Advocacy Training for Pediatricians: The Experience of Running a Course in Leeds, United Kingdom

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ABSTRACT. The Issue. Given the critical role of pediatricians in child advocacy, it is important to understand how to train pediatricians to speak out to improve the health and well-being of children. This article describes the experience of developing and implementing a 5-day child advocacy course at the University of Leeds, which formed part of a master’s program. Eight community pediatricians and pediatric registrars participated in the initial course. The material from the course has been published in *Archives of Disease in Childhood.* This exercise was about the only time as a teacher that I also started at the same level as the students in the course. We started off by defining what we meant by advocacy. The definition that we chose was “the active support of a cause or course of action,” and we applied this to any child problem for which the system was at fault and use of action was required. What is needed to be an effective advocate? One must have an awareness of issues confronting children, in particular on the local level and not only on the national and international levels. One then needs to gain an understanding of the political framework of the issue, how change can occur, and how one can contribute to bringing about the necessary change. Then follows the identification and acquisition of the practical skills and competencies related to effecting these changes. Finally, one needs to have a successful experience tackling a particular issue to realize that one can be effective. *Pediatri cs* 2003;112:749–751; advocacy, advocacy curriculum, advocacy training, advocacy issues, child advocacy.

We generated a framework for developing competencies as advocates. Table 1 outlines the elements of the curriculum and teaching strategies used in the course to increase our awareness of issues, understand problems and the “politics” of issues, acquire skills, and gain experience. We wanted to ensure that we were aware of the sorts of issues that might demand advocacy. We started by looking at issues encountered in the course of our own daily work. The method that we used was to keep diaries for 2 weeks, recording every patient contact for which we thought we might have a role in trying to resolve an issue. Over the ensuing weeks, we discussed the issues and analyzed them. The value of doing this was not only to increase our own awareness but also to recognize that there was a commonality among the sorts of problems that we were facing across England.

We also surveyed newspapers. Each person took 1 newspaper and for a period of 2 weeks clipped articles that related to children. It became very clear that the issues that we identified in our diaries were not the same as those presented in the media. This generated much discussion as to how one might try to attract the media to deal with these issues. Realizing that in 2 weeks we would not encounter all the problems and frustrations in the media that confront us at work, we also kept a personal list of issues that would like to see tackled.

What is the root cause? Having gained an awareness of the sorts of issues that needed to be changed, we went on to explore the root causes of these problems. We spent much time developing a system to analyze issues and generate strategies to tackle them. We constructed 2 schemes. The first (Table 2) looked at the root cause of the problems that we were encountering, and the second (Table 3) addressed the level of advocacy at which we should be pitching our efforts to effect change.

The following illustrates examples of what was found with respect to the types of problems (Table 2) identified. Most problems related to issues at the patient and/or family level or issues within the health service, with few extending beyond that.

- Fifteen family issues in which we considered the provision of services to be satisfactory but not accessed by the family were identified. An example was a family with a child with chronic fatigue syndrome. Health professionals were doing their utmost to return the child to school, but the family was intent on allowing the child to rest at home.
- The most common problems identified were within agencies, including issues such as long

### TABLE 1. Developing Competency in Advocacy

<table>
<thead>
<tr>
<th>Awareness</th>
<th>Diaries</th>
<th>Newspaper search</th>
<th>Personal list of issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding</td>
<td>Developing a system to analyze issues</td>
<td>Lecture by member of parliament</td>
<td>Meeting successful advocate</td>
</tr>
<tr>
<td>Practical skills</td>
<td>Learning stakeholder analysis</td>
<td>TV/radio interviews</td>
<td>Writing press releases, letters</td>
</tr>
<tr>
<td>Gaining experience</td>
<td>Developing a plan for action and having a go</td>
<td></td>
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</tbody>
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The last category was discrimination. We had 1 case in which a family failed to receive input for a child who was disabled because there was a language problem and no interpreters were provided.

Table 3 addresses the level of advocacy required to tackle these issues. It fits in nicely with the pyramid described by David Wood, MD, in Session 1. We defined 4 levels: advocacy at the individual, local community, city, and national levels. Again, it is important to note that the majority of issues demanded local action, rather than political activity at the national level.

### THE CURRICULUM

Developing a scheme for analyzing the issues that we identified helped us to understand what was wrong with the system and what was required to improve it. The next stage of our training was to understand the political framework and what we needed to know to achieve change. We did this in a number of ways. We had a member of parliament talk about the political/parliamentary system and how it works, whom we should approach, and how and when to approach them. This provided insight into how to affect the political process. Several successful advocates discussed their experience. This provided perspective on how and when to be proactive or reactive to a situation, how to use the media, and how to develop circumstances and create situations and/or drama that can attract media attention.

What are the practical skills and competencies required to be an effective advocate? One helpful tool is “stakeholder analysis.” This involves analyzing problems in detail, identifying key stakeholders, and equipping oneself with an understanding of where and how actions should be targeted.

We recognized the media to be a potential ally and included a session with the head of media studies at the University of Leeds. He set up a studio for us, complete with sound gallery and camerapeople, and interviewed each of us in turn about a topical issue. We reviewed and critiqued the videos and then repeated the whole process again. Improvement in our skills to respond to a difficult interviewer was evident through the course of the afternoon. The university press officer spoke to us about writing press releases. We had a go at that, along with practice in writing letters with a message.

Our last task was to gain some experience in the real world. Because of our time constraints, this had to be more theoretical than practical. We focused on the issue of behavioral and emotional problems in children. Each of us identified 1 aspect of the issue and developed a plan of action to address it. By the end of the 5 weeks, tremendous creativity had been unleashed and many ideas and materials developed. Consideration was given to move some of these ideas forward.

Reflecting on our experience, our approach seemed to be effective. We developed an awareness of issues requiring advocacy and an understanding of the political framework and processes to effect change; participants were afforded the opportunity to acquire practical skills and experience. Framing discussions with a consideration of the types of problems that arise in the course of clinical work and the

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**TABLE 2. Classification of Issues Requiring Advocacy: Types of Problems That Arise in the Course of Clinical Work**

<table>
<thead>
<tr>
<th>Type of Problem</th>
<th>Definition</th>
<th>No. of Problems</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family issue</td>
<td>Where provision is present but not accessed by the family</td>
<td>15</td>
<td>Parental refusal to send a child with chronic fatigue syndrome to school despite medical advice to do so</td>
</tr>
<tr>
<td>Within-agency issue</td>
<td>A system has failed the child or family</td>
<td>24</td>
<td>Excessive waiting lists for mental health services for children</td>
</tr>
<tr>
<td>Interagency issue</td>
<td>Interaction between agencies has failed</td>
<td>13</td>
<td>Lack of coordination of health needs in children moving from one foster placement to another</td>
</tr>
<tr>
<td>Inadequate or absent provision</td>
<td>A problem that requires a “political” solution has arisen</td>
<td>7</td>
<td>Lack of respite care for children with complex disabilities</td>
</tr>
<tr>
<td>There is an element of discrimination</td>
<td>Family experience apparent racist response from service</td>
<td>1</td>
<td>Home education service and educational psychology input denied because of family’s inability to speak English</td>
</tr>
</tbody>
</table>

**TABLE 3. Classification of Issues Requiring Advocacy: Hierarchy of Levels of Advocacy**

<table>
<thead>
<tr>
<th>Level at Which Advocacy Is Required</th>
<th>No. of Problems</th>
<th>Example of Issue Requiring Advocacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Individual level</td>
<td>33</td>
<td>Inadequate housing for a family</td>
</tr>
<tr>
<td>B. Public health level within community*</td>
<td>16</td>
<td>Disability access at a primary school</td>
</tr>
<tr>
<td>C. Public health level within city*</td>
<td>15</td>
<td>Insufficient provision of child care facilities, road safety near schools</td>
</tr>
<tr>
<td>D. Public health level nationally</td>
<td>15</td>
<td>Breastfeeding, poverty, children’s rights</td>
</tr>
</tbody>
</table>

* Levels B and C are exclusive of each other as level C advocacy would include level B.
hierarchy of levels of advocacy required to address them provided context and insight with which participants can integrate advocacy into their daily work. Curricula in the future should afford trainees longer periods to tackle projects.

CONCLUSIONS

There are a number of opportunities to advance child advocacy and to work together as a group of transatlantic pediatricians (Table 4). Collaboration to further develop curricula in child advocacy would be valuable. The American Academy of Pediatrics already has an excellent web site with advocacy materials, and the results of this American Academy of Pediatrics-Royal College of Paediatrics and Child Health meeting could be included on the site.

In a previous session on medical education, we focused on assessment of curricula and trainees as a driving force for learning and change. If child advocacy is required to improve health outcomes for children, then we need to implement curricula in pediatric training programs to deliver relevant knowledge, skills, and attitudes and assess the competence and experience of trainees. Change in traditional pediatric curricula would occur quickly if programs were required to include child advocacy training as components of curricula and demonstrate competency on the part of trainees.

In addition to joint development of training material, perhaps registrars and residents could share their experiences with advocacy projects. The major challenge to engaging trainees in child advocacy is to identify projects that can be completed in a period that fits their schedules and facilitates completion of the initiative. Through the exchange of registrars and residents, we might get a better idea of the sort of endeavors that are reasonable and able to be completed. We could even develop an award to be given to the registrar or the resident who completes the best advocacy project in the course of his or her training. This could help to encourage and motivate pediatricians in training to speak on behalf of children. The most effective way of ensuring that pediatrics deals with inequities in child health is to provide young pediatricians with the skills and experience to be effective advocates.

REFERENCE


SUGGESTED READING


Blair M. Taking a population perspective on child health. Arch Dis Child. 2000;83:1,7–9


Serving the Underserved Curriculum web site. Available at: http://www.servingtheunderserved.org

TABLE 4. Suggestions for Promoting Training in Advocacy

| Developing a curriculum          |
| Assessment of trainees and programs |
| Developing training materials    |
| Sharing experiences              |
| Awards for achievement           |
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