PEDIATRICS PERSPECTIVES

Advocating for Advocacy in Pediatrics: Supporting Lifelong Career Trajectories

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ABBREVIATION

AAP—American Academy of Pediatrics

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DEFINING PEDIATRC ADVOCACY

As called for by Dr David Satcher, former US Surgeon General, pediatricians should be advocates to address both individual and community health issues.[1] Child advocacy represents actions that promote child health and welfare on a population level, distinct from individual-patient advocacy. Pediatricians could advocate by collaborating with community groups to advance child health and updating legislators to enable more educated decisions regarding laws these policy makers consider. Less than 40% of pediatricians are involved in community-health activities, representing a downward trend from nearly 60% in 1989.[2] Pediatricians feel responsible for the broader context of their patient's health; however, personal and work-related matters may limit their involvement. To address this lack of engagement among the remaining 60% of pediatricians, as well as encourage future pediatricians to help sustain an advocacy mission, we propose the following:

1) Mechanisms to increase and improve training of new advocates across the career life course, emphasizing partnerships between community and academia.
2) An instrument for pediatricians to document advocacy work, rationalizing protected, nonclinical time.

Community advocacy has been an essential part of pediatrics since its inception. Dr Abraham Jacobi, considered the founder of pediatrics in the United States, established public milk stations dispensing boiled milk, thus preventing diseases associated with feeding infants raw milk.[3] Advocacy was also essential in the formation of the American Academy of Pediatrics (AAP), which stemmed from frustration among pediatricians with the American Medical Association's condemnation of the Sheppard-Towner Maternity and Infancy Act. This legislation addressed high maternal and infant mortality rates by funding state-based public health programs, but was viewed by the American Medical Association as a threat to physician autonomy.

Today, pediatricians remain a trusted source of health information.[4] Leveraging this role with legislators makes pediatricians ideal agents for change at the community, state, and national levels. Pediatricians have a long track record of creating sustained partnerships toward improving child health through access, education, and advocacy (Supplemental Table 1).

TRAINING FUTURE ADVOCATES

Medical schools vary in the amount of community health and advocacy taught, although there is debate regarding whether this is a worthwhile endeavor.[5,6] Nevertheless, pediatric educators recommend more training in these areas to provide more public-health focused, professional, and ethical patient care.[7,8] Such training should include more information about community health and advocacy training during medical school and residency. This would create better appreciation of advocacy as a discipline, and help groom future advocates.

Knowledge deficits about community health begin in medical school where disease pathophysiologies and pharmacologic treatments are emphasized. Community toxic stressors modulate the neuro-immuno-hormonal axis, increasing the risk of chronic diseases throughout life and across generations through epigenetics; thus providing opportunities to connect established molecular biology with social issues.[9,10] Significant aspects of health are determined by factors such as poverty and health care access. Many students, however, are unaware of these social influences and their mechanisms.[10] Social stressors need to be reframed as the pathophysiology of community health, for which physician advocacy is the indicated "pharmacologic" treatment. Improved awareness of social determinants of health would offer a better transition to residency, where pediatricians can further develop these skills.[8,11]

In response to changes in Accreditation Council for Graduate Medical Education mandates, advocacy skills are increasingly being taught in residency, but implementation varies.[12] Furthermore, Accreditation Council for Graduate Medical Education recommendations are unfunded mandates, as GME reimbursement cannot be appropriated for nonclinical activities. This may contribute to the absence of public policy programs in most pediatric departments.

As new trainees navigate "individualized" curricula, the need to create advocacy opportunities becomes more salient. Programs should consider incorporating the AAP's Community Pediatrics Training Initiative into their syllabus to achieve initial competency.[13] This online, open-source, program aims to train residents and academic and community-based practitioners in advocacy. Elements of the program have been incorporated into multiple residency programs as part of training in longitudinal, block advocacy and community projects.[14] The Dyson Initiative, an additional resource, builds on this education by funding the integration of a community-pediatrics perspective into residency training. Residents with deeper advocacy interests will require mentored opportunities, making the need for trained faculty-level advocates essential. Models of successful residency advocacy tracks within pediatric departments exist and are summarized in Supplemental Table 2.

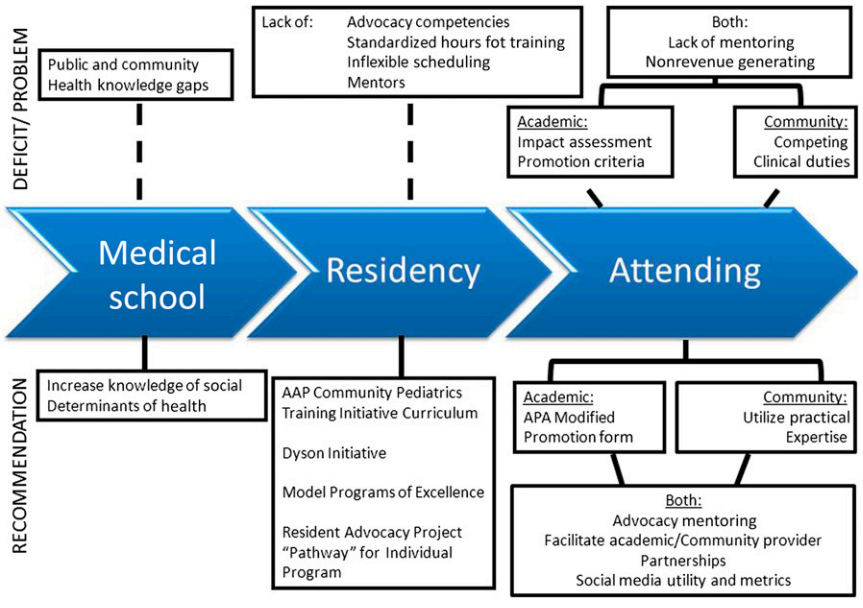

FIGURE 1

Schematic of deficits and recommendations to improve pediatric advocacy. Outline of knowledge deficits impeding implementation of long-term advocacy training in pediatrics coupled with suggestions for improving the advocacy infrastructure across the continuum of pediatric training.

CAREER DEVELOPMENT

Regardless of the setting, individual pediatricians can be effective advocates. Professional organizations like the AAP can provide attending-level mentoring and opportunities such as the Community Pediatrics Training Initiative. StateView, an AAP resource from the Committee on State Governmental Affairs, provides summaries and materials to help support grassroots physician-advocacy efforts.[15] Although the ultimate interests of community and academic pediatric advocates are similar, the competing pressures and pathways to a sustained advocacy career differ. A "life course" advocacy approach that fosters career development is shown in Fig 1. Regardless of practice type, ongoing professional training that sustains lifelong advocacy should offer both theoretical and practical education aimed at advancing these skills at every level of ability and experience. Continuing medical education programs, such as the AAP Annual National Legislative Conference, not

only teach basic advocacy skills, but also enable experienced participants to refine skills through tailored workshops, role-playing, and didactic sessions. Many AAP chapters and districts also offer similar training, often in conjunction with state-based advocacy days.

The most effective model for advocacy occurs when partnerships are created by community and academic physicians with public health departments and community health centers. Although advocacy can occur at multiple levels and settings within pediatrics, the partnership model offers benefits to both academic centers and community physicians. Academic centers offer access to specialists and health care policy experts, provide clinical care spanning a larger regional area than a traditional practice, and provide educational opportunities for medical trainees. Community pediatricians have more thorough knowledge of patients' direct needs and comprehensive knowledge of regional resources with which to partner.

Community

Many pediatric advocates hail from private, multispecialty groups unaffiliated with academia.[2] Pediatricians outside the academic sphere are well-suited to provide firsthand testimony as to the practical, local implications of a policy. Although time and financial constraints are often cited as barriers, examples of effective advocacy work by community practitioners that require minimal time commitment exist.[16] One suggested mechanism for private practice advocacy work is to adapt the legal firm equivalent of a pro bono model investing in local well-being.[7]

Academic

Similarly, academia may devalue advocacy work as an alternative to revenue-generating activities. Because advocacy does not often provide traditional quantifiable work products such as grants or peer-reviewed publications, it may be hard to define a child advocate's impact. It is important to emphasize a robust advocacy program benefits academic health centers by improving community health and relations.

EVALUATING ADVOCATES

Social media platforms provide novel tools for amplification of advocacy messages. The AAP Twitter handle "@putkids1st" allows for AAP-sponsored content to be quickly shared with users in real-time, enabling physicians to rally around a specific issue at critical times. There is however, a paucity of outcomes-based, peer-reviewed literature on the impact of social media. After a social media campaign including Facebook, Twitter, and a Web site, one study revealed adolescents were more aware of the availability of local mental health resources.[17]

Community Evaluation

Advocacy efforts can be used by community pediatricians to justify protected, nonclinical time by demonstrating benefit to their practice group. Opinion-editorial submissions demonstrate authority within a pediatric practice, improve public relations, and potentially widen the patient base. Community physicians can use social media to stay informed of advocacy issues, promote their local expertise, and engage patients around a specific health issue.

Academic Evaluation

Absence of standardized evaluation tools impedes the promotion of advocates in academic settings. Some advocates begin with a traditional research/public health background, providing papers and grants as standard academic deliverables, and become engaged in promoting an issue related to their research. Others focus on curriculum design, and have co-opted education research to publish work on advocacy training.

Social media can represent the scope of an advocate's work by "quantifying" one's advocacy output. Promotion committees and administrators should become more comfortable with these technologies as they strive to better recognize this work through the promotion process.

Modification of existing portfolios already in use by clinical educators may be beneficial in understanding the impact of physician advocacy. The Academic Pediatric Association Education Template may be adapted to provide a format for type and topic of advocacy activity and time invested[18] (Supplemental Table 3). Promotion committees can use these portfolios in evaluating advocates' scholarly activities. We also suggest adopting pre-existing criteria used for determining promotion such as the American Association of Medical College's Toolbox, which provides a framework and rigor to evaluation of nontraditional academicians.[19]

CONCLUSIONS

To create a sustainable future for pediatrician-advocates, systemic changes must occur. Specific educational goals, time commitments, and experiences in advocacy need to be better defined, represented on medical board examinations, and integrated into residency training. Academic programs and community physicians must recognize the synergistic value of their partnerships to promote health. Child advocates should receive recognition by promotions committees or protected time in a private practice, with respect of the value of this work in all child-health settings. Modified advocacy portfolios

and next-generation social media tools may aid in pursuit of advocacy message. These prescriptions will prevent marginalization of children at the policy level, protecting their unique social and medical needs.

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