LCC Session 39 - Advocacy

CanMEDS competency: Health Advocate

Dr. Andrea Hunter

What will happen in this session?

Large group session:

Introducton – CanMEDS 2015, Health Advocate role updates
  • Dr. Andrea Hunter

How can physicians best interact with government officials?
  • Chris Charlton, MP for Hamilton Mountain

Case discussions in small groups (if time allows)

Suggested time: 60 minutes

Readings:
  - Canada’s premiers should connect the dots between health and poverty (by Andrew Lynk, CPS president) – Toronto Star July 22, 2013. http://www.thestar.com/opinion/commentary/2013/07/22/canadas_premiers_should_connect_the_dots_between_health_and_poverty.html

CanMEDS 2015 – version III – Health Advocate role (p. 21-22)

See also attached list of resources, for further reading on advocacy topics/organizations
Cases:

Case 1 – Booster Seats

• A 7 year old child is late for an appointment in your clinic. His parents apologize but are quite frustrated as on their way to your office they were stopped by the police. They were ticketed and fined because their son was not in a booster seat. They were not aware of the new law mandating this in Ontario and tell you that they think it is ridiculous.
• After your interaction with the previous family, you decide to start asking each parent whether or not their child is using a booster seat. You are surprised to find out that of the next 10 children of the appropriate age, only 3 are in booster seats. That evening, you are wondering what, if anything, you can do.
• What are your professional obligations in responding to these parents? What role can you have beyond the direct interactions with your patients in this situation?

Case 2: Social Determinants of Health

• You are working in your senior resident community-based continuity clinic. You see an 8 month old child for plateau in weight gain (weight previously at 50th tile for age, now at 5-10th percentile for age). After a very thorough history and physical exam, you find no concerning findings of malabsorption, increased metabolic needs or losses. She was hospitalized at 6 months of age for RSV bronchiolitis, and mom offers that she found this a particularly stressful few days. As you are leaving the room to review with your staff, mom asks if you have any formula samples available. With some inquiry, you learn that she has been 'couch-surfing' with friends for the last 4 months, has left her previous partner and was laid off from her part-time job last month.
• What are your next steps? What resources are you aware of that would assist you and/or this family in this situation? What role can you have beyond the direct interactions with this family, in this situation?

Case 3: Medication error

• You are the resident representative on your hospital patient safety committee and one month you review 2 cases where patients were inadvertently given excessive doses of morphine during the night. In both cases, the doses were given intravenously instead of orally as had been intended. On further review it becomes evident that the orders were given verbally by a resident to the nurse – in one case, the appropriate oral dose was prescribed IV by a junior resident; in another, the ward was very busy and the nurse was not able to double check the dose with a second nurse before administering.
• How could you address this issue: within your division? Hospital wide? At a health policy level?
Case 4: Bullying

- 16 year old girl presents to your clinic for prolonged fatigue with some mood symptoms. Preliminary workup indicates no red flags for weight loss, fever, inflammatory conditions or self-harm and normal laboratory screening. History reveals that she is going to sleep at 1:30am because of homework, and feels a great deal of stress due to their school work and high parental expectations. She little time for physical activity, leisure, and doesn't spend much time with friends. She disclosed a long history of being bullied at school towards the end of your visit.

- What are your next steps? What resources are you aware of that would assist you and/or this family in this situation? What role can you have beyond the direct interactions with this family, in this situation?
HEALTH ADVOCATE

Health Advocate Role Expert Working Group

Chair: Jonathan Sherbino

Core members: Deirdre Bonnycastle, Brigitte Côté, Leslie Flynn, Andrea Hunter, Daniel Ince-Cushman, Jill Konkin, Ivy Oandasan, Glenn Regehr, Denyse Richardson, Jean Zigby

Advisory members: Marcia Clark, Sherissa Microys

For further information about the deliberations of the CanMEDS Health Advocate EWG in revising this Role for CanMEDS 2015, please see their February 2014 Report.

Definition

As Health Advocates, physicians contribute their expertise and influence as they work with communities or patient populations to improve health. They work with those they serve to determine and understand needs, speak on behalf of others when needed, and support the mobilization of resources to effect change.

Description

Physicians recognize their duty to participate in efforts to improve the health and well-being of their patients, their communities, and the broader populations they serve. Physicians possess medical knowledge and abilities that provide unique perspectives on health. Physicians also have privileged access to patients' accounts of their experience with illness and the health care system. Improving health is not limited to mitigating illness or trauma, but also involves disease prevention, screening, health promotion, surveillance, and health protection. Improving health also includes promoting health equity, whereby individuals and populations reach their full health potential without being disadvantaged by, for example, race, ethnicity, religion, gender, sexual orientation, age, social class, economic status, or level of education.

Physicians leverage their position to support patients in navigating the health care system and to advocate with them to access appropriate resources in a timely manner. Physicians seek to improve the quality of both their clinical practice and associated organizations by addressing the health needs of the patients, communities, or populations they serve. Physicians promote healthy communities and populations by influencing the system (or by supporting others who influence the system), both within and outside of their work environments.

Advocacy requires action. Physicians contribute their knowledge of the determinants of health to positively influence the health of the patients, communities, or populations they serve. Physicians gather information and perceptions about issues, working with patients and their families† to develop an understanding of needs and potential mechanisms to address these needs. Physicians support patients, communities, or populations to call for change, and they speak on behalf of others when needed. Physicians increase awareness about important health issues at the patient, community, or population level. They support or lead the mobilization of resources (e.g., financial, material, or human resources) on small or large scales.

* In the CanMEDS framework, a "community" is a group of people and/or patients connected to one's practice, and a "population" is a group of people and/or patients with a shared issue or characteristic.

† Throughout the Series III draft of the CanMEDS 2015 Framework and Milestones Guide, phrases such as "patients and their families" are intended to include all those who are personally significant to the patient and are concerned with his or her care, including, according to the patient's circumstances, family members, partners, caregivers, legal guardians, and substitute decision-makers.
Physician advocacy occurs within complex systems and thus requires the development of partnerships with patients, their families and support networks, or community agencies and organizations to influence health determinants. Advocacy often requires engaging other health care professionals, community agencies, administrators, and policy-makers.

**Key concepts**

- Adapting practice to respond to the needs of patients, communities, or populations served: 2.1, 2.2
- Advocacy in partnership with patients, communities, and populations served: 1.1, 1.2, 2.1, 2.2, 2.3
- Continuous quality improvement: 2.2, 2.3
- Determinants of health, including psychological, biological, social, cultural, environmental, educational, and economic determinants, as well as health care system factors: 1.1, 1.3, 2.2
- Disease prevention: 1.3, 2.1
- Fiduciary duty: 1.1, 2.2, 2.3
- Health equity: 2.2
- Health promotion: 1.1, 1.2, 1.3, 2.1
- Health protection: 1.3
- Mobilizing resources as needed: 1.1, 1.2, 1.3
- Principles of health policy and its implications: 2.2
- Potential for competing health interests of the individuals, communities, or populations served: 2.3
- Responsible use of position and influence: 2.1, 2.3
- Social accountability of physicians: 2.1, 2.3

### Key competencies

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<thead>
<tr>
<th>Key competencies</th>
<th>Enabling competencies</th>
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<tr>
<td><strong>Physicians are able to:</strong></td>
<td><strong>Physicians are able to:</strong></td>
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<tr>
<td><strong>1. Respond to the individual patient’s health needs by advocating with the patient within and beyond the clinical environment</strong></td>
<td>1.1 Work with patients to address determinants of health that affect them and their access to needed health services or resources</td>
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<td>1.2 Work with patients and their families to increase their opportunities to adopt healthy behaviours</td>
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<td>1.3 Incorporate disease prevention, health promotion, and health surveillance into interactions with individual patients</td>
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<td><strong>2. Respond to the needs of the communities or patient populations they serve by advocating with them for system-level change</strong></td>
<td>2.1 Work with a community or population to identify the determinants of health that affect them</td>
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<td>2.2 Improve clinical practice by applying a process of continuous quality improvement to disease prevention, health promotion, and health surveillance activities</td>
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<td>2.3 Participate in a process to improve health in the community or population they serve</td>
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Research has established that social environments affect human health. Acknowledged social determinants of health — including racial or ethnic background, occupation, and the use of alcohol and tobacco — also influence the effectiveness of health care delivery. But other social factors, such as the ability to afford medications, access to transportation, available time, and competing priorities, may influence health outcomes even more. Although we believe that exploring these issues constitutes an essential part of the medical examination, the most important and relevant social history questions are rarely asked or acted on.

Applying social science principles to medicine — a practice sometimes called “social medicine” — enables us to contextualize patient care to achieve more sustainable and equitable health outcomes. Social medicine elucidates how patients’ environments influence their attitudes and behaviors and how patients’ agency — the ability to act in accordance with their free choice — is constrained by challenging social environments.

Physicians often see patients with complex social situations as a burden — requiring extra work that is neither reimbursable nor central to our core clinical expertise. Unfortunately, we inculcate these attitudes in trainees, implicitly and explicitly, perhaps because of our discomfort with hearing difficult stories or our sense of powerlessness or incompetence in addressing these root problems. Whereas biologic pathology may present specific targets for intervention, social or structural pathology is difficult to treat.

Since social problems affect patients’ health and treatment effectiveness, however, we cannot afford to ignore them in assessments and treatment plans if we hope to improve outcomes, reduce costs, and improve patient satisfaction. Moreover, clinicians’ simple acknowledgment of social forces can strengthen their therapeutic alliance with patients. Patients know clinicians cannot alleviate their poverty, but empathy and concern shown by a clinician who explicitly addresses it constitute powerful medicine.

So how should we teach students and clinicians to explore social determinants of health? How can we encourage healthcare teams to explore social factors that influence health care delivery? And how should clinical teams address these issues?

To start, obtaining a more appropriate and comprehensive social history can enable proper assessment of a patient’s social environment. Although many social barriers exist between patients and providers, deliberate inquiry into the social environment allows clinicians to understand behaviors such as nonadherence to treatment plans, missing of appointments, or failure to fill prescriptions not as products of ignorance or willful misbehavior but rather as results of the complicated interplay of individual factors with a complex social environment.

For example, a proper social history of a “brittle diabetic” patient may reveal a very limited income that precludes purchasing healthy foods. Social isolation may prompt excessive emotional eating, limited mobility may hinder monthly visits to the pharmacy to pick up prescriptions, depression or poor coping skills may thwart lifestyle modifications, family lore regarding “low sugars” may impede adherence to insulin regimens, and life with arthritic knees in a third-story walk-up in a violent neighborhood may make prescribed daily walks seriously challenging.

Adopting the social medicine framework, we revised our list of social history topics in an effort to strengthen our therapeutic alliances, better contextualize patients’ diagnostic and treatment plans, and improve health outcomes (see box). Our topics extend well beyond the common “TED” (tobacco, ethanol, drug use) questions, encompassing six categories: individual characteristics, life circumstances, emotional health, perceptions of health care, health-related behaviors, and access to and utilization of health care. Primary care clinicians may find that such a comprehensive history is best obtained over multiple visits, but we believe it is ideal to revisit these questions annually; inpatient clinicians probably need to be more target...
ed but could, with training, obtain similar relevant information. Of course, clinicians should use their judgment regarding the appropriate timing of these conversations, since patients may need to establish trust and rapport before sharing intimate information.

To obtain proper social histories, clinicians could be trained in basic and motivational interviewing techniques and challenged to examine their own biases, since unexplored prejudices influence our ability to obtain or act on important information. We also recommend that clinicians attempt to visit the neighborhoods where the majority of their patients live, since such experiences can enhance clinicians’ social perspective and help them understand their patients’ “health homes.” Such visits might inform clinicians about people or services in their patients’ world that could be organized to help them achieve better health and about the forces working against their engagement in health-promoting or harm-reducing behaviors.

In addition to learning how to obtain this social information, clinicians need to learn how to use it — specifically, they need training in ways of developing individualized care plans that take into account patients’ personal and structural barriers to good health. Using shared-decision-making techniques and appropriate pedagogical and counseling skills, clinicians can help prioritize patients’ goals and empower patients to make lasting changes to achieve self-identified objectives. Increasingly, through shared-savings contracts and reimbursement for care-coordination activities, clinicians will receive financial incentives to make

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### Common Current Topics and Proposed Comprehensive Topics for the Patient Social History.

#### Common current topics
- Racial or ethnic background
- Marital status and children
- Occupation
- Highest level of education
- Tobacco, ethanol, drugs (“TED”)
- Seatbelt and helmet use
- Firearms in the home
- Victim of domestic violence

#### Proposed new topics
- Individual characteristics
  - Self-defined race or ethnicity
  - Place of birth or nationality
  - Primary spoken language
  - English literacy
  - Life experiences (education, job history, military service, traumatic or life-shaping experiences)
  - Gender identification and sexual practices
  - Leisure activities
- Life circumstances
  - Marital status and children
  - Family structure, obligations, and stresses
  - Housing environment and safety
  - Food security
  - Legal and immigration issues
  - Employment (number of jobs, work hours, stresses or concerns about work)
- Emotional health
  - Emotional state and history of mental illness (e.g., depression, anxiety, trauma, post-traumatic stress disorder)
  - Causes of recent and long-term stress
  - Positive or negative social network: individual, family, organizational
  - Religious affiliation and spiritual beliefs
- Perception of health care
  - Life goals and priorities; ranking of health among other life priorities
  - Personal sense of health or fears regarding health care
  - Perceived or desired role for health care providers
  - Perceptions of medication and medical technology
  - Positive or negative health care experiences
  - Alternative care practices
  - Advance directives for cardiopulmonary resuscitation
- Health-related behaviors
  - Sense of healthy or unhealthy behaviors
  - Facilitators of health promotion (e.g., healthy behaviors among close social contacts)
  - Triggers for harmful behaviors and motivation to change (may be determined through motivational interviewing)
  - Diet and exercise habits
  - Facilitators or barriers to medication adherence
  - Tobacco, alcohol, drug use habits
  - Safety precautions: seatbelts, helmets, firearms, street violence
- Access to and utilization of health care
  - Health insurance status
  - Medication access and affordability
  - Health literacy and numeracy (may be ascertained with specific tools; e.g., “The Newest Vital Sign”)
  - Barriers to making appointments (e.g., child care, work allowance, affordability of copayment, transportation)
appropriate referrals to both institution-based and community-based resources and to communicate effectively with social workers, community health workers, lawyers, therapists, counselors, and other service providers.

For example, an individualized care plan for a woman with diabetes might include referrals to a food pantry and farmer’s market for purchasing fresh produce; referral to a community-based walking program, where neighbors help her up and down the stairs; sending prescriptions to a pharmacy that delivers medication to her home; referral to a medicolegal group for contract assistance concerning her unsafe housing situation; and referral to a community health center that holds group meetings where she can build relationships, explore new explanatory models of disease, and learn from others’ stories of illness and coping. For the most challenging “nonadherent” patients, a structured home visit by medical team members would be ideal.

Medical education curricula could be revised to incorporate this approach. Students and residents could learn how to conduct structured home visits and patient care mapping exercises to better understand all the places, people, and directives that patients must negotiate in seeking better health. What happens, for instance, when a patient with low literacy is discharged after a hospitalization with new prescriptions, orders to follow up with three subspecialists, and a referral to outpatient rehab — and has to contend with the eviction notice, unpaid utility bills, and isolation that await him at home?

Trainees could learn how to assess patients’ literacy and health literacy and how to deliver information using well-established pedagogical techniques. They could practice motivational interviewing techniques using role playing and learn, in real clinical settings, how to motivate and empower patients to engage in health-promoting behaviors. Audiotaping or videotaping of history taking, counseling, and care-planning activities can provide opportunities for giving feedback and honing skills. Clinicians-in-training can be taught how to enhance shared decision making, create individualized care plans, and work effectively in teams — all principles that we believe should be incorporated into the U.S. Medical Licensing Examination3 and the Accreditation Council for Graduate Medical Education and American Board of Medical Specialties core training competencies. If we gear training toward a more comprehensive approach to understanding patients, clinicians will gain tools for developing therapeutic plans that take into account patients’ complex social environments.

We hope that the teaching and assessment of such an approach will foster a new generation of clinicians who provide more personalized and appropriate care. Attention to the social forces in our patients’ lives would allow us to provide better and less costly care to patients with the most complex conditions and situations — thereby increasing satisfaction among both patients and caregivers. Failure to attend to these forces will perpetuate the cycle of poor outcomes, high costs, and dissatisfaction among our neediest patients.

William Osler said, “The good physician treats the disease; the great physician treats the patient who has the disease.” To be able to treat the patient, a physician must ask the right questions and know how to act on the answers.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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Advocacy Resources
Child/Pediatric Advocacy

Caring for Kids New to Canada

• Developed by the Canadian Paediatric Society with input from a range of experts and organizations, Caring for Kids New to Canada has evidence-based information on assessing and screening patients, medical conditions, health promotion, child development, and much more. It also explores how issues beyond the clinical setting affect health, such as culture, social and environmental conditions, health care systems, and public policy.  
www.kidsnewtocanada.ca

Canadian Pediatric Society

• The Canadian Paediatric Society is the national association of paediatricians, committed to working together to advance the health of children and youth by nurturing excellence in health care, advocacy, education, research and support of its membership.

Advocacy toolkit:  

Advocacy Centre:  
http://www.cps.ca/en/advocacy-defense

CMAJ Electives

CMAJ

Contact:  
Carole Corkery, Executive Assistant to the Editor-in-Chief:  
carole.corkery@cmaj.ca

Refugee Health

Refuge: Hamilton Centre for Newcomer Health (HNCH)

• A community leader in the provision of high quality health care services to Hamilton’s newcomer population.

Contact:  
www.newcomerhealth.ca  
184 Hughson Street South  
Hamilton, ON  
info@newcomerhealth.ca  
905 526 0000

Legal

Your Legal Rights

• Free legal information on a wide range of topics, in a variety of languages, produced by hundreds of organizations across the province.

• Topics include: Abuse and family violence, consumer law, criminal law, employment and work, family law, health and disability, housing law, immigration and refugee, legal system, social assistance and pension, American Sign Language resources, ESL resources for teachers. Available under ‘resources’

Information:
Community Legal Education Ontario (CLEO)

- CLEO produces clear, accurate and practical legal information to help people understand and exercise their legal rights. Our work focuses on providing information to people who face barriers to accessing the justice system, including income, disability, literacy, and language. As a community legal clinic and part of Ontario’s legal aid system, we work in partnership with other legal clinics and community organizations across the province.

  Browse Resources:
  http://www.cleo.on.ca/en/resources-and-publications

  Refugee Claimants:
  www.refugee.cleo.on.ca

  Additional Information on Refugee Hearings:
  http://refugeehearing.cleo.on.ca/

PLE Learning Exchange

- A network that supports organizations across Ontario in developing and delivering effective public legal education (PLE) to their communities.

  Information:
  http://www.plelearningexchange.ca/

Medicare

Canadian Doctors for Medicare

- Canadian Doctors for Medicare stepped into the national health care debate in May 2006 when a group of physicians and friends became concerned about the increased privatization in Canadian health care and the development of a two-tier health care system that would allow the wealthy to buy private insurance for private care at the expense of the vast majority of Canadians.

  http://www.canadiandoctorsformedicare.ca/

Adults with Developmental Disabilities

ARCH Disability Law Centre

South Asian Legal Clinic of Ontario (SALCO)

- ARCH Disability Law Centre and the South Asian Legal Clinic of Ontario (SALCO) have partnered to develop this factsheet for settlement and frontline workers. The factsheet discusses services and supports that may be available through Developmental Services Ontario (DSO).

- Adults labeled with intellectual disabilities may be able to get some services and supports through the DSO. A person can apply for supports and services if they qualify under the Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act.

- Front-line workers may be able to:
  - 1. Tell people about these services and supports
  - 2. Help people gather the documents they need to apply
  - 3. Tell people where to get more information if the DSO does not help them

  Accessing Factsheet:
  http://www.archdisabilitylaw.ca/node/980
Social Media

Twitter accounts to watch:

CMA: @CMA_Docs
OMA: @OntariosDoctors
Federal Minister of Health: @MinRonaAmbrose
Ontario Minister of Health and Long-Term Care: @DrEricHoskins
Chris Charlton (NDP MP for Hamilton Mountain): @ChrisCharltonMP
CMAJ: @CMAJ_News
CMAJ Blogs: @CMAJ_Blogs
Canadian Pediatric Society: @CanPaedSociety
Caring for Kids (Canadian Pediatric Society): @CaringforKids
Andre Picard (health reporter, Globe & Mail): @picardonhealth
Helen Branswell (health reporter, Canadian Press): @HelenBranswell
Healthy Debate: @healthydebate
Brian Goldman (emergency physician, host of CBC's White Coat Black Art): @NightShiftMD
Richard Horton (Editor-in-Chief, The Lancet): @richardhorton1
Matthew Stanbrook (CMAJ associate editor): @drstanbrook
Mark Cherrington (Youth at risk worker in Edmonton): @MarkCherrington
Upstream (Social determinants of health): @UpstreamAction
Jim Dunn (McMaster Research Chair on Neighbourhoods, Housing and Health): @UrbanHealthProf
Medical Reform Group: @MedReformGroup
Doctors for Refugee Care @Docs4refugeehc
Ritika Goel (Toronto based family doctor, health justice activist): @RitikaGoelTO
Gary Bloch (Toronto family physician focusing on poverty, sdoh) @Gary_Bloch
Tom Cooper (Director, Hamilton Roundtable for Poverty Reduction): @TomCoopster

Pharmacare 2020 (Organization advocating for better access to medications and toward a pharmacare plan in Canada/Ontario) @pharmacare2020
Canadian Health Coalition @healthcoalition
Prabhat Jha (Toronto-based MD, head of Grand Challenges Canada) @countthedead
Monika Dutt (Nova Scotia MD and Chair of Cdn Docs for Medicare) @monika_dutt
Canadian Doctors for Medicare @CdnDrs4Medicare
Health Providers Against Poverty @hpap_ontario
Evidence Network (online resource that compiles both journal articles and Op-Ed pieces regarding Canadian health policy issues) @evidencenetwork
Irfan Dhalla (Toronto-based MD, VP of Health Quality Ontario – government agency responsible for health QI) @irfandhalla

MSF access to essential medicines campaign @MSF_access
Children’s Mental Health Ontario (network of community-based children’s mental health centres in Ontario) @kidsmentalhlth
Ontario Advocate (Provincial Advocate for children and youth receiving care under the Child and Family Services Act) @OntarioAdvocate