

# The CanMEDS Role of Health Advocate in Postgraduate Education at UBC:

## Summary Report

### Project summary

The recommendations in this summary report come from a project funded by the UBC Faculty of Medicine Special Populations Fund: 'Addressing CanMEDS competencies through the involvement of patients and community organizations in postgraduate medical education' and are supported by the Postgraduate Dean. They are offered in the context of the *Collective Vision for Postgraduate Medical Education in Canada* (FMEC-PG) which recommends that "Responding to the diverse and developing health care needs of Canadians requires both individual and collective commitment to social accountability". The specific project goals were to:

- Identify opportunities to involve patients and community organizations in residency training with special reference to the CanMEDS competencies of Health Advocate, through a needs assessment with residency program leaders, residents and community-based advocacy organizations.
- Obtain community perspectives on health advocacy, on the roles that physicians do or could play, on the competencies that physicians should have, and how community organizations could be involved in the training of residents about health advocacy.

The project comprised a needs assessment and educational forum that involved consultations with leaders of 19 community-based organizations, 15 postgraduate medical education (PGME) leaders and 7 residents (see appendix for list of contributors). The findings and recommendations cluster into three areas: Philosophical underpinnings / principles for curriculum development; Teaching and learning; and Collaboration.

### Recommendations

#### Philosophical underpinnings / Principles for curriculum development

##### 1. Advocacy should be integrated throughout residency training

- i) The needs assessment highlighted that all CanMEDS roles come into play in health advocacy. Consequently, training in other physician roles should integrate opportunities to teach about health advocacy, and likewise health advocacy training would necessarily build competencies for other roles. For example, the communicator and collaborator roles are particularly good areas for incorporating teaching about health advocacy because they include skills frequently used for health advocacy.
- ii) Health advocacy should not be viewed as an extracurricular activity for a few residents. Opportunities should be sought to weave advocacy activities into everyday thinking and practice.

## **2. Postgraduate teaching and learning about health advocacy requires institutional support**

- i) The needs assessment and forum suggested that advocacy should be embedded as 'part of what being a doctor is about'. However, lack of time and competing priorities are barriers to teaching and learning about health advocacy. Residents and faculty admitted that their main focus during residency training is on the medical expert role. Advocacy is taught if time allows. This approach implies that the health advocate role is optional and not important.
- ii) There was also consensus that teaching and learning about health advocacy requires good mentoring / role modeling and that many faculty are ill equipped to teach health advocacy. For many, the health advocate role did not exist when they were training and therefore they do not have any models of how to teach it. Protected faculty time and faculty development for teaching health advocacy are needed. A framework for faculty development could be created to embed advocacy training throughout postgraduate medical education.

### **Recommendations for teaching and learning**

## **3. The use of an agreed framework could help residents and preceptors to think more broadly about advocacy**

- i) In the needs assessment, most PGME leaders and residents found it difficult to define health advocacy. At the forum we explored the use of a framework developed by Carlisle (2000); most participants found it to be a useful tool to describe their advocacy work and think about other approaches to advocacy issues. Having such a framework is a good way to introduce and challenge misconceptions about approaches to advocacy that are less common in medicine, such as community development and activism. For example, at the forum we found that activism is often seen narrowly as protesting or expressing opinions as medical experts rather than one's capacity to engage in the public sphere through writing and expressing opinions informed by knowledge, experience and practice.
- ii) Practical examples in each advocacy domain that illustrate a range of advocacy activities could help individuals identify the areas and types of advocacy that are of interest to them (e.g. 'thank you campaign' as an example of activism). This could be part of a toolbox to help learners and preceptors develop plans for teaching and learning the health advocate role.

## **4. Develop formalized opportunities to learn how to do advocacy that provide selections of 'hands on' activities, driven by resident interest and community identified needs**

- i) Participants agreed strongly that learning how to do health advocacy requires getting involved in health advocacy work, taking action and experiencing making a difference. However, not all residents will be well-suited to all domains of advocacy. They may be at different stages in terms of their knowledge, skills and experience with advocacy. Learning opportunities should be made available for residents with different levels of expertise and residents should be able to choose the domains of advocacy work that are of interest to them.
- ii) The current approach of giving residents ownership of advocacy projects has many strengths but needs to be supported by faculty mentorship and a mechanism for promoting sustained activity (to avoid a fragmented and sporadic approach as residents come and go).

- iii) Residents should have opportunities to get involved in advocacy outside of their specialty (see 7 below).
- iv) Advocacy needs and approaches should ideally be identified by or with the community.

#### **5. Explore ideas and tools for assessment**

- i) Almost all PGME leaders and residents found the current assessment of the health advocate role to be problematic. Residents found the inclusion of health advocate on the standard ITERs to be meaningless (it was either checked as could not assess, or given a token rating). Advocacy projects or student-driven activities were generally not assessed (no credit given) or even monitored as having occurred. The introduction of portfolios in some programs offered opportunity to document advocacy activities but this is at an early stage.
- ii) Assessment is an area where there could be collaboration across postgraduate programs.

#### **Recommendations for collaboration**

#### **6. Create opportunities for on-going collaborations with community-based organizations**

- i) Community organizations have a wealth of expertise in health advocacy and employ many of CanMEDS roles in their advocacy work. Yet, preceptors and residents were unfamiliar with local community organizations (e.g. many come from out of town) and do not have an easy way to connect with them for the purposes of teaching and learning about health advocacy. An academic half-day that provides an orientation to Lower Mainland organizations and opportunities to discuss advocacy ideas and ways to work together (e.g. 'Advocacy with the community 101') could be offered.
- ii) Forum participants identified sustainability of advocacy initiatives as a concern. Advocacy projects take time and residency is relatively short. A 'sail in, sail out' approach is problematic for building good relationships in the community. Short-term projects to check off the advocacy 'tick box' are seen by the community as self-serving to the resident and/or medical school. It is preferable to provide opportunities for residents to get involved in existing advocacy work that will build their capacity to develop collaborative relationships and can be carried forward and/or handed over to incoming residents when they leave. The focus of advocacy training in residency should be on the processes involved in advocacy (e.g. building relationships, working collaboratively) not the outcomes.

#### **7. Create opportunities for collaboration and sharing between programs.**

- i) Some residency programs have well-developed initiatives (e.g. Social Pediatrics Initiative, Geriatrics Interest Group) for teaching advocacy while others programs' approaches are more ad hoc. Advocacy was seen as an opportunity for 'cross-pollination' where sub-specialties could come together and share what is being done across programs.
- ii) There were also concerns that residency programs, especially sub-specialties, isolate students into silos whereas health advocacy often requires multisectoral collaboration. Opportunities for residents to work collaboratively were proposed (see 4 iii).

## Appendix: ideas and potential action items

- Identify champions at higher levels.
- Protected faculty time
- Identify what is already being done and label as advocacy (if appropriate).
- Dashboard / menu of opportunities developed collaboratively and promoted across programs (regardless of program / specialty) by a mobile team of community, faculty and residents that could be handed down from current to future residents
- Toolbox for teaching and learning advocacy
- Develop assessment tools (based on outcomes)
- Faculty development
- Joint faculty / resident work (residents get involved in faculty advocacy projects)
- Post-graduate non-medical experience (e.g. like fellows non-medical experts half-day).
- Tiers of learning (baseline knowledge to more advanced).
- Create opportunities for advocacy work outside of specialty (intra-professional education)
- Facilitate connections / develop collaborative partnerships between community and postgraduate programs
- Community demonstrations for residents (e.g. shadowing)
- Strategies / opportunities for dialogue / making connections / developing collaborative partnerships between community and postgraduate programs (e.g. newsletters, info bulletin, forum, face-to-face) Pre-project mentoring (use community as a resource) to build skills, how to building relationships, work collaboratively, safe environments for learning about advocacy.

## Appendix: project contributors

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