Emergency medicine health advocacy: foundations for training and practice

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ABSTRACT

Emergency physicians (EPs) are uniquely positioned to act as health advocates for individual patients, emergency department (ED) patient populations and the Canadian public. However, most ED practice environments do not encourage health advocacy, and staff EPs often do not feel adequately prepared to address many health-determinant issues. The mandate to provide health advocacy training to emergency medicine residents must be addressed in light of these challenges. This report defines the role of EPs as health advocates and summarizes the advantages and disadvantages of the ED as a forum for advocacy. At the University of Toronto, we have developed a new curriculum using evidence-based ED initiatives, examples of Canadian EP advocacy, and a description of organizations involved in advocacy, and we have incorporated several principles of adult learning to increase learner investment, maximize relevancy for EPs and optimize retention into practice. Residents believe the curriculum is highly relevant, allowing them to recognize advocacy opportunities in their own practices.

Key words: public health; advocacy; prevention; education; emergency medicine; curriculum development

RÉSUMÉ

Les médecins d'urgence sont dans une position unique pour agir comme défenseurs des patients, du personnel des départements d'urgence et de la population canadienne en matière de santé. La plupart des milieux de pratique de la médecine d'urgence ne favorisent toutefois pas une telle action, et le personnel des urgences ne se sent en général pas suffisamment préparé pour aborder de nombreuses questions déterminantes en santé. Il faut donc aborder la formation des résidents en médecine d'urgence à la représentation en matière de santé à la lumière de ces défis. Le présent article définit le rôle du médecin d'urgence en tant que défenseur de la santé et résume les avantages et inconvénients du département d'urgence comme forum de représentation. À l'Université de Toronto, nous avons établi un nouveau programme d'études à partir d'initiatives fondées sur les données probantes mises en place dans des département d'urgence, d'exemples de représentation par des médecins d'urgence au Canada et d'une description des organismes intervenant en représentation, et nous avons intégré au programme plusieurs principes de l'apprentissage chez les adultes afin de rehausser la participation de l'apprenant, de maximiser la pertinence pour les médecins d'urgence et d'optimiser la rétention de l'information et son application dans la pratique. Les résidents jugent que le programme est très pertinent et leur permet de reconnaître les occasions de représentation dans leur propre pratique.

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Introduction

Canadian physicians have a responsibility to act as health advocates for their patients, their practice populations and the Canadian public,[1–5] but advocacy is typically associated only with primary care or public health physicians.[6] The Canadian Medical Association (CMA) Code of Ethics and the mission statement of the Canadian Association of Emergency Physicians (CAEP) both include health promotion.[2,7]

Emergency departments (EDs) have a high profile and a valued position in the public eye. Patients often come to the ED for primary care, and EDs form a key interface between the health care community and the public, being for many people their only connection with the health care system.[6,8–11] Emergency physicians (EPs) are uniquely positioned to be successful health advocates because of the broad clinical spectrum of their practice, the combination of primary and secondary care they provide, and their daily liaisons with other physicians and allied health care professionals.[6,11–16] EPs often see conditions that could be influenced by preventive measures or behaviour modification.[6,15] Many ED presentations provide an opportunity for the EP to intervene at a time when patients may be most receptive to health advocacy initiatives.[15,17,18] Pointing out to a patient that ongoing smoking can cause or worsen their pneumonia or that wearing glasses could have prevented a corneal foreign body are excellent examples. Despite this, the health advocate role is poorly taught in EM training programs, and many EPs feel inadequately prepared in this regard.[6,10,19–22]

In this paper I summarize the health advocate role, review evidence that may guide its successful implementation in EM practice and present a model curriculum for incorporating health advocacy into residency training programs using evidence-based interventions and prominent EP advocacy efforts.

The role of the emergency physician as health advocate

In the document *Achieving Health for All: a Framework for Health Promotion*,[23] Health Canada defined prevention, one of three fundamental health challenges, as "activities and approaches which reduce the likelihood that a disease or disorder will affect an individual, interrupt or slow the progress of the disorder, or reduce disability." The World Health Organization defined health promotion as "The process of enabling people to increase control over and improve their health."[24] A conference cosponsored by these two organizations and by the Canadian Public Health Association characterized the connection between health promotion and advocacy as follows: "Political, economic, social, cultural, environmental, behavioral and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favorable through advocacy for health."[24] Herein lies the mandate of the physician advocate: to support behaviours, actions and events that are likely to promote health-related change and to discourage those that impede it.

The two organizations that credential EPs in Canada incorporate health advocacy in their training frameworks. The Royal College of Physicians and Surgeons of Canada (RCPSC) CanMEDS framework states: "Specialists recognize the importance of advocacy activities in responding to the challenges represented by the social, environmental, and biological factors that determine the health of patients and society. They view advocacy as an essential component of health promotion that occurs at the level of the individual patient, the practice population, and the community. Health advocacy is appropriately expressed both by the individual and collective responses of specialist physicians in influencing public health and policy."[1] The College of Family Physicians of Canada (CFPC) mandates that "The family physician views his or her practice as a population at risk and organizes the practice to ensure that patients' health is maintained," and states further that "Family physicians have the responsibility to advocate public policy that promotes their patients' health."[4]

Health advocacy should be a pervasive part of a physician's practice, targeting individual patients, the physician's immediate practice population, institutions, social organizations, and various levels of policy-makers and the Canadian public.

Challenges to health advocacy in emergency medicine

Prevention strategies are classified as primary (before any evidence of disease is present), secondary (after risk factors have declared themselves) or tertiary (after development of a disease to reduce deterioration in health).

Impediments to effective health advocacy in EDs include long patient waiting times, multiple simultaneous time demands and the lack of ongoing contact with patients necessary to reinforce important points.[10,19,21,25] Also, although the overall cost of providing primary health advocacy in EDs is debatable, it may be a significant burden for individual departments.[11,26–28]

EPs often see tertiary prevention activities, such as iden-

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tifying child abuse or addressing hypertension in a patient with ischemic heart disease, as within their scope of practice, butthis is seldom the case with primary and secondary prevention initiatives,[11,20,29] possibly because EM training programs and practice assessments do not emphasize the advocacy role.[6,10,19–21] Unfortunately, many advocacy initiatives have not been formally evaluated and lack proof of effectiveness.[29]

Effective health advocacy measures for the emergency physicians

Advocating for individual patients

A recent evidence-based review of ED health promotion initiatives found sufficient evidence to support smoking cessation counselling, pneumococcal vaccination, referral of children to a primary care physician, and screening and referral for hypertension, HIV risk factors, and alcohol abuse.[6,11] Conversely, there was insufficient evidence to support the following interventions: identification of risk factors for falls in geriatric patients; Papanicolaou tests for women undergoing pelvic examinations; counselling for smoke detector use, safe firearms storage, motorcycle helmet use and youth violence; and screening for social services, depression and domestic violence.[6,11] Evidence has recently evolved to support: screening questions for domestic abuse and alcohol dependence; counselling about adolescent suicide prevention and smoking cessation; referral to substance abuse programs; and referring and screening for STDs in pregnant patients.[13,14,16–18,25,30–35] It seems there is fertile ground for ED health promotion, and up to 96% of people in ED waiting rooms are interested in receiving some form of preventive health information.[36] The topics of greatest interest were prevention of breast and prostate cancer, stress reduction, exercise, blood pressure and depression screening, immunizations, smoking cessation and safe driving practices.

Advocating through organizations

Individual EPs may be most effective lobbying through an established organization. Many health care organizations include advocacy as an organizational goal and provide guidance to those interested in pursuing advocacy issues. Examples include the RCPSC,[1] CMA,[2,3] Ontario Medical Association,[37] CAEP,[7] Health Canada,[23] the CFPC,[9] the Trauma Association of Canada,[38] and SMARTRISK.[39] For example, CAEP published "Recommendations for the management of rural, remote and isolated emergency health care facilities in Canada" and recently published a Position Statement on ED overcrowding.[40,41] Both of these important documents were the product of committed EPs working through their national organization.

Some physicians, including the Northern Ontario EPs who ran a public education program to decrease trauma deaths in their community, have addressed local issues by bringing concerns to municipal and provincial governments.[42-45] Other hospital-based community programs such as SMARTRISK,[39] PARTY (Prevent Alcohol and Risk-Related Trauma in Youth)[46] and CHAT (Community and Hospital Against Trauma)[47] also benefit from physician involvement.[29]

Institutional measures, such as submitting hospital policy proposals to the medical advisory committee, may be effective. Recent examples in our institution include policies to identify the best admitting service for given patient conditions, and maximum wait time limits for consultations, both designed to expedite patient care in the current era of overcrowding and ambulance diversions.

Advocating on a general population level

EPs have influenced federal legislation[29] by lobbying for stricter tobacco advertising regulations, by leading efforts to reduce second-hand smoke in public places,[37] and by lobbying Parliament to change gun control policy.[5] With respect to gun control, Fisher and Drummond[5] not only described an advocacy process but took on an advocacy role themselves by raising awareness in a mainstream clinical journal. Similarly, physicians in the United States have been involved in traffic safety initiatives ranging from local education to testifying before legislatures and Congress — activities that produced drastic decreases in vehicle crash injuries.[20,48]

The most effective strategies are often born out of local need.[49] Physicians are encouraged to explore and research their own advocacy challenges. This involves identifying the key risk factors for a given patient or population, assessing the availability of primary care, acting on information volunteered by the patient, arranging for appropriate referral to specialists, ancillary health providers or social workers as appropriate, and gathering data to address an unmet advocacy need. A sound understanding of resources available in the local community is invaluable.

Integrating health advocacy into resident training programs

The RCPSC and the CFPC both require training programs to prepare residents as health advocates.[1,4] Despite this, the health advocate role is the role least understood and least addressed by program directors and residents in Canadian

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training programs.[50] In anticipation of forthcoming training mandates, the Emergency Medicine Subspecialty Training Committee of the RCPSC has developed curricula to address unmet CanMEDS training objectives. In 2002, the University of Toronto's Fellowship EM training program implemented a formal curriculum to address the health advocate role in emergency medicine. Medical educators have found that assessing motivation, demonstrating per-

Table 1. Selected examples of resident advocacy developed for Module Three of the model curriculum

Situation	Advocacy (good example v. lesson learned)	Quote
Patient suffering from cancer and depression was recently discharged with a diagnosis of substance abuse and little follow-up.	Single patient: the resident conducted proper screening, referred the patient to the detoxification unit, cancer support group, and psychiatric group practice.	"By taking a few extra minutes to talk to the patient in the department and provide some positive solutions and avenues for support the patient is more likely to have a good outcome."
Patient from an underserviced community had a gangrenous foot. The senior RN was intent on inappropriate precipitous discharge.	ED population: the resident confronted the RN about obligations to treat patients from underserviced communities, and explored the possibility of bias against the poor.	"This was not a tactic destined to lead to a desirable outcome. Although the patient was properly cared for, the underlying issues of intolerance and poor understanding of mental illness, homelessness, and other determinants of health were left rotting, much like my patient's foot."
Children in pain were undertreated by surgeons and staff EPs.	ED population: in the experience of this resident advocacy in the form of educating peers was uncommon.	"I know that I have stood by while a painful procedure was being done to a child without advocating for them. A desirable outcome might be an initiative to teach EPs about pediatric pain scores and appropriate analgesia and conscious sedation in children."
A security guard, bitten by a patient, was not immunized.	Population: Hospital Occupational Health Unit was contacted regarding immunization policies for staff.	"The security guard was informed of the risks of diseases such as hepatitis B and C and HIV in his line of work."
A visitor to Canada, seen in the ED with acute asthma, was homeless and had no means of support	Single patient: Counselling about smoking, supply of medications given, referred to a social services agency.	"…we were limited by his status as a visitor to Canada with no health insurance."
A homeless patient with type II diabetes had a foot ulcer requiring vacuum therapy. There was no place to reliably provide treatment after discharge.	Single patient: Resident had spent time at a local shelter and educated staff physicians about options at men's shelter, including availability of infirmary bed. Treatment proceeded with the proper standard of care.	"…wound care team were hesitant to send expensive equipment to a hostel, but fortunately our staff agreed with my argument."
The staff internist spoke to the estranged parents of a 16-year-old comatose overdose patient about doing an emergent HIV test. The resident was a medical student at the time.	Single patient: The medical student argued that the HIV test was not immediately necessary, that the patient would likely be able to consent within hours, and that the family was estranged. The medical student was ignored and felt intimidated. Testing proceeded anyway.	"I was attempting to advocate for the unconscious woman, who regained consciousness quickly and whose rights as a patient were violated. In retrospect I should have pursued the discussion with the internist, or talked to another physician about the situation. Ever since this situation, I have become more confident about pursuing difficult discussions with staff physicians when patient advocacy is involved."
Trauma exposure during residency identified predictable patterns of injury.	Population: The resident formulated an academic subspecialty around injury prevention including research into youth wilderness experience, and participated on an advisory committee for injury prevention foundation, and teaching trauma care.	"My efforts can be, and will be improved upon. It is clear that in spite of the knowledge we have about trauma and injury prevention, we are struggling to translate knowledge into behavioural change."

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sonal relevance, using active problem-solving techniques, and incorporating students' own values and experiences are keys to success in adult education.[51,52] Appendix 1 details a modular small-group session curriculum incorporating these principles. This program uses examples from the Canadian experience to help participants develop a better understanding of health advocacy, then encourages them to critically examine specified ongoing initiatives as well as initiatives relevant to their own practice. Residents rated elements of the curriculum on a 5-point Likert scale with specific descriptors. The average scores for relevance to emergency medicine and curriculum format/delivery were, respectively, 4.1 and 4.3 out of 5 — between "above average" and "outstanding." Impact of the curriculum on practice patterns has yet to be measured. Table 1 includes several examples of advocacy experiences that the residents offered for discussion.

Summary

Despite limited advocacy training and the challenging ED environment, EPs have an ethical mandate to advocate for their patients specifically and the population in general. A curriculum that uses relevant examples and encourages personal reflection while teaching the fundamentals of health advocacy should help residents integrate the advocate role into their daily emergency practice.

Competing interests: None declared.

References

1. Societal Needs Working Group. Skills for the new millennium. Ann Roy Coll Phys Surg Can 1996;29(4):206-16.

2. Canadian Medical Association. Code of Ethics. CMAJ 1996;155 (8):1176A-D.

3. Canadian Medical Association. The role of physicians in prevention and health promotion (Update 2001) [policy statement]. Ottawa: The Association; 2001. Available: www.cma.ca (accessed 2003 Aug 6).

4. College of Family Physicians of Canada. Standards for accreditation of residency training programs. Mississauga: The College; 2002. Available: www.cfpc.ca/English/cfpc/programs/patient%20care/elderly/default.asp?s=1 (accessed 2003 Aug 6).

5. Fisher H, Drummond A. A call to arms: the emergency physician, international perspectives on firearm injury prevention and the Canadian gun control debate. J Emerg Med 1999;17(3):529-37.

6. Rhodes KV, Gordon JA, Lowe RA. Preventive care in the emergency department, Part I: Clinical preventive services — Are they relevant to emergency medicine? Society for Academic Emergency Medicine Public Health and Education Task Force Preventive Services Work Group. Acad Emerg Med 2000;7(9): 1036-41.

7. Canadian Association of Emergency Physicians. Policies and guidelines. Ottawa: The Association; 2001. Available: www .caep.ca/002.policies/002-00.main.htm (accessed 2003 May).

8. Schmidt TA. When public health competes with individual needs. Acad Emerg Med 1995;2(3):217-22.

9. Bernstein E, Bernstein J. Case studies in emergency medicine and health of the public. Boston: Jones and Bartlett; 1996.

10. Williams JM, Chinnis AC, Gutman D. Health promotion practices of emergency physicians. Am J Emerg Med 2000;18(1): 17-21.

11. Babcock IC, Wyer PC, Gerson LW. Preventive care in the emergency department, Part II: Clinical preventive services — an emergency medicine evidence-based review. Society for Academic Emergency Medicine Public Health and Education Task Force Preventive Services Work Group. Acad Emerg Med 2000;7(9):1042-54.

12. Lowenstein SR, Tomlinson D, Koziol-McLain J, Prochazka A. Smoking habits of emergency department patients: an opportunity for disease prevention. Acad Emerg Med 1995;2(3):165-71.

13. Bernstein E, Bernstein J, Levenson S. Project ASSERT: an ED-based intervention to increase access to primary care, preventive services, and the substance abuse treatment system. Ann Emerg Med 1997;30(2):181-9.

14. Kruesi MJ, Grossman J, Pennington JM, Woodward PJ, Duda D, Hirsch JG. Suicide and violence prevention: parent education in the emergency department. J Am Acad Child Adolesc Psychiatry 1999;38(3):250-5.

15. Rodriguez RM, Kreider WJ, Baraff LJ. Need and desire for preventive care measures in emergency department patients. Ann Emerg Med 1995;26(5):615-20.

16. Ernst AA, Romolo R, Nick T. Emergency department screening for syphilis in pregnant women without prenatal care. Ann Emerg Med 1993;22(5):781-5.

17. Miller WR. Motivational interviewing: research, practice, and puzzles. Addict Behav 1996;21(6):835-42.

18. Miller CE, Johnson JL. Motivational interviewing. Can Nurse 2001;97(7):32-3.

19. Prochazka A, Koziol-McLain J, Tomlinson D, Lowenstein SR. Smoking cessation counseling by emergency physicians: opinions, knowledge, and training needs. Acad Emerg Med 1995;2 (3):211-6.

20. Bernstein E, Goldfrank LR, Kellerman AL, et al. A public health approach to emergency medicine: preparing for the twenty-first century. Acad Emerg Med 1994;1(3):277-86.

21. Fleming MF, Manwell LB, Kraus M, Isaacson JH, Kahn R, Stauffacher EA. Who teaches residents about the prevention and

treatment of substance use disorders? A national survey. J Fam Pract 1999;48(9):725-9.

22. Anglin D, Hutson HR, Kyriacou DN. Emergency medicine residents' perspectives on injury prevention. Ann Emerg Med 1996; 28(1):31-3.

23. Achieving health for all: a framework for health promotion. Ottawa: Health Canada; 1996.

24. Ottawa Charter for Health Promotion. First International Conference on Health Promotion; 1986 Nov 21; Ottawa. Ottawa: World Health Organization. Available: www.who.int/hpr /archive/docs/ottawa.html (accessed 2003 Aug 6).

25. Rhodes KV, Levinson W. Interventions for intimate partner violence against women: clinical applications. JAMA 2003;289(5): 601-5.

26. Tyrance PH Jr, Himmelstein DU, Woolhandler S. US emergency department costs: no emergency. Am J Public Health 1996;86(11):1527-31.

27. Williams RM. The costs of visits to emergency departments. N Engl J Med 1996;334(10):642-6.

28. Clancy CM, Eisenberg JM. Emergency medicine in population-based systems of care. Ann Emerg Med 1997;30(6):800-3.

29. Bandiera GW, Hillers TK, White F. Evaluating programs to prevent unintentional trauma in Canada: challenges and directions. J Trauma 1999;47(5):932-6.

30. Feldhaus KM, Koziol-McLain J, Amsbury HL, Norton IM, Lowenstein SR, Abbott JT. Accuracy of 3 brief screening questions for detecting partner violence in the emergency department. JAMA 1997;277(17):1357-61.

31. Mayfield D, McLeod G, Hall P. The CAGE questionnaire: validation of a new alcoholism screening instrument. Am J Psychiatry 1974;131(10):1121-3.

32. Morrison LJ. The battering syndrome: a poor record of detection in the emergency department. J Emerg Med 1988;6(6):521-6.

33. Morrison LJ, Allan R, Grunfeld A. Improving the emergency department detection rate of domestic violence using direct questioning. J Emerg Med 2000;19(2):117-24.

34. D'Onofrio G, Degutis LC. Preventive care in the emergency department: screening and brief intervention for alcohol problems in the emergency department: a systematic review. Acad Emerg Med 2002;9(6):627-38.

35. Rollnick S, Heather N, Bell A. Negotiating behavior change in the medical setting: the development of brief motivational interviewing. J Mental Health 1992;1:25-37.

36. Llovera I, Ward MF, Ryan JG, LaTouche T, Sama A. A survey of the emergency department population and their interest in preventive health education. Acad Emerg Med. 2003;10(2):155-60.

37. Ontario Medical Association. More smoke and mirrors: tobacco industry-sponsored youth prevention programs in the context of comprehensive tobacco control programs in Canada. Feb 27, 2002. Toronto: The Association; 2002. Available: www.oma .org (accessed 2003 Feb).

38. Trauma Association of Canada. Mission Statement. The Association; 1997. Available: http://tac.medical.org/html/mission.html (accessed 2003 May).

39. SMARTRISK Web site [Internet]. Vol. 2003: SMARTRISK; 2003. Available: www.smartrisk.ca (accessed 2003 May).

40. Canadian Association of Emergency Physicians. Recommendations for the management of rural, remote and isolated emergency health care facilities in Canada. Ottawa: The Association; 1997. Available: www.caep.ca/002.policies/002-01.guidelines/recommendations/executive-summary.htm (accessed 2003 Aug 6).

41. Canadian Association of Emergency Physicians, National Emergency Nurses Affiliation. Joint Position Statement on emergency department overcrowding. Can J Emerg Med 2001;3(2): 82-4.

42. Rowe BH, Therrien S, Johnson C, Sahai VS, Bota GW. Regional variations of northern health: the epidemic of fatal trauma in northeastern Ontario. Can J Public Health 1995;86(4):249-54.

43. Spears T. Northern Ontario MDs seek solution to region's huge accidental-death toll. CMAJ 1996;155(1):101-2.

44. Rowe BH, Therrien SA, Bretzlaff JA, Sahai VS, Nagarajan KV, Bota GW. The effect of a community-based police surveillance program on snowmobile injuries and deaths. Can J Public Health 1998;89(1):57-61.

45. Rowe B, Milner R, Johnson C, Bota G. Snowmobile-related deaths in Ontario: a 5-year review. CMAJ 1992;146(2):147-52.

46. PARTY Program. Sunnybrook and Women's College Health Sciences Centre. Available: www.sw.ca (accessed 2003 Aug 6).

47. Community and Hospital Against Trauma. Hamilton District Trauma Prevention Council. Available: http://traumaprevention.on.ca/chat.html (accessed 2003 May).

48. Bernstein E, Roth PB, Yeh C, Lefkowits DJ. The emergency physician's role in injury prevention. Pediatr Emerg Care 1988;4 (3):207-11.

49. Baren J. Injury prevention, emergency medicine, and sports medicine on the same playing field. Acad Emerg Med 2000;7 (12):1424-7.

50. Frank JR. CanMEDS 2002, Success in Paradigm Shift. Royal College of Physicians and Surgeons of Canada Annual Conference. Ottawa: The College; 2002.

51. McKeachie W. Teaching tips. Strategies, research and theory for college and university teachers. 10th ed. Boston: Houghton Mifflin Company; 1999.

52. Tiberius R. Small group teaching: a troubleshooting guide. 1st ed. Toronto: Ontario Institute for Studies in Education; 1995.

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Appendix 1. Model curriculum

The curriculum consists of three modules that take the resident progressively closer to implementation of the concepts. (The references for this paper include many examples of ED advocacy that can be used as a basis for discussion.)

Module One: What is a health care advocate?

1. Preparation (distributed one week before the first session): Define health advocacy in a single paragraph and describe a situation you have encountered in which health advocacy was practised.

2. Discussion: Use the examples provided in the assignment to stimulate discussion of the advocate role around the following questions:

- What is advocacy?
- What are the levels of advocacy?
- How can physicians influence policy?
- Who is active in advocacy?

3. Relation to literature and theoretical bases: a) Explore participants' definitions and compare them to definitions of advocacy from general and medical sources. b) Categorize participants' examples into the three basic types of advocacy: single patient, ED population, and Canadian public. Either highlight how their examples demonstrate the spectrum of advocacy initiatives or discuss reasons why their examples fail to demonstrate it. c) Identify attempts at policy change from participants' examples or from this paper. Discuss how the example is advocacy, the target outcome, and what resources were used. Emphasize the various levels at which policy change can occur. d) Solicit examples of organizations active in health advocacy and embellish the list with examples from this paper.

Participants are asked to think about their current conceptualization of advocacy and provide one example, thus establishing their own frame of reference and starting point. The discussion encourages them to discuss and refine their thinking. Relevance is ensured because participants use their own examples. The interactive discussion promotes learner investment. Ongoing feedback is provided by the facilitator, peer participants, and literature references.

Module Two: What is happening now?

1. Preparation (distributed at the end of the first module): Find an example of a past or ongoing health advocacy initiative related to EM from the medical literature, mainstream media, or personal experience. Describe the initiative, the beneficiary, the target (e.g., hospital administration, government, individual patient), and the outcome.

2. Discussion: Have the participants summarize their examples, encouraging them to categorize the initiatives into a framework developed in module one. Emphasize comments and discussion about outcomes and effectiveness.

3. Relation to literature and theoretical bases: Discuss how the examples fit in to previously discussed classification of advocacy issues, how they were designed, and how effective they were at achieving the goal.

This approach keeps the resident centred and maintains relevance while adding the task of evaluating novel material based on a previously discussed framework. It is meant to encourage residents to think about activities they encounter as advocacy issues explicitly and critically. Participants also learn to appreciate how advocacy issues are disseminated and portrayed in various media.

Module Three: Your practice

1. Preparation (distributed at the end of the second module): Prepare a one-page report about an interaction you have had in which advocacy was or was not undertaken. Explain how the advocacy effort was, or may have been, made and what could be improved upon.

2. Discussion: Ask participants to review their personal examples. Ask about the impediments to the initiative, practicalities of implementation, and future directions. Ask participants to comment on each other's examples and how they may have approached them differently.

3. Relation to literature and theoretical bases: Ask about similar initiatives described in the literature and discuss similarities and differences. If there are no related reports, discuss why this may be and how the literature in this area might be embellished.

This module asks participants to reflect on their own practice in a prospective fashion to develop their sensitivity to advocacy opportunities. It reinforces the context of the learner's own practice and allows them the flexibility to address self-defined examples of the material. Participants see how their colleagues define learning needs and address similar issues.

Trainees are evaluated on their assignments and on their participation in the discussion.

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