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COMMENTARY

From health advocacy to collective action

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The paper in this issue from Kahlke and colleagues[1] explores the contextual barriers and affordances to health advocacy. In the medical profession, health advocacy can be thought of as the 'activities related to ensuring access to care, navigating the system, mobilizing resources, addressing health inequities, influencing health policy and creating system change' (p. 128).[2] Kahlke et al.[1] explained how individual learners made context-specific decisions within health systems about whether, and how, to advocate on behalf of individual patients, incorporating complex and dynamic consideration of social and systematic factors.

Their research reminds us that, despite the best intentions of policymakers and professionals, health systems are imperfect, and care is not distributed equitably. In addition, individual learner decisions about when to advocate for a patient were influenced by the strength of their connection, which was itself influenced by several factors related to potential inequity. Kahlke et al.[1] proposed some excellent recommendations to support individuals and health systems to develop health advocacy, including patient-centred education, faculty development and practice-based learning opportunities, both intra-professional and interprofessional. These insights have the potential to transform learning contexts within health systems into environments that enhance individual health advocacy learning and practice.

Yet, health advocacy is just one pillar of being (and becoming) a 'good doctor'. In the CanMeds framework of physician competencies, for example, Health Advocate sits alongside themes of Scholar, Professional, Communicator, Collaborator and Leader.[3] In other graduate outcomes frameworks,[4,5] it takes a less prominent position, and research suggests that health advocacy can be seen as 'going above and beyond' their regular activities by learners.[6] Themes within graduate outcomes frameworks are typically intended to be overlapping and holistic. Yet, the reality within medical programmes is that curriculum themes often become 'atomised'. For instance, themes become domains, and domains become topics, which are then mapped to meet accreditation requirements. Theme leads, as a result, often need to wrestle for curriculum space to ensure 'their theme' is included.

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Whilst this is just one example, it highlights the decision-making challenges faced by medical educators. As a community of medical educators, how do we decide where to focus our scarce resources? Tensions exist between developing all the capabilities of a doctor and being realistic about available resources. These tensions are heightened when finances are stretched, and doctors are urgently needed. Choosing to use precious resources in one way and over another often requires trade-offs. We may need to make tougher decisions in the face of contracting resources. How can we think about this and on what basis can we make these decisions?

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To address these gnarly questions, perhaps we should zoom out from individual learners, medical schools and health systems and consider how the most pressing issue faced by humankind—the climate

crisis—is being addressed. In 2015, all United Nation (UN) Member States adopted the 2030 Agenda for Sustainable Development,[7] which provides a plan for **peace** and **prosperity** for **people** and the **planet** through **partnership**. This plan, addressed through 17 Sustainable Development Goals (SDGs), is a call for action by all countries. The UN SDGs highlight the importance of improving health and education, reducing inequality and supporting economic growth, in order to tackle climate change. For example, SDG 3 is 'to ensure healthy lives and promote well-being for all at all ages', and SDG 4 is 'to ensure inclusive and equitable quality education and promote lifelong learning opportunities for all'. What is clear from the 2030 Agenda, and relevant to addressing medical education challenges, is that to achieve global outcomes, we must adopt a holistic approach and ensure all perspectives are voiced (and heard) whilst tackling inequalities at source.

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Reflecting on Kahlke et al.'s article[1] and the UN SDGs, we need to recognise and appreciate the opportunities for holistic learning (as opposed to atomised) that can be harnessed from clinical environments. As medical education researchers interested in prescribing medications, we note some striking parallels between prescribing and health advocacy. Prescribing, like health advocacy, is a complex activity requiring individual learners to make context-specific decisions whilst incorporating nuanced interprofessional team and system factors. Our research, like Kahlke et al.'s, suggests that a greater focus on the environments in which learning and practice occur, rather than individual experiences, holds significant promise[8] and can lead to novel approaches such as junior doctors co-working with pharmacists.[9] Moreover, we anticipate mutual benefits and more holistic learning if prescribing and health advocacy were considered together. For example, Kahlke et al.'s[1] participants felt they sometimes lacked the agency and autonomy to undertake health advocacy, yet prescribing typically provides plentiful decision-making opportunities, even early in a medical career. Incorporating patient perspectives and preferences would enable improved prescribing decision-making, and health advocacy could follow if the system does not support patient needs.

We do not anticipate holistic learning will be consistently afforded in clinical environments, however. Unfortunately, as with health advocacy, there are significant remaining challenges for prescribing education and research, for example, we know that patients are not always foremost in the minds of early-career prescribers.[10] So rather than atomising this challenge, how can we holistically ensure that the diverse perspectives of patients and carers, doctors at all career stages and the wider health professional team are heard? The themes of inclusivity, equity and partnership in the UN SDGs provide the foundations for ensuring that less dominant voices are listened to, understood and accommodated. Similarly, inclusivity and equity within health care environments, and working in partnership with patients, other health professionals and external organisations, could provide the foundations for improving the learning and practice of health advocacy and prescribing—and probably several other curricular themes. Thus by reconfiguring health care cultures and processes to focus on developing inclusive and equitable learning environments, we may facilitate multiple pillars of becoming a 'good doctor' concurrently.

The themes of inclusivity, equity and partnership in the UN SDGs provide the foundations.

So what does this mean for medical education? Long journeys must start with a first step, and we believe that Kahlke et al.'s research viewed through the lens of the UN SDGs offers clues about what to prioritise. We need to focus on holistic learning by developing inclusive, equitable environments and working in partnership with patients, other health professionals and a range of organisations. Then, instead of different 'elements' of medical education competing for scarce resources or curriculum time, we may be able to optimise learning environments such that they prepare doctors more holistically, as well as developing our trajectory towards sustainable development. Collective action from our medical education community is required to address shared challenges, such as easing pressures caused by atomisation of curricular content and prioritising strategies to tackle them together. An important first step, as an international community of medical educators with shared interests in healthy lives and quality education, will be to facilitate inclusive discussions (including patients, carers and other health professionals) to identify these challenges and collaboratively generate solutions.

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AUTHOR CONTRIBUTIONS

Christy Noble: Conceptualization; writing—original draft; writing—review and editing. **Karen Mattick**: Conceptualization; writing—original draft; writing—review and editing.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analysed in this study.

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