Attitudes Toward Advocacy Do Not Match Actions: A Cross-sectional Survey of Residents and Fellows

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ABSTRACT

BACKGROUND/OBJECTIVE: We sought to determine baseline physician advocacy knowledge and attitudes of resident and fellow trainees at our institution to inform future graduate medical education (GME) activities.

METHODS: A cross-sectional survey was developed and administered to all house staff in 2014 at Lifespan Hospitals, affiliated with The Warren Alpert Medical School of Brown University.

RESULTS: The response rate was 24% (134/558). Eighty-eight percent reported voting in the 2012 presidential election, with lower participation in regional elections. Less than 25% felt comfortable explaining the Affordable Care Act, communicating with media, or influencing legislation on a health care issue. The majority (94%) agreed that "as a physician I have a duty to advocate." Few reported receiving adequate advocacy training in medical school (18%) or residency (12%).

CONCLUSIONS: House staff agreed that physicians have a duty to advocate, but this did not translate into knowledge or action. GME should increase curricular efforts for trainees in the health care advocacy domain.

KEYWORDS: physician advocacy, graduate medical education, advocacy training

INTRODUCTION

The physician's role in advocacy and civic engagement is increasingly recognized as an important component of a career in medicine. Medical professional organizations have declared that a physician's responsibilities include "advocacy for social, economic, educational, and political changes"[1,2] and "promot[ing] justice in the health care system."[3]

Despite the societal importance of health care, doctors have been less engaged in advocacy and civic activities than others. One study found that doctors voted in national elections between 1996 and 2002 at lower rates than the general population (42% vs 50%) and lawyers (64%).[4] Physicians were half as likely to have volunteered in the past month than the general public or lawyers.[5]

While there have been previous studies on attitudes toward advocacy of practicing physicians who have completed training [6-9], and pre-post surveys after advocacy teaching or experiences[10-12], little is known about the baseline attitudes and advocacy experiences of resident and fellow (house staff) physicians.

A study of house staff showed that 89% agreed that health policy is important, but only 21% felt confident in their knowledge of health policy.[13] Another study of Canadian medicine residents, administered after a required academic retreat focused on advocacy, showed that while a majority agreed that advocacy was part of a physician role, most were not participating in advocacy activities as residents.[14] A qualitative study of residents identified advocacy as essential, but challenges included professional boundaries and personal discomfort.[15]

We sought to determine baseline knowledge and attitudes of physicians-in-training at our institution to inform future graduate medical education (GME) activities regarding physician advocacy.

MATERIALS AND METHODS

We developed a survey based on themes derived from a literature review on physician advocacy topics. We found no previously validated survey instrument published on this topic.

A pilot study of graduating residents and fellows at Lifespan Hospitals, a major teaching affiliate of The Warren Alpert Medical School of Brown University, was administered in April 2014 to improve internal validity of the survey instrument (N = 171). Using these data, questions were clarified. Subsequently, a cross-sectional study was performed of all residents and fellows at Lifespan Hospitals (n = 558). The study was deemed exempt by the Lifespan Institutional Review Board (IRB).

The survey was distributed electronically through the GME listserv over an 8-week period, from September – October 2014. Participants received no compensation for participation. Study data were collected and managed using REDCap electronic data capture tools hosted at Lifespan.

Analyses were conducted with SAS Software 9.4 (SAS Inc., Cary, NC). Responses were examined as both discrete variables with the Chi Square test using the FREQ procedure and as ordinal variables with generalized linear modeling assuming a binomial distribution using the GLIMMIX procedure. All interval estimates were calculated for 95% confidence and alpha was set, a priori, at the 0.05 level.

RESULTS

There were 134 responses, for a response rate of 24% (134/558). The majority were residents (77%), while the remainder were fellows (23%). Eighty-five percent were in a medical subspecialty, while 15% were in a surgical subspecialty. Of the respondents, 56% were female, while 63% reported being Non-Hispanic white. Postgraduate year (PGY) breakdown was approximately 20% each for years one, two and three, with the remaining PGY-4 or higher (**Table 1**).

Trainees reported generally high levels of social engagement. Approximately 80% keep up with current events and are registered to vote. Of those registered to vote, 88% reported voting in the 2012 presidential election. Fewer reported voting in state and local elections; 37% reported voting "always" or "often" with 55% voting "sometimes" or "rarely."

House staff were less comfortable with their knowledge of health care issues and related advocacy activities. Less than a quarter (24%) felt comfortable explaining the Affordable Care Act (ACA) to patients and colleagues. Only 22% reported that they would feel comfortable communicating with media about an advocacy issue, while 13% felt comfortable advocating for legislation about a health care issue.

Table 1. Characteristics of Survey Respondents (N = 134)

		Percent Respondents
Training Level	Residents	77%
	Fellows	23%
PGY[1]	1	21%
	2	22%
	3	22%
	4	14%
	5	11%
	6	8%
	7	2%
Specialty	Medical	85%
	Surgical	15%
Sex	Female	53%
	Male	47%
Race	Non-Hispanic White	63%
	Asian/Asian American	23%
	Black/African American	6%
	Hispanic/Latino	4%
	Other	5%
Citizenship	U.S.	95%

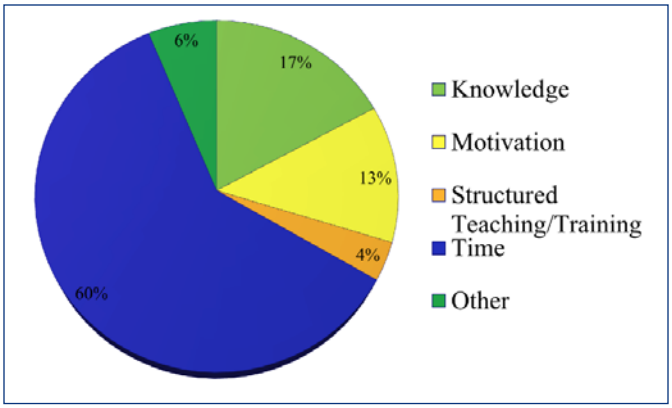
[1]PGY = post graduate year

Table 2. Survey Likert Scale Questions with Response Mean and Confidence Interval (CI)

Question	Mean (1-5)	95% CI	
I feel comfortable… (1) Strongly Disagree to (5) Strongly Agree			
Using the internet to contact my elected official. (This includes using social media, online form, and email.)	3.5	[3.3	3.7]
Calling my elected official	2.7	[2.5	2.9]
Visiting my elected official	2.3	[2.1	2.5]
Writing an op-ed or letter-to-the-editor	2.5	[2.3	2.7]
How often have you… (1) Never to (5) Always			
Used the internet to contact your elected official. (This includes using social media, online form, and email.)	1.7	[1.5	1.9]
Called your elected official	1.2	[1.0	1.4]
Visited your elected official	1.2	[1.0	1.4]
Written a letter-to-the-editor or an op-ed	1.2	[1.0	1.4]
(1) Strongly Disagree to (5) Strongly Agree			
I am able to help my patient(s) navigate the health care system	3.0	[2.8	3.2]
I understand the opportunities available for physicians to advocate for health care issues.	2.8	[2.6	3.0]
I can describe how health policy impacts the health of populations that I serve.	3.2	[3.0	3.4]
I feel comfortable explaining the Patient Protection and Affordable Care Act to patients and colleagues.	2.5	[2.3	2.7]
I feel comfortable working on getting legislation or policy passed about an issue in health care that I care about.	2.2	[2.0	2.4]
I feel comfortable communicating with the media about an advocacy issue I care about.	2.4	[2.2	2.6]
I feel comfortable identifying practice or hospital-level (management) issues impacting my patients and working to find a solution to these issues.	3.0	[2.8	3.2]
As a physician I have a duty to be an advocate for my patients.	4.3	[4.2	4.5]
As a physician I can have an influence on the media.	3.5	[3.3	3.6]
As a physician I can have an influence on health care legislation.	3.4	[3.2	3.6]
I received adequate training in medical school in physician advocacy.	2.4	[2.1	2.6]
I receive(d) adequate training in residency in physician advocacy.	2.3	[2.1	2.5]
I think advocacy training should be a part of medical school education.	3.8	[3.6	3.9]
I think advocacy training should be a part of residency education.	3.8	[3.6	4.0]
I plan to be involved in advocacy during my career as a physician.	3.3	[3.1	3.5]
How likely in the future will you… (1) Very Unlikely to (5) Very Likely			
Communicate with elected officials	2.9	[2.7	3.1]
Write an op-ed or letter-to-the-editor	2.5	[2.3	2.7]
Teach students, residents or colleagues about health policy	3.4	[3.2	3.6]

Figure 1. Barriers to Advocacy

Which of the following is the most significant barrier to your involvement in advocacy?



While trainees lacked comfort with knowledge of health care issues and related advocacy activities, the vast majority (94%) agreed that "as a physician I have a duty to advocate." Few reported feeling that they received adequate advocacy training in medical school (12%) or residency (18%), yet 69% agreed it should be a part of medical school training and 73% residency training. Half (50%) were undecided about future advocacy involvement. When asked about barriers to advocacy involvement, 60% reported time to be the biggest barrier, while 17% selected knowledge (**Figure 1**). **Table 2** summarizes responses in their original Likert form.

Significant differences were found between PGY1 interns and PGY2 and higher trainees such that 72% of PGY1's reported they were not comfortable explaining the Affordable Care Act to patients and colleagues while 53% of PGY2 and higher trainees expressed the same discomfort, p=.0292. Nevertheless, 50% of PGY1's reported plans to be involved with advocacy in their careers while only 31% of PGY2's and higher reported having the same plans, p=.0178.

DISCUSSION

House staff overwhelmingly agreed that a physician has a duty to advocate (94%), similar to a previous study[16]; however, this did not necessarily translate into knowledge or action. Less than one quarter of respondents indicated comfort with discussing the ACA with patients or colleagues, communicating with media or influencing legislation. More than 60% did not feel they had adequate training in advocacy activities in either medical school or residency, yet the majority agreed that it should be included in their training (70%). A gap exists between what house staff recognize as important to learn versus what is being taught in residency programs.

Since time and knowledge, rather than motivation, were noted as the biggest barriers to participation in advocacy activities, one possible solution is to engage physicians by incorporating advocacy curricula and activities into GME. This would address the time and knowledge barriers noted by respondents. Furthermore, house staff earlier in training (PGY1) expressed less comfort with explaining health care policy but more intent to be involved with advocacy, indicating a possible window of opportunity to build advocacy skills and interest early in their careers during residency training.

The strengths of this study include its breadth of resident and fellow specialties surveyed, as well as the cross-sectional design. The assessment of trainee advocacy perceptions and experiences not connected to an advocacy experience is a unique, unexplored area of study.

This study has several limitations. We surveyed house staff at only one academic institution, which limits generalizability of results. The response rate of 24% would ideally be higher, and is subject to participation bias, thus making conclusions more difficult to draw. This response rate, however, is in line with response rate of physician surveys without an incentive.[16]

This study demonstrates possible areas of further study. There is burgeoning literature on the attitudes, knowledge, and experiences of medical students toward policy and advocacy[17,18]; there is yet to be a similar large-scale study of house staff. Future studies should include a larger sample size, multi-site and regional surveys to better characterize attitudes and differences among groups.

CONCLUSIONS

This study evaluates resident and fellow trainees across specialties about attitudes and experiences toward advocacy not related to a training or intervention. House staff acknowledge that they have a duty to advocate, and may participate in more advocacy activities if training were provided. Given the increasing complexity of health care and the mandate by many professional organizations that a physician's responsibility is to advocate, leaders in GME should bolster educational requirements and curricular efforts for resident physicians in health care advocacy.

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