

Teaching Advocacy Through Pediatrics: A Natural Approach to a Complex Challenge

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The late Dr. Arnold Relman—former editor for the *New England Journal of Medicine*—described the physician contract for patient advocacy beautifully: “... society grants us great power and influence over the lives of our patients who expose their bodies and their psyches to us, put their lives in our hands ... Society grants all of these things to its physicians in exchange for one basic thing, which is that physicians agree to serve the health care needs of their patients first and foremost.”¹ Dr. Relman’s statement, published in 1990, describes the challenge of translating science into compassionate care. Twenty-five years later, we continue to struggle with this same challenge; yet we now hope that physicians can address health care needs not only for individuals but also for entire populations. To do that, we must consider how to train the next generation in advocacy.

For decades, medical educators have strived to train doctors who understand the social determinants that underlie the health of patients and communities. Social determinants of health are briefly defined as “the economic and social conditions that shape the health of individuals and communities.”² Most physicians enter the medical field inspired to improve the health of others. Yet, at times we struggle to develop and implement optimal curricula that prepare future physicians to translate that inspiration into genuine advocacy and partnership.

Many physicians have not received formal training in advocacy as a critical domain of clinical practice. Advocacy has been described as “action by a physician to promote those social, economic, educational, and political changes that ameliorate the suffering and threats to human health and well-being that he or she identifies through his or her professional work and expertise.”³ In the field of pediatrics, the Pediatric Milestone Project⁴ was developed to delineate key competencies that pediatricians would ideally attain

over a continuum from undergraduate medical education through their careers. Advocacy was included as a core responsibility of our field. Specifically, the expectation is that, regardless of specialty, pediatricians by definition will engage in advocacy both within and outside of the hospital and at multiple levels, including individual, local, regional, national, or global settings.⁵ Advocacy can be thus manifested in diverse ways (see Table 1 for examples) such that any physician can find a “home” that can blend his or her interests, capacity, and strengths.

Recognizing that residents must be competent with such patient issues, the ACGME has created advocacy education requirements for many residency programs in keeping with their competency-based system of training. For instance, in Pediatrics, residents must have “ambulatory experiences to include elements of community pediatrics and child advocacy.”⁶ This competency requirement has prompted residency program leaders to create new experiences for their residents and find faculty willing and able to lead the charge on advocacy education. In our residency program, residents visit community centers impacting patient health (e.g., Legal Aid, WIC office, public schools) to garner a working relationship with these community partners and a better understanding of how to utilize the services available to our patients. We also develop advocacy projects while in training to help foster practical skills at identifying problems and effecting changes in our society. This is indeed a valuable step forward in creating physician advocates, but we should not settle for advocacy education only at the graduate level.

Though still an important issue, 25 years after Dr. Relman’s remarks, we have come a long way in advocacy education. Indeed, much progress has been made right here at Wake Forest School of Medicine. The MD goals and objectives state that “by the time of graduation, students are expected

to advocate for quality patient care and optimal care systems.” To help address this competency, first-year medical students begin their training with the LAUNCH curriculum. This innovative program includes a service learning experience for each student in the very first days of their professional medical training. A select group of second-year students, Service Learning Scholars, help coordinate and enrich the service experiences that first year students have during the LAUNCH program and offer additional training and experience for interested students. This program is a prime example of how service learning can be a conduit for teaching advocacy and can provide the basis for advocacy training throughout clerkships.

There is no perfect curriculum to teach medical students everything they will need to know to practice medicine. However, where we currently stand, there is only a small subset of medical schools that explicitly include advocacy training in the undergraduate curriculum. Some schools have supported faculty-led or student-organized advocacy small groups that meet on an elective basis for interested parties. While many schools are moving to expand clinical time and consolidate classroom time, some may feel that there’s no room for mandating advocacy in the curriculum for undergraduate medical education. A natural fit for including advocacy education may lie in the field of Pediatrics. After all, in Pediatrics, we take care of a large population of patients who are unable to speak or advocate for themselves. For instance, at Wake Forest School of Medicine, advocacy talks have been integrated into third-year Pediatrics clerkships. In addition, we are looking to facilitate medical student involvement in resident-led advocacy projects. Furthermore, it will be essential to consider ways in which advocacy projects can be translated into science to measure the outcome of these efforts in community engagement.

To train the next generation of physician advocates, there must be greater emphasis placed on advocacy at the level of medical education. Ideally, the foundation would be laid in

Table 1: Examples of Advocacy Across Multiple Levels and Diverse Specialties

Orthopedic Surgery	– Recreational off-road vehicle (ROV) safety
General Surgery	– Injury prevention (seatbelts, car seats)
Anesthesiology	– Preventing toxicity of anesthetics and sedation drugs
OB/Gyn	– STI & teen pregnancy prevention
Psychiatry	– Access to mental health services
Dermatology	– Tanning bed restrictions
Primary Care	– Access to care
Emergency Medicine	– Accidental Ingestions, trauma prevention
Pathology	– Prognosis of childhood cancers
Radiology	– Limiting radiation exposure risk
Urology	– Multidisciplinary care for neonates with ambiguous genitalia
Neurology	– Athlete concussion education and prevention
Plastic Surgery	– Firearm Safety, burn prevention
ENT	– Obesity and Obstructive Sleep Apnea
Ophthalmology	– Preventing blindness globally
Neurosurgery	– Bicycle Helmet Safety

the undergraduate years in the form of formal course work, small group practicums, and real life advocacy work. It is time for medicine to commit to training individuals who are prepared not only to serve, but also to speak on behalf of and partner with patients, families, and communities.

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