

A Model of Advocacy to Inform Action

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The need for effective advocacy on the part of health professionals has never been greater. The recent COVID-19 pandemic has made the connection between human health and social conditions clear, while highlighting the limitations of biomedical interventions to address those conditions. Efforts to increase the frequency and effectiveness of advocacy activities by health professionals have been hampered by the lack of a practical framework to define and develop advocacy competencies among trainees as well as to plan and execute advocacy activities. The authors of this article propose a framework which defines advocacy as occurring across three domains of influence (practice, community, and government) using three categories of advocacy skills (policy, communication, and relationships). When these skills are successfully applied in the appropriate domains of influence, the resulting change falls into three levels: individual, adjacent, and structural. The authors assert that this framework is immediately applicable to a broad variety of health professionals, educators, researchers, organizations, and professional societies as they individually and collectively seek to improve the health and well-being of those they care for.

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INTRODUCTION

The COVID-19 pandemic laid bare the stark inequities in health that have long characterized life in the USA. It revealed in new ways the maldistribution of resources related to social determinants of health that have always left behind the poor as well as the structural barriers that have negatively impacted the health of racial and ethnic minorities. Through the pandemic, these groups suffered a profoundly disproportionate burden of COVID-19 cases, hospitalizations, and deaths.^{1–6} In 2020, life expectancy for Black people decreased by 2.7 years, Latinx people by 1.9, and non-Latinx White people by 0.8 years.⁷

Efforts to address these realities through public policy have been hampered by political polarization and governmental dysfunction. Clinicians live in the middle of this reality—daily witnesses to dysfunctional care systems and to the social, economic, political, and structural factors that preserve an unjust status quo.^{8–11} Many are motivated and feel compelled to translate their professional experience and expertise into change that could mitigate the harms they see, yet few feel prepared to engage in advocacy.^{12–15}

Over the last decade, a number of efforts have emerged to better prepare those who want to move beyond the passive role of witnesses into active roles as leaders and advocates. Professional organizations have created policy-focused committees and some offer health policy mentorship and training.^{16–18} Even in the absence of a clear set of competencies, educators are developing advocacy curricula. The Accreditation Council for Graduate Medical Education (ACGME) issued a call for a standard set of competencies in this area.^{19–24} In a previous publication, we offered a definition of physician advocacy in an effort to move beyond aspirational language and toward a working concept of the scope and shape of advocacy.²⁵ A definition, however, is not enough.

In this paper, we propose a theoretical model, which is based on observation, practice, discussion with effective advocates, our own experiences as advocates, the application of the curricula we have developed in teaching leadership and advocacy to graduate healthcare students, and the evolving literature.

THEORETICAL ADVOCACY MODEL

Our model of advocacy (Fig. 1) delineates three domains of influence (illustrated as lug nuts) and three categories of advocacy skills (illustrated as a wrench) necessary for successful change to occur in any of three levels (illustrated as concentric circles). We define the domains of influence as practice, community, and government. The advocacy skills categories include policy, communication, and relationships. Finally, the application of these advocacy skills within the domains of influence can produce change in any of three levels, including individual, adjacent, and structural.

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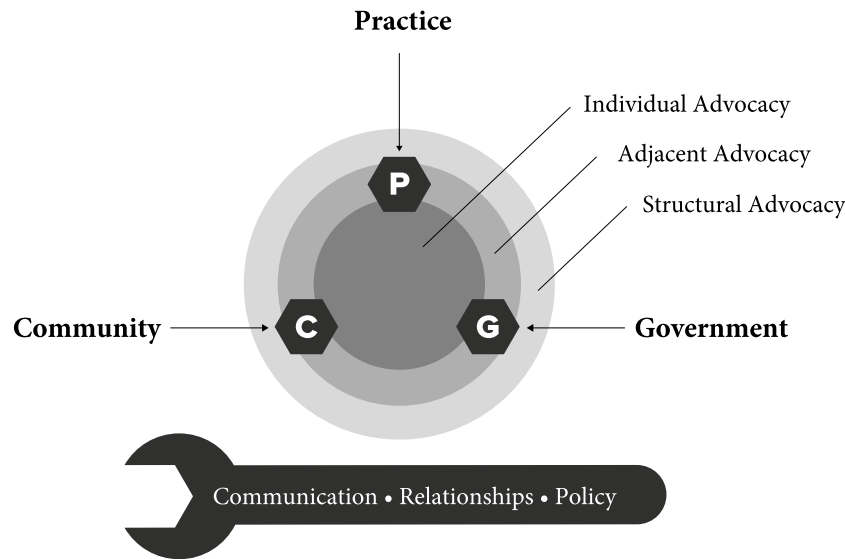


Figure 1 A model of advocacy.

Domains of Influence—Practice, Community, and Government

Graphically (Fig. 1), we represent the domains of influence (practice, community, and government) as lug nuts to emphasize that advocacy requires the application of influence or force (illustrated by a wrench) to effect change. Change may occur within a single domain or may require coordinated or sequential action in other domains. Successful advocacy requires a critical appraisal of the problem and thoughtful analysis to mobilize action within the domains.

The Practice Domain. We define practice as a health professional's work environment including the organizations and institutions connected to their work. For most clinicians, this is a clinical practice, yet it may involve research, administration, education, or other professional activities. A clinician may advocate within their practice to improve quality or access. They may work on the perimeter of their practice, advocating with payers, creditors, healthcare systems, or pharmaceutical companies. A clinician may also, through individual or collective action, act in the other domains to facilitate those changes that will improve the health of their patients.

The Community Domain. Community consists of the people, institutions, and non-governmental organizations surrounding the practice and the patient interests that a practice serves. The community includes individuals as well as schools, faith groups and organizations, businesses, and a variety of non-profit and for-profit organizations, associations, and community groups. The term community implies a local focus, but it may have a national or international reach.

A clinician's work in the practice domain determines the needs they identify and informs their work in other

domains. A physician may see the impact of local school policy on the physical activity or nutrition of the children in their practice; the effect of a local manufacturing concern on air quality and asthma control; the impact of local employment policies on the ability of families to care for their children; or the effect of zoning ordinances on pedestrian safety. In each case, action solely within their practice domain will inadequately address the health threats they have observed. Correcting those threats requires action in the other domains. It was a pediatrician in Flint Michigan, Dr. Mona Hanna-Attisha, who sounded the alarm about lead in the community's drinking water.²⁶

The Government Domain. The domain of government consists of all the institutions of local, state, and national government. This includes policy-making bodies such as school boards, city councils, and public health departments, as well as state and national legislatures. This also includes executive branch functions from local Mayors and state Governors to the US President and all the various departments and agencies controlled at each of those levels. This domain also includes the judiciary and penal system.

Health professionals can play a critical role in influencing governmental action. Physicians can provide testimony, lobby, or engage the media to impact policy-making from local executives and city councils, to analogous bodies at the state and national levels. Their action can affect health care directly through expanded access or indirectly, through broader social and public health interventions that improve opportunities for health and well-being. For example, Dr. Lilia Cervantes' persistent work led to a change in Colorado's Medicaid fee schedule allowing maintenance dialysis for undocumented residents—a policy innovation that is now spreading across the country.²⁷

Advocacy Skills—Policy, Communication, and Relationships

Improving health for individuals and populations is a complex process. Expertise and knowledge of a problem are not enough to correct it. Applying facts, statistics, or data to describe or define a problem is insufficient. Analysis to develop a solution or menu of options toward a solution is an important step but still falls short. Correcting an underlying problem or changing a social or structural determinant of health requires applying knowledge and expertise within a domain of influence through the application of the following advocacy skills: policy, communication, and relationships (Fig. 1). These skills appear as a wrench—a graphic reminder that without the application of power, the status quo will persist.

Policy. A policy, formal or informal, is simply an established way of doing things. Effectively advocating for change requires identifying the policy or policies that preserve an unacceptable status quo and the process through which those policies can be changed. It also involves defining a new policy to replace the old. Formal policy exists in laws, regulations, and established institutional priorities and procedures. Informal policy may be represented in the unwritten practices and precedents of groups, institutions, and communities. Changing the status quo usually involves a change in policy. Effective advocacy requires identifying the decision-maker and engaging the decision-making process to change the policy supporting the status quo. This is true whether the unit of decision-making is an individual, a practice, an institution, or an agency or branch of government. Such processes may be quite simple or procedurally complex.

Communication. Effective communication is essential to enable change. Messages that engage, inspire, and move the listener are concise, compelling, and clear. Health professionals are uniquely able to translate complex scientific data into understandable, compelling narratives. When new knowledge is needed to fully understand a problem and its potential solutions, health professionals are often the only people with the situational knowledge and research skills needed to fill in the gaps. Both Drs. Hanna-Attisha and Cervantes conducted research to complete the story they needed to tell to enable change to occur.

A message must also be tailored to the audience and the medium through which it is conveyed, whether a brief electronic communication, a traditional “old media” publication, or something recorded and broadcast. The ability to frame and deliver a message to a patient, a peer, a group, or a mass audience is a core skill for effective advocacy that can be taught and mastered.

Relationships. Change can rarely be accomplished alone. Effective advocacy requires identifying and partnering with the stakeholders necessary to achieve the desired change. This may include engaging a single individual, or cultivating a

broad coalition of individuals or organizations. Power builds collectively and relationships are the key to building power. Success may also require identifying stakeholders who are threatened by a change in the status quo and developing strategies to shift their values or points of view. Whether stakeholders become allies or opponents, advocates will need to manage relationships with them to further the cause.

Levels of Advocacy—Individual, Adjacent, and Structural

The final element of our model delineates the three levels of advocacy: individual, adjacent, and structural.

Individual Advocacy. Individual advocacy is what clinicians are most familiar with: a patient has an unmet need, and the clinician advocates for the changes necessary to meet that need. Individual advocacy affects the patient alone, with little impact beyond that individual and their loved ones. This form of advocacy is most closely tied to a clinician’s day-to-day work. Its impact is local and less generalizable. Examples might include getting medication or some needed service for a patient.

Adjacent Advocacy. Adjacent advocacy exists between the two poles of individual advocacy and structural advocacy and may share similarities with one or the other. The effort alters the milieu of the patient and individuals like them without necessarily changing the policies around them. Adjacent advocacy often involves activating others to act on behalf of individuals or groups of individuals with a particular characteristic or need. Ultimately, it affects more than the single individual who may have called the advocate to action, and yet falls short of a durable, structural change.

Structural Advocacy. Structural advocacy changes policies, rules, and resources in a permanent way such that the circumstances that impede or impair health are permanently altered. Effective structural advocacy reduces the likelihood of an unjust or inequitable health outcome occurring again in the future. Examples of structural advocacy are broad and diverse. Physicians were among the key leaders who pushed a ballot initiative raising the price of tobacco in Colorado—an intervention that has raised hundreds of millions of dollars for healthcare and prevention while averting thousands of teens from taking up smoking.²⁸ A Canadian neurosurgeon has been a critical voice in changing building codes to prevent children from falling from windows.²⁹ Changing access to dialysis for the undocumented or switching the water supply for a community to prevent lead poisoning are both examples of structural advocacy.

DISCUSSION

Health professionals encounter regular threats to health and well-being and yet the healthcare system that is supposed to

address these threats remains stubbornly dysfunctional. Many of the institutions that we rely on to correct our problems have grown parietic and polarized. Against this reality, health professionals have increasingly asserted the responsibility to advocate. Physicians advocating for change to reduce gun violence coined the phrase, “This is our lane” in response to those who would wish and argue otherwise.³⁰

Limitations exist. While the obligation to patients doesn’t end at the bedside, the further from this center a health professional moves, the less clear the obligation becomes. Gruen et al.³¹ described a continuum extending from the individual patient to the global community and a shift along that continuum from professional obligation, where action is required, to professional aspiration, where it is not. As one moves out from the domain of practice, where health professionals have a great deal of agency and control, to communities and governmental institutions, health professionals become much less central. And yet, change may never happen without the constructive participation of health professionals.

Advocacy also has its pitfalls. Health professionals have significant interests that can often conflict with the best interests of the individuals and communities they serve. They advocate from a position of privilege, with social capital and access to power that can be dramatically disparate from those they seek to help. This imbalance is in part what makes their advocacy so crucial, yet it carries risks that must be managed. A privileged advocate should function as a servant rather than a savior, and should strive always to practice cultural humility and “center the margins” by partnering with the community at the onset.³² Action that proceeds without the full partnership of the affected community can further the power differentials that are at the heart of structural racism.^{33–36} Health professionals will almost always be most effective in coalition with others, contributing to a collective effort, lending their voice and power to create change or advance goals, and yet lending agency to others is not necessarily a natural or comfortable position for health professionals, especially physicians.^{33–37}

We propose this theoretical model as a way of breaking down the complex, multi-faceted work of advocacy into a concrete framework to enable action. Over nearly a decade, through individual conversations, formal classes, and national workshops, we have tested and shared this model with scores of people. Through that process, the model has been used to teach advocacy and to plan action. Our model has not been formally validated. We publish it now, because we are confident that the framework is sound and stable and think that if it needs further refinement, that will best occur through the scrutiny of a broader audience.

Each health professional who seeks to work effectively as an advocate will be faced with a set of challenges and questions they must address. What is the threat to health that concerns me? Can I identify a solution to that threat? How much can I accomplish in my practice? Will we need action in the community or the government to make a difference? How much can I do alone? What partners do I need and how can I

find or develop them? Where do I need to lead and where am I more effectively contributing to someone else’s effort? What skills and resources do I contribute, and which do I need to look to others for? The advocacy model we present here should serve as a template to help frame and answer those questions. We hope as well that it will inform individuals and groups planning to advocate as well as educators working to develop students, residents, and colleagues as effective advocates. Ultimately, we hope this conceptual model will help our profession realize some of its tremendous yet untapped potential to improve the health of our patients and our nation.

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Declarations:

Conflict of Interest: The authors declare that they do not have a conflict of interest.

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