

Advocacy and activism in emergency medicine

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What is advocacy?

Advocacy can be defined as speaking forth in order to compel positive change at a personal, institutional or governmental level. Advocacy is a central part of medical professionalism and of the growing movement of preventative medicine, which extends from the bedside to the global community.¹ Although the subjects and means of advocacy vary, several fundamental elements are common to successful endeavours. These include knowledge, passion, skilled communication, vigilance and perseverance. Residency presents an opportunity to learn and practise advocacy, a skill that can be carried forward into our careers as emergency physicians.

Some consider an advocate to be an intercessor — one who supports, pleads or speaks forth on behalf of another.² Activism, on the other hand, is defined as vigorous actions to achieve political or other goals.³ It is not clear when advocacy becomes activism, but the 2 are part of a continuum designed to reach similar ends. We may engage in advocacy with or on behalf of individual patients, local communities or broader communities, such as those at a state, provincial, national or global level. We act as bedside advocates when we counsel patients to quit smoking, wear bicycle helmets and use seatbelts. Community advocates might lobby for improved street lighting at a dangerous intersection or a needle exchange for drug addicts. Advocacy for improved traffic legislation and disaster preparedness, for example, affect the larger community. We can embark on these activities as individuals, as members of a physician organization such as the Canadian Association of Emergency Physicians (CAEP), or as members of

community organizations such as Families for Seismic School Safety.^{4,5}

Professional and ethical responsibility

Wynia and colleagues point out that the Latin root of the word “profession” means “speaking forth.”⁶ Medicine has been upheld as an example of professionalism for many generations,⁷ and there is little doubt that as physicians we are engaged in a social contract. Our profession is granted prestige, status within the community and the privilege of self-regulation with the understanding that we will use our knowledge and skills in the service of others. We are expected to exhibit commitment to competence, integrity, altruism and promotion of the public good.⁸ While some tout the responsibility of self-regulation as one of the defining features of professionalism, others see negotiating social priorities as its core.⁶ As such, advocacy is woven into the very fabric of professionalism.

CAEP includes advocacy as part of its mission: “empowering physicians to provide excellent emergency care through leadership, education and advocacy.”⁹ Advocacy is an ethical duty cited in the American College of Emergency Physicians’ (ACEP) Code of Ethics as part of the “emergency physician’s relationship with society.”¹⁰ Emergency physicians are uniquely positioned to bear witness to the immeasurable human toll of disease and the impact of failed social policies. Our role on the front lines, so to speak, makes us visible in the community. For these reasons and others, the public often holds us in high esteem, lending credibility and legitimacy to our opinions. In short,

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we have a strong voice in the community and, as professionals, an obligation to use it.

Outstanding examples of successful advocacy

What follows are 2 illustrative stories of successful advocacy that are relevant to emergency medicine in Canada. The first example demonstrates how CAEP's collective voice, led by 2 passionate physicians, influenced government and helped bring about stringent firearm legislation. The second example is about an emergency physician whose vision and leadership is helping to improve health care at home and abroad.

Gun control in Canada

The 1989 mass killing of 14 women at the Montreal l'École Polytechnique by a man using a legally owned firearm galvanized the gun control debate in Canada. While early debates often peered at gun control through the lens of criminality, Chapdelaine's epidemiologic study demonstrated that most Canadian firearms deaths were suicides.^{11,12}

Although CAEP had not yet established its voice as an advocate in the public health arena, it joined the Canadian Coalition for Gun Control in 1992 to transform the face of the gun control debate. Led by Dr. Al Drummond, then president of CAEP, and Dr. Harold Fisher, a physician at Mount Sinai Hospital in Toronto, CAEP changed gun control into a public health and injury prevention issue through an evidence-based position paper and presentations to the House of Commons Standing Committee on Justice and Legal Affairs, and the Senate Committee on Legal and Constitutional Affairs. Bill C-68, the toughest gun legislation in the Western World, was passed into law one day before the sixth anniversary of the Montréal massacre.^{13,14}

CAEP's credibility rose from its unique perspective as an organization of physicians who were directly involved in treating gun-related injuries. They emphatically conveyed their special knowledge about firearms injury to decision-makers and their extraordinary efforts were one of the reasons the law was successfully passed.¹⁵ While it is not possible to quantify the effect of the legislation, the number of gun-related deaths has dropped by 37% since 1994, to a level of 2.6 per 100 000 population (a total of 816 firearms deaths in 2002).¹⁶

Advancing care of patients with HIV/AIDS in Africa

As a physician working overseas in King Edward VII Hospital in Durban, South Africa, Dr. Michael Schull bore witness to a steady flow of sick and injured patients. Although able to help individual patients, he was discouraged by his

limited impact on the community as a whole. After returning to Canada, Dr. Schull joined Médecins Sans Frontières (MSF), an organization committed to international aid and advocacy. As part of an organized group of committed volunteers, he saw the strength of coordinated action combined with advocacy. He witnessed the broad impact of these actions firsthand through projects in Iraq, Bangladesh, Burundi, Rwanda, Uzbekistan and the Democratic Republic of Congo.

Today, Dr. Schull works with Dignitas International, an organization devoted to developing community-based health care for the prevention and treatment of HIV/AIDS, particularly in rural and remote villages in resource poor countries.¹⁷ Through cooperation with local and national institutions in Malawi, the Dignitas program aims to dramatically increase access to treatment by decentralizing AIDS care to rural settings. Dignitas is working to leverage its work by sharing knowledge with other ministries of health and non-governmental organizations so they can develop similar community-based models in their settings.

Advocacy has also become an integral part of Dr. Schull's academic career. As a health services researcher, Dr. Schull is building a base of evidence that not only lends credence to the phenomenon of overcrowding, but also underlines the contributing factors and consequences.¹⁸⁻²⁰ In an effort to ensure these findings are translated from the research setting into effective policy, Dr. Schull works with decision-makers and communicates with the public through the media.

Dr. Schull's bedside experiences in Africa and at home in Toronto moved him to become an advocate in the larger community, and his vigilance enabled him to identify opportunities for improvement through aid and research.

Ingredients for successful advocacy

As these examples illustrate, successful advocacy is built on passion, expertise, skilled communication, vigilance and perseverance:

- *Passion:* The possibilities are endless, as are the obstacles. To maintain motivation in the face of opposition, it is vital to choose an issue or cause that makes you "angry" or inspires you — something about which you can be passionate.
- *Knowledge:* Know the cause in terms of its benefits, harms and proposed alternatives. Grounding arguments in "evidence" will make it difficult for opponents to dispute. Expertise also helps in formulating and articulating key messages to patients and decision-makers.

- *Skilled communication*: Communicating the message in a succinct and understandable fashion can help disseminate it to individual patients, policy-makers and, through the media, to the larger community.
- *Vigilance*: Discovering opportunities for advocacy requires vigilance. It is essential to recognize opportunities for advocacy, such as the so-called “teachable moment” at the bedside, when they arise.²¹
- *Perseverance*: The need for perseverance is self-evident; advocacy may be difficult with infrequent or hard-won successes. Perseverance is fostered by participating in a community of advocacy through an organization or with the support of colleagues in your department. Forming a coalition with like-minded individuals or organizations may also lend further credibility to the message.

How to get involved

The critical first step is to find an issue that engages you, something you care about. Learn the facts, the arguments and current activities underway to spread the message and effect change. Working with a group of like-minded individuals or with an organization like CAEP will ensure a coordinated effort and may increase the credibility of your message. Some resources are listed in Table 1.

Role-modeling is an essential component of socialization in medicine, impacting the values and behaviours adopted by residents.^{7,22} Aligning yourself with exemplary role models will improve your advocacy skills.

Advocates face many challenges. Perhaps the greatest concern for us as residents is further demands on our time. While practising advocacy at the bedside requires vigi-

lance and continued commitment, it usually adds only minimally to workload. Political or community advocacy requires greater time and energy.

Conclusions

Emergency physicians have an ethical obligation and professional responsibility to act as health advocates. This responsibility also extends to us as residents. Our unique perspective on the front lines of healthcare and status as professionals lends particular credibility to our voices as individuals and collectively. Physicians like Drs. Drummond, Fisher and Schull are outstanding role models; their efforts illustrate that advocacy is not only doable, it can achieve remarkable results. While advocacy in the broader community requires time, energy and commitment, it is rewarding. Whether at the bedside or in the broader community, find an issue about which you are passionate and speak forth. Be an advocate!

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Table 1. Selected Canadian advocacy resources

Organization	Web address
Canadian Association of Emergency Physicians (CAEP)	www.caep.ca
Improved access to care	www.caep.ca/stophewait/
Canadian Association of Physicians for the Environment (CAPE)	www.cape.ca
Canadian Council for Tobacco Control	www.cctc.ca/
Canadian Medical Association (CMA)	www.cma.ca
MD-MP contact program	
“Doctors in house”	
Coalition for Gun Control	www.guncontrol.ca/
Médecins sans Frontières (MSF Canada)	www.msf.ca
Medical relief	
Mothers Against Drunk Driving (MADD)	www.madd.ca
Physicians for Global Survival (PGS)	www.pgs.ca
Abolition of nuclear weapons and peaceful conflict resolution	
SMARTRISK	www.smartrisk.ca/
Injury prevention	

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Erratum

In the conclusion section of the Abstract as well as in the main conclusion section of the March 2007 original research article,¹ the word "blood" was used in 2 instances that should have read "urine." The sentences appear in their corrected form below. We apologize for any inconvenience this has caused.

"In the elderly, reagent testing is an unreliable method of identifying patients with positive urine cultures." (p. 87 and 91)

"Urine cultures, regarded by many as the criterion standard for UTI, do not have sufficient specificity to confirm the diagnosis of UTI in elderly patients with non-specific symptoms." (p. 87 and 91)

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