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Letters to the Editor

Managerial Epidemiology Is the Best Evaluation Tool for Our New Health Care System

To the Editor: Given that the overarching goal of health care reform is to improve the health of our population, the focus of health services management (as well as clinical practice) should be on the health of the populations they serve and not solely the fiscal health of their institutions.¹ For this reason, I maintain that the science of public health management, namely *managerial epidemiology*, is the evaluation tool of choice. It is that branch of epidemiology that utilizes the traditional quantitative and causal reasoning methods taught in medical schools. It also incorporates the business aspects of health care that monitor demand, delivery, clinical outcome measurement, resource allocation, strategic analysis, program planning, and managed care. With 30 million more people in our health care system, we need to refine further our ability to provide equitable care while containing costs and ultimately reducing the demand for health care. Managerial epidemiology is “the scientific basis for any health system reform”² and is the science that must pervade professional preparation in both clinical and management practice.

Our health care leaders and providers need to be change agents in aligning social and economic objectives so that the improvement of population health is the prime metric of success. Integrating public health and personal health care policy and services is the silent and significant challenge. Distinctively, managerial epidemiology can measure the effectiveness of our newly revised system. It can tell us whether our reformed health care system is any more effective in improving the human condition. It is the metric to assess the implications of health care reform.

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Time to Clarify Guidelines for Researchers and IRBs in Medical Education Research

To the Editor: I applaud the requirement announced by the editor of *Academic Medicine* that reports of studies submitted to the journal must include details of ethical approval for the research or, if the author does not have access to a formal approval process, information about the treatment of the study’s human participants.¹

In addition to the editor’s five reasons for this requirement, I would add another one: that students or residents or even faculty recruited for educational research studies are potentially vulnerable to coercion to participate, loss of privacy, or adverse actions.

It is not always easy to balance this potential vulnerability of students, residents, and faculty against existing regulations and researchers’ goals in recruiting subjects. Medical education research may be exempt from institutional review board (IRB) approval, under the provisions of Subpart A, Section 46.101 of the Federal Code of Regulations regarding “research conducted in established or commonly accepted educational settings, involving normal educational practices.”² However, there appears to be considerable variation in the way this provision is interpreted and implemented by different IRBs, as previously reported in *Academic Medicine*.^{3–5}

I hope the journal will publish more discussion about the ethics of medical education research. It’s time to clarify the guidelines for researchers and IRBs.

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A Framework for Designing Training in Medical Advocacy

To the Editor: In their January article, Earnest et al¹ adeptly highlight the need for the creation and delivery of more formalized training in medical advocacy. Toward this worthwhile goal, we offer the following framework of learning objectives, derived from our experiences teaching advocacy to medical students at the Boston University School of Medicine (BUSM). Our program is student-led in conjunction with mentorship from faculty at BUSM and the professional advocates at the National Center for Medical–Legal Partnership.² Over the past six years, it has evolved from a single elective to a multiyear curriculum with both clinical and preclinical components. The learning objectives we present here arose from this continuing curricular development and might provide a starting point for other institutions interested in designing formalized training in medical advocacy for medical students.

To skillfully engage in the types of advocacy that Earnest et al describe, medical students need to develop skills in advocacy theory, execution, and communication. Formal study of the theory of advocacy helps medical students define their roles as advocates and explore their positions along the spectrum of physician advocacy.

Experience in executing defined advocacy projects removes potentially formidable barriers to using advocacy in clinical settings by honing skills and developing both competence and confidence. Finally, training in communication enables medical students to translate clinical observations for wider audiences and to teach advocacy to other medical professionals.

Learning objectives dealing with advocacy theory might include (1) formally identifying and distinguishing between the roles that physicians must, should, and could perform within the spectrum of physician advocacy, and (2) developing a rigorous understanding of the social determinants of health.

Learning objectives centered on advocacy execution might include practice in distilling clinical observations from multiple patients into a well-defined issue in need of advocacy, then engaging in a small-scale advocacy project. Examples include writing an op-ed for a local paper or developing an "advocacy code card" that clerks can use to help their patients receive benefits like Womens, Infants, and Children nutrition vouchers.

Learning objectives dealing with advocacy communication might include completing a press release, oral presentation, or lecture for a nonmedical community, or presenting a patient whose clinical course is complicated by socioeconomic issues to a group of medical peers.

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In Reply: We applaud the efforts described by Dworkis et al at BUSM in developing a longitudinal educational experience in advocacy. They describe a useful framework in which to plan and implement a curriculum where advocacy competencies are developed as a part of physician practice and professionalism. Their program and our LEADS (Leadership Education Advocacy Development Scholarship) program at the University of Colorado, as well as a handful of other programs across the country, represent a growing interest in this type of training. The success of these emerging courses demonstrates the feasibility of implementing such curricula.

In our article, we highlight several examples of physicians incorporating advocacy into their professional roles. Each example emphasizes an advocacy-related competency or skill. We assert that these competencies need to be incorporated into medical training so that every physician achieves some basic level of competence in advocacy. Reaching this goal would require that advocacy become an accepted component of professionalism and that licensing and accrediting bodies recognize it as such. Only through these means will we move beyond our current status of professional aspiration without commensurate professional action. We see these curricular innovations as a

critical step in the process toward institutionalizing these values and developing the skills. Given the variation among current programs, an important next step is to promote collaboration and ultimately consensus on a common set of competencies and learning objectives. Achieving this goal will require new funding sources and the creation of new courses at additional medical schools; these courses should be rigorously evaluated and validated through peer review.

To our knowledge, the most organized effort to move this agenda has been through the Center for Medicine as a Profession, which sponsors a grants program supporting such curricular development. A key component of their initiative has been to create dialogue among interested programs and physicians. Perhaps this group could serve as a nidus for a larger conversation.

As we move forward toward the goals stated above, we must keep in mind their purpose. The practice of advocacy should produce measurable outcomes for patients and populations we serve and help create a health system that is more responsive to the health needs of individuals and communities.

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