professional development. *Journal of General Internal Medicine*. 2008; 23(12):2066-2070.

27. Wear D, Zarconi J. Can compassion be taught? Let's ask our students. *Journal of General Internal Medicine*. 2008; 23(7):948-953.

28. Cha SS, Ross JS, Lurie P, Sacajiu G. Description of a Research-based Health Activism Curriculum for Medical Students. *Journal of General Internal Medicine* 2006; 21(12): 1325–1328.

29. Flynn L, Verma S. Fundamental components of a curriculum for residents in health advocacy. *Medical Teacher*. 2008; 30(7):e178-183.

30. Hufford L, West DC, Paterniti DA, Pan RJ. Community-based advocacy training: applying asset-based community development in resident education. *Academic Medicine*. 2009; 84(6):765-770.

31. Kaczorowski J, Aligne CA, Halterman JS, Allan MJ, Aten MJ, Shipley LJ. A block rotation in community health and child advocacy: improved competency of pediatric residency graduates. *Ambulatory Pediatrics*. 2004; 4(4):283-288.

32. Oandasan IF, Barker KK. Educating for advocacy: exploring the source and substance of community-responsive physicians. *Academic Medicine*. 2003; 78(10):S16-19.

33. Vanderbilt SK, Wynia MK, Gadon M, Alexander GC. A qualitative study of physicians' engagement in reducing healthcare disparities. *Journal of the National Medical Association*. 2007; 99(12):1315-1322.

34. Thrash TM, Elliot A. Inspiration as a psychological construct. *Journal of Personality and Social Psychology.* 2003;84(4):871–889.

35. Schwandt TA. Three epistemological stances for qualitative inquiry: Interpretivism, hermeneutics and social constructionism. In: Denzin NK, Lincoln YS, editors. *Handbook of qualitative research.* Thousand Oaks, CA: Sage; 2000. p. 189-213.

36. McLellan E, MacQueen K, Neidig J. Beyond the Qualitative Interview: Data preparation and transcription. *Field Methods*. 2003; 15:63-84.

37. Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess R, editors. *Analysing qualitative data.* London: Routledge; 1993. p. 173-194.