Between the Idea and the Reality:
An Intersectional Analysis of the Challenges of
Teaching Health Advocacy as a Means to Achieve Social
Responsibility in Medicine

By

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A thesis submitted in conformity with the requirements for the
degree of
Doctor of Philosophy

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(Ontario Institute for Studies in Education)
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Abstract  

Canada, like other countries around the world, has health inequities. The literature on social accountability and responsibility urges medical schools to be grounded in the needs of communities to address health inequities. The Canadian professional and regulatory bodies promote the CanMEDS Competencies of which one, the Health Advocate Competency, speaks of addressing community issues. Yet medical schools face challenges actualizing social responsibility and teaching the Health Advocate Competency. Therefore it is important to understand how the teaching of health advocacy and social responsibility is incorporated into the undergraduate curricula of self-defined socially responsible medical schools in Canada.  

In this study, mixed methods were used beginning with a semi-structured questionnaire administered to undergraduate Course Directors at two medical schools in Canada with a response rate of 74% (n=60). This was followed by a series of open-ended interviews with eleven equity leaders to bring their perspective into the data collection and establish knowledge about frontline intersectional equity work. The major theoretical lens
Encircling this work was intersectionality which examines historical oppression and how the intersection of gender, race, and class compound health inequities.

Questionnaire results made it clear that biomedical ideology and the CanMEDS Medical Expert Competency were privileged in the undergraduate curriculum at the expense of other knowledge such as health advocacy and social responsibility. The objective biomedical discourse ignores or marginalizes important social influences on health which are highlighted by using an intersectional lens. The semi-structured interviews provided rich data about working in an intersectional equity framework highlighting the impact of the intersections of race, gender, class and other identities on health inequities. These interviews also demonstrate the importance of health advocacy in improving health care outcomes and addressing social responsibility.

Incorporating intersectionality into previously accepted assessment tools for physicians adds an important dimension to the health care encounter. Explicitly embedding social responsibility and health advocacy in the medical school mission and curriculum is essential to their acceptance. A series of supporting recommendations are offered.
Acknowledgements

A thesis is never the work of just one person. It is a difficult and challenging journey which requires the assistance and support of a number of people. As a first acknowledgement, it goes without saying that this thesis would have been impossible without the contributions of the 60 Course Directors who completed my questionnaire and the 11 equity leaders who gave of their time to meet with me and speak of their work. Without their input, I would have no data to analyze, no recommendations to make. I am especially grateful for everyone’s candor whether responding to the questionnaire or answering my interview questions. These participants and their contributions were crucial to my work.

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Dedication

For Gabriel, Ella and Lia
May they grow up in a kinder, gentler world.
Chapter 1

Introduction

*Between the idea*
*And the reality*
*Between the motion*
*And the act*
*Falls the shadow*

*Between the conception*
*And the creation*
*Between the emotion*
*And the response*
*Falls the shadow*

_T.S. Eliot: “The Hollow Men”_

This thesis explores what is being taught in Canada in terms of health advocacy as a means to actualize social responsibility and address health inequities. The shortfall between the idea of health advocacy and social responsibility and the reality of these concepts in medical education gradually emerges through the literature review, questionnaire responses and the use of intersectional theory as the critical lens which is applied to this work. Interviews with equity leaders in the community contribute to the development of a proposed template to bridge the idea and the reality of these concepts.

1.1 Social Responsibility of Medical Schools, Health Advocacy and Health Inequities: A Brief Introduction

The literature speaks of health inequities in every country including Canada (Casa-Zamora & Ibrahim, 2004; Black, 1980; Mackenbach & Bakker, 2003; Institute of Medicine Unequal Treatment, 2003; Bramley, Herbert, Jackson & Chassin, 2004; Canadian Journal of Public Health, March/April, 2005; Frohlich, Ross & Richmond, 2006; Sanson-Fischer, Williams & Outran, 2008; Mackenbach et al., 2008). According to the Toronto Public Health
report, The Unequal City (McKeown et al., 2008), health inequities, also known as health disparities: “refers to differences which constitute a social injustice because the *inequalities* result from preventable causes- remediable, systematic barriers and forms of social exclusion” (p. 3).¹

The Toronto Central Local Health Integration Network (TC LHIN) health equity discussion paper (Toronto Central LHIN, 2008) notes that many chronic diseases follow a socio-economic gradient with certain diseases being more prevalent in low income rather than high income neighborhoods. Laveist, Gaskin and Trujillo (2011) in their recent report for the United States Joint Centre for Political and Economic Studies showed how the conditions (referred to in their study as the Determinants of Health) in low-income and non-White neighborhoods exacerbate health inequities and in fact lead to much shorter lives for these residents. In Status Syndrome, Sir Michael Marmot (2004) writes extensively about how the subtle differences in social standing can translate into important differences in life and health. Mackenbach et al. (2008) showed the same link between socioeconomic inequities and poor health across European countries irrespective of disease prevalence or risk factors. Dahlgren and Whitehead in their 2006 WHO report also discuss the systematic differences in health between socio-economic groups and state that this social pattern of disease is universal though its magnitude varies among countries. They further note that it is social processes and not biological divergence that produce health differences and therefore these health differences can be classed as health inequities.

The government of Canada acknowledges that there are health disparities in this country and have expressed a commitment to addressing issues of health inequities. For example, in September 2003, the Canadian Federal Minister of Health, along with the Minister of Labour, the Minister Responsible for Homelessness and The Canadian Institutes of Health Research (CIHR) announced funding of more than 1.2 million dollars for research to address health disparities and to reduce systemic barriers for vulnerable populations identified as: Aboriginal people, immigrants and refugees, people with disabilities, the elderly, the homeless and women (CIHR Press Release, 2003).

In June 2009, the Standing Senate Committee on Social Affairs, Science and Technology released its report entitled: *A Healthy, Productive Canada: A Determinant of Health Approach* (Keon & Pepin, 2009). This document defines health disparities or health

¹Please note that I use double quotation marks to designate quotations. Single quotations marks indicate my problematization of a term or a phrase.
inequities as the variations or differences in health status, resulting from the distribution of the effects of health determinants between and among different populations. They further note that although some disparities are the result of biological variations (15%), some to the external environment (10%), some the health care system (25%), most, (50%), are attributable to the social and economic environment, clearly the most powerful determinant of health. They acknowledge that ill health is disproportionately distributed in the entire population with Aboriginal peoples and the poor bearing a huge burden of illness. The report goes on to say that the socio economic status of Aboriginal peoples is lower than non-Aboriginal people on almost all measures, and their life expectancy is five to ten years less than Canadians as a whole. The report states categorically that it is unacceptable for a privileged country like Canada to continue to tolerate such disparities. They mention that good population health policies not only improve the health of all the population but also foster economic growth, productivity and prosperity.

As they note, a healthy population requires less government expenditures on income support, social services, health care and security. This statement is corroborated in a study by Sharpe and Arsenault (2009) which calculated that if the Aboriginal population was to attain education and labour outcomes similar to the non-Aboriginal population, there would be a net improvement in the government budget of some 12 billion dollars in 2026. The Senate report proposed a series of recommendations which include: research to obtain good population health data; reorienting government policy to create a national plan to improve population health and reduce health disparities; strengthening inter-sectorial actions towards the same goal; and implementing an Aboriginal Population Health Strategy. Although this report is thoughtful and gives good direction for the future, it is yet another study in a series of studies which appear to have produced little improvements. Gupta, in Dua and Robertson (1999) comments that whenever a report on race relations calls for more research, this is a code for “paralysis of action” (p. 197).

Even though Canadians speak of a universal and accessible health care system (excluding dental care and drugs), in crude terms, it is really a collection of 10 mostly autonomous provinces and 3 territories who function within the requirements of the Federal Government’s 1984 Canada Health Act in order to receive transfer payment to help defray health costs. The federal government is also directly responsible for the health care of veterans and Aboriginal peoples living on reserves.
One of the provinces, the province of Ontario, has recently identified health equity as a key component of quality care and is attempting to weave health equity into the basic fabric of health planning. To support improvements in health equity, the Ontario Ministry of Health and Long term Care has developed a Health Equity Impact Assessment form. This form is a tool with a number of objectives including the identification of the unintended potential impact of decisions on health equity for specific groups. A similar tool, which has the support of the WHO, is being used in Australia, New Zealand, and the United Kingdom. (Simpson, Mahoney, Harris, Aldrich, & Williams, 2005)

From the above, it appears that the present political climate in Canada is increasingly supportive of health equity initiatives. Boelen (1999) and others have written that addressing health inequities is a complex undertaking requiring partnerships with key stakeholders including governments, communities, policy makers, health professionals, and medical schools.

Medical schools are perceived to have a responsibility to society which includes addressing health inequities as part of that mandate. This responsibility is encapsulated in the WHO statement (Boelen & Heck, 1995) defining the Social Accountability of medical schools which reads: “the obligation to direct their education, research and service activities toward addressing the priority concerns of the community, region and/or nation they have a mandate to serve” (p. 3).

Medical schools whose programs fulfill this obligation are said to be socially responsible. What should be the role of Canadian medical schools in relation to health inequities? The Association of Faculties of Medicine of Canada (AFMC) in their 2009 Future of Medical Education in Canada report state as the first of ten recommendations that:

Social responsibility and accountability are core values underpinning the roles of Canadian physicians and Faculties of Medicine. This means that both individually and collectively, physicians and faculties must respond to the diverse needs of individuals and communities throughout Canada, as well as meet international responsibilities to the global community (AFMC 2009, p. 5).

What does the literature tell us is being done in medical schools to expose medical students to these issues?

Using the keywords “health disparities and medical education” or “health inequities and medical schools” the Scholar’s portal database was searched from 1990 to the present.
Articles were identified which described a variety of programs addressing health inequity issues. Subsequent readings identified through the primary documents provided additional information. A summary of these readings follows.

There is a one month curriculum aimed at first year internal medicine and paediatric residents at Cook’s County Hospital/Rush medical College (Jacobs, Kohrman, Lemon & Vickers, 2003). A “social activism” elective program at the University of California, San Francisco is described by Moyers, Lunan, Wagner, Fernandez and Jain (2001). Another program is described at this same university integrating social and behavioural science with biomedical sciences (Satterfield, Mitteness, Tervalon & Adler, 2004). A four year program on health disparities is offered to 2 internal medicine residents/year at Brigham and Women’s Hospital (Furin, Farmer, Wolf & Levy, 2006). A “Caring for the Underserved” program is accessible during the 6 week paediatric clerkship at the University of Wisconsin Medical School (Cox et al., 2006). The University of California PRIME program is being introduced in all campuses and will eventually enroll 60 to 80 additional students who will focus on different inequity issues depending on their specific medical school (Nation, Gerstenberger & Bullard, 2007). The University of Chicago Pritzker School of Medicine offers “Health Care Disparities in America”, a 5 day elective course for first year medical students (Vela, Kim, Tang, & Chin, 2008). Other articles identified in this search suggested changes in addition to curricular changes to address health inequities. These include changing the student selection process to include selection algorithms that prioritize student characteristics that suggest humanism and orientation towards service (Freeman, Ferrer & Greiner, 2007; Sanson-Fisher et al., 2008). The importance of conducting health inequity research and committing to health inequity issues by instituting high profile academic appointments in this area is discussed by Sanson-Fisher et al. (2008). Koehn and Swick, (2006) write about a transnational competence curricula in lieu of the awkward ‘cultural competence curricula’. They consider ‘cultural competency curricula’ awkward for a number of reasons including unspecified conceptual framework, vision limitations (preparing students to address the health care of one ethnic population), action limitations (training does not include an advocacy component), alliance limitations (failure to teach the importance of team work and networking to address health disparities), pedagogical limitations (lack of pedagogical cohesiveness and integration longitudinally in the curriculum).

Brown medical school has a two year course entitled Doctoring which exposes students one day a week to a community practice followed by another day/week of case-
based learning facilitated by a physician and a social/behavioural expert and supported by reflective field notes (Smith, Goldman, Dollase, & Taylor, 2007).

Promising programs have been those inaugurated at the newest Canadian medical school, Northern Ontario School of Medicine (NOSM). As of 2006, all 56 first year students are sent in pairs to live and learn for one month in Aboriginal communities across Northern Ontario. The program is preceded by an intensive orientation to the experience and is followed by a self-study reflective project. This NOSM learning experience is supported by information technology programs and pre-packaged curriculum on student computers. In their second year, students participate in four week rural and remote experiences, some of which are in francophone communities (Tesson, Hudson, Stasser & Hunt, 2009). These experiences expose the medical students to marginalized/underserved communities.

In a study with colleagues from the Wilson Centre, we describe a conceptual model to teach all final year medical students about social responsibility and health advocacy (Girard-Pearlman Banack, Albert, Byrne & Walters, 2011). The model, applied during the 4 week Ambulatory Community Experience (ACE) course, a final year core curriculum experience for all medical students at the University of Toronto, has three distinct elements. First, vetted ambulatory/community clinical placements of 3 to 4 weeks, second, individual pedagogical approaches and finally, a narrative/reflective assignment based on objectives with a health advocate perspective. The study results indicated that this model, which was applied for 16 years, supports the acquisition of health advocacy and supports social responsibility. This study will be further discussed in Chapter 2 under the Health Advocate section.

From this brief search, it appears that there is no established model in the literature outlining the important elements of a curriculum to expose students to health inequities other than the fact that exposures to marginalized communities are beneficial. However, no systematic approach woven through the 4 year undergraduate medical education to teach about health inequities was found. In fact the programs described in the literature, in many instances, do not target all undergraduate or post graduate students, are one of a kind, and offer but a brief interlude in an otherwise bio-medically focused curriculum.

In The United States, the Institute of Medicine Unequal Treatment report (2003), which highlighted health inequities in The United States, made 21 specific recommendations to address these inequities including health system interventions, legal, regulatory and policy interventions, patient education and empowerment, data collection and research. The recommendation from this report which has received the highest profile in the literature
relates to the introduction of ‘cultural competency curricula’ for health care practitioners. As an example of the high profile of this recommendation, *Academic Medicine*, a respected high impact medical journal devoted most of the June 2003 issue to this topic publishing 12 papers on ‘cultural competency’.

A search using Scholar’s Portal and the key words “physician cultural competency” was undertaken from 1990 to the present. Additional journals were identified from a review of references. Fox (2005) defines ‘cultural competency’ as a:

…body of knowledge, skills, attitudes and behavior in which physicians ought to be trained if they are to deliver sensitive, empathic and humanistic care that is respectful of patients, involves patient centered communications and responds to patients’ psychosocial issues and needs (p.1316).

Kawaga-Singer and Kassim-Lakha (2003) define ‘culturally competent practice’ as: “…a skill that enables a physician, in a culturally discordant encounter, to respectfully elicit from the patient and family, the information needed to make accurate diagnosis and negotiate mutually satisfactory goals for treatment” (p. 580). They also note that the first step to ‘cultural competence’ is for providers to be aware of their own beliefs, values and biases.

Crampton, Dowell, Parkin and Thompson, (2003) discuss a ‘cultural immersion’ and ‘cultural safety programs’ which teaches students to examine their own realities and attitudes and to combat racist attitudes that are unconsciously inherited. Students are immersed for one week in a Maori community providing them with an opportunity to critically reflect on their attitude towards racial and ethnic differences. This experience in the Maori community also helps them to develop insights and knowledge about their own culture, the impact of their prior socialization as well as the cultures of other peoples.

However, the term ‘cultural competency’ and the movement to introduce such curricula in medical education are problematic. The literature which follows addresses some of the concerns with this approach and I will add my own critique at the end of this section.

Nunez (2000) states: “the term cultural competency implies a discrete knowledge set that focuses on the culture of the patient only as something ‘other’ and therefore aberrant from the norm. Such an approach may actually perpetuate stereotypes” (p.1072). She further notes that this approach is ethnocentric and she advocates for the term “cross-cultural efficacy” which she states puts the culture of both the caregiver and the patient on the same level.
Hixon (2003) notes that Tervalon and Garcia’s (1998) cultural humility construct is more useful than that of ‘cultural competence’. As he notes: “culture is not a finite data set to be mastered but a concept that is complex, dynamic and individual” (p. 634). He suggests that ‘cultural competence’ programs appear to be based on the medical culture and its need to achieve competence. Cultural humility is built on concepts “of self-reflection, self-critique, skills critical to lifelong learning” (p. 634). He recommends that medical education frameworks be designed to produce students with skills based on an attitude of openness, flexibility, self-reflection and humility to be able to care for diverse populations.

Frank and MacLeod (2005) also express concerns that diversity education appears to be treated as incidental and becomes the ‘four D’s’ of multiculturalism which stands for dress, diet, dialect and dance. This discourse then becomes saturated with dualistic ‘othering’ language. They also believe that this type of education may contribute to the reproduction of cultural stereotypes. They suggest that education should encourage reflective thinking and a critical approach which considers inequities as structural and institutionally produced.

Duarte and Smith (2000) as well as Wear (2003) advocate for what they call “insurgent multiculturalism” which looks at group differences and shifts the discussion to the foundations of inequities and how power relations structure racial and ethnic identities. Insurgent multiculturalism also moves the focus from non-dominant groups to the social causes of inequalities and dominance. Wear posits that students should learn to identify and analyze unequal distributions of power that allow some groups, but not others, to acquire and keep resources. Wear (2003) further states that ‘cultural competency curriculum’ is “theoretically truncated and may actually work against what educators hope to achieve (p. 549)”.

Beagan (2003) studied the effect of exposing medical students to a new course in the first and second year of medical school which addressed social and cultural issues in medicine. She notes that: “While students were sometimes willing to recognize group differences, they were less willing to recognize social relations of dominance/subordination: power/relations” (p. 610). She strongly recommends that any course designed to address ‘cultural competency’ must explicitly address power relations and the lessons should be reinforced during the clinical education years.

Crandall, George, Marion and Davis (2003) state that the published literature on the outcomes of ‘cultural competency’ curriculum is scarce. They discuss a cultural competence program offered to 12 students, who volunteered out of a class of 113, for this course, which
appeared to yield positive results. However, they note that whether these results would continue in a clinical encounter has not been tested. I would add that the outcome of a study based on 12 students who volunteer for the course may not necessarily be reliable or reproducible.

Whitley (2007) also bemoans the fact that ‘cultural competence’ is not evidence-based and not supported by robust evaluation research. He suggests that there is an urgent need to develop models that can be rigorously assessed. These models should be developed in collaboration with ethno-cultural groups and tested with these groups in their setting with their physicians.

Lucas, Michalopoulou, Falzarano, Menon and Cunningham (2008), note that most existing measures of ‘cultural competency’ assess provider rather than recipient perceptions and that these assessments are problematic for many reasons. To address these limitations they developed an assessment tool to measure patients’ perceptions of their physicians’ cultural competency. However, they recognized the limitations of their measurement tool (focused on just one group, as well as time when the tool was applied) and suggest further studies to validate its effectiveness.

Dolhun, Munoz and Grumbach (2003) as well as Kripalani, Bussey-Jones, Katz and Genao (2006) note that there is no consensus as to what should be taught in terms of key thematic areas, teaching methods, and skill sets in ‘cultural competency curricula’. Williams (2006) notes that the lack of a coherent theory base for ‘cultural competency’ makes it difficult to evaluate its effectiveness in practice. She suggests that developing clear models will guide practice and evaluation of effectiveness of ‘cultural competence.’ Beach et al. (2005) reviewed 34 studies of ‘cultural competency’ curriculum and found that, although these curricula showed promise as a strategy for improving knowledge, attitudes and skills of health professionals, there was no evidence that these curricula improved equity of services for racial and ethnic groups. They suggest that further research should focus on a number of issues such as: development of standard instrument to measure cultural competence; evaluation of different methods to teach cultural competence; measuring patient outcomes and equity of services across racial and ethnic groups after the completion of this type of intervention. Dogra, Connin, Gill, Spencer and Turner (2005) surveyed medical schools in the United Kingdom and found that cultural diversity training was being taught but was fragmented. What constitutes cultural diversity training and its value to staff and students was also unclear.
Kehoe, Melkus and Newlin (2003) did a review on culturally relevant interventions for the past 20 years. Although they found that culturally relevant interventions did improve health outcomes for patients with certain diseases, they also found that:

Because the [cultural competency] studies are highly variable with respect to design and method, it is difficult to isolate which particular aspects of interventions are specifically associated with favourable outcomes. In addition, few of the studies examined long term effects of the intervention or outcomes (p. 351).

Tervalon (2003) states that few medical schools have longitudinally integrated issues of culture in their curricula. She offers list of core components to be included throughout the four year undergraduate curriculum. These include: 1- rationale for this teaching, 2-culture basics (definitions, language, basis in social science and anthropology etc.), 3-health status (demographics, historical context etc.), 4-clinical encounter (knowledge, tools and skills), 5-provider focus (attitudes and behaviours), 6-community participation (relationships and power), and finally, 7-institutional culture and policies.

Roberts, Sanders and Wass (2008) studied second year medical students at two United Kingdom medical schools to explore the students’ understanding of race, ethnicity and culture as they relate to cultural awareness in the curriculum. This study was subsequent to their literature review which showed a lack of consensus on terminology, educational objectives and fragmented delivery of ‘cultural/diversity/ awareness/competence’ curricula in the United Kingdom. The result of their study indicated that the dominant White students group was anxious and fearful of revealing ignorance of other cultures and causing unintended offence. The minority student groups were uncomfortable about being perceived as different. However, all were comfortable in discussing the ‘medicalization’ of race in relation to disease, but discourse beyond the ‘medicalization’ of these identities was considered problematic.

Seeleman, Suurmond and Stronks (2009) note that the term ‘cultural competence’ suggests that culture and ethnicity are equivalent and interchangeable. They further suggest that the practical implementation of educational objectives related to cultural competence appears to be problematic and the teaching fragmented. They suggest that teaching cultural competence must address the fact that doctors are not culturally or ethnically neutral and that the learning environment of most students is predominantly ‘White’ and ‘Western’. They suggest incorporating other elements related to patient care such as epidemiological
differences, cultural issues, the patient’s social context, prejudice and stereotyping. They comment that more work needs to be done in terms of evaluating cultural competency.

Kumas-Tan, Beagan, Loppie, MacLeod and Frank (2007) did a systematic review of 20 years of literature to identify the most frequently used ‘cultural competence’ measures. Their findings indicate that cultural competence measures are embedded with highly problematic assumptions of what constitutes cultural competence. For example, the measures ignore power relations of social inequity and assume that individual knowledge of the ‘Other’ is sufficient for change. Often, they equate culture with ethnicity and race. Additionally, dominant groups are seen as not having a culture, that is, “whiteness is understood and presented as the norm” (p. 551), and there is a: “focus on disadvantage, constructing a deficit model concerning ethnic and racialized minority groups rather than focusing on privilege and domination” (p. 552). Further, they assume that the practitioners are White and Western and once they achieve greater confidence in dealing with patients from another culture they will have increased their cultural competence. The authors also note that there is little uniformity in the methods used to evaluate ‘cultural competency programs.’ Kumagai and Lypson (2009) suggest that ‘cultural competency’ education should go beyond the notion of competency and the biomedical model to foster critical awareness of concepts such as social justice.

Betancourt (2003) suggests that both the patient and the provider’s “culture” are important in the medical encounter. He proposes three conceptual frameworks: 1- focusing on the attitude of the provider, 2- focusing on multicultural knowledge and 3- focusing on communication skills. He notes that there has been limited publication on the impact of cross-cultural medical education and no current standards or consensus on core objectives and competencies of this education. He further suggests that there are significant challenges for evaluating this education which goes beyond the actual course to include evaluating the desired outcome of better patient care. There is a paucity of literature that discusses patient care outcomes. Betancourt suggests that designing an appropriate evaluation is extremely complex because linking cross-cultural curricula to health care outcomes necessitates the inclusion of other strong influences/determinants of health such as social factors that impact patient care outcomes.

Taylor (2003) in speaking of future directions in ‘cultural competency’ quotes Guarnaccia and Rodriguez: “...more recent approaches to culture in anthropology provide a more dynamic perspective...viewing culture as a process in which views and practices are
dynamically affected by social transformations, social conflicts, power relationships, and migrations” (p.556). Taylor (2003) goes on to say that it is important to understand: “...how do particular ways of conceptualizing and talking about “culture” relate to the socio-cultural organizations of medicine and medical education” (p.556). She posits that medicine understands itself as dealing with real knowledge and to be a “culture of no culture” (p.557). She suggests that until medicine accepts that it also has a culture and that real and cultural knowledge are not mutually exclusive terms, students will continue to reproduce themselves into the “culture of no culture.”

A curriculum focused on cultural differences could stifle opportunities for self-reflection on historical processes of power, power differentials, privilege, inequities, ethnocentrism, racism, oppression and stereotyping. Such curricula may be based on unacknowledged assumptions that normality is White, Western culture and that “others” are non-White, non-Western. Equally problematic is that it seems that many of these curricula are developed by the dominant White group. The stance of cultural competency curricula supports the reductive binary of ‘us’ and ‘them’ and overlooks structural inequities. As many have said, these curricula assume that competence is reached when the health care professional has acquired enough information about the ‘Other’ since the root cause of the problem is identified as lack of information. These curricula focus on differences in ‘Others’. In this model, teaching about other cultures assumes that all individuals in a given group are homogenous and possess the same characteristics. The different social identities of any individual associated with age, social class, gender, sexual orientation, religion, life experiences etc. are ignored. These curricula do not acknowledge intersections of these and other identities that further compound and marginalize or privilege specific individuals and groups. Social/health equity is therefore reduced to an individuals’ skill set around competency rather than a deep understanding of the subtle covert ways in which marginalization exists. A cultural competency approach would seem to be the ultimate essentialization of a group of humans. As some critics of the ‘cultural competence curriculum’ have suggested, focusing only on ‘cultural competency curriculum’ could also be a mechanism for the dominant group to appear to be dealing with health inequities while preserving its power and privilege. This training also misses the opportunity to educate about common structures in society which systematically privilege some while marginalizing others. Additionally, this type of education may not support patient-centered care, another “buzz” word in today’s health care system. Most importantly, cultural competency does not
incorporate activism or support politicking to create change, both important elements of advocacy. Therefore, this set of practices is inadequately developed and operates at the edge of equity issues rather than impacting root causes.

In the Canadian context, 8 of the 16 Faculties of Medicine in existence in 2002, participated in a study about ‘cultural competency’ and indicated that they had statements about cultural sensitivity within their general objectives. Almost all the schools listed curriculum content which discussed cultural sensitivity topics. None reported having a curriculum which incorporated issues of power and privilege. (Azad, Power, Dollin & Cherry, 2002).

It would appear that ‘cultural competency curricula’ are not the panacea which will address health inequities unless the objectives, themes and content are substantially revised. This revision should include a strong focus on social justice, provider beliefs, biases, stereotyping, and unearned privilege. The revision should also discuss the potential impact of intersecting identities, systems of oppression, as well as power structures which impact marginalized individuals and groups. There should also be discussion of the historical context which has resulted in the marginalization of certain groups and the prioritization of others.

Health inequities are not new and throughout history, starting with Hippocrates, medicine had voiced its obligations to society. Warren (2008) quotes, Virchow, a physician advocate in the 19\textsuperscript{th} century, who said: “physicians are the usual attorneys of the poor and the social problems should largely be solved by them” (p.728). He also quotes epidemiologist Geoffrey Rose who noted that: “the primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social. Medicine and politics cannot and should not be kept apart” (p. 728).

Waitzkin (1989) who has written extensively on physicians and their role in society, states that most physicians want to help their patients but believe they are unable to personally change the social structures at the source of their patient’s problems. This is a key statement. It suggests that if the curricula for physicians-in-training included information on social structures and systems of oppression that create health inequities, physicians might feel competent and empowered to address these inequities. Throughout history, there is evidence of the power of physicians to influence the public and the state in many discourses. Stevens and Hall (1994) acknowledge this power and note:
Medicine’s power in the realm of social control stems from its authority to define which behaviors, persons, and things are “normal”. Deviance from the normal refers to those behaviors that are defined in particular sociopolitical context as inappropriate to or in violation of certain powerful groups’ conventions (p. 237).

And Shermin (1992) notes: “With its authority to define what is normal and what is pathological and to coerce compliance to its norms, medicine tends to strengthen patterns of stereotyping and reinforce existing power inequalities” (p. 22). A pertinent question might be: Can medical schools harness the power of medicine to meet their social responsibility mandate by teaching students about social responsibility, systems of oppression, health inequities and mechanisms to address these inequities?

While exploring the literature for potential contributions to the health inequities challenge, The Royal College of Physicians and Surgeons of Canada (RCPSC) CanMEDS Health Advocate Competency came to the forefront. This competency is one of seven RCPSC CanMEDS Competencies deemed to be necessary for all Canadian specialty physicians-in-training (Frank, 2005). These competencies are also integral to The RCPSC maintenance of certification programs for specialists in practice. It should be noted that when writing about the CanMEDS Competencies these will be capitalized as mandated by The RCPSC.

A further review of the literature indicated that health advocacy is also incorporated in the 4 Principles of Family Medicine of the Canadian College of Family Physicians (College of Family Physicians of Canada, 1993). Within the 4 Principles there are statements that physicians are seen as advocates for their patients including advocating for public policy which promotes their patient’s health. The 4 Principles apply to all family physicians in-training and are considered essential for family physicians in practice.

A literature review on the Health Advocate Competency found many examples of physicians understanding their power, both as individuals and as members of their professional societies. For example, Lynk and Issenman (2007) discuss The Canadian Paediatric Society (CPS) advocacy work and note that governments often remind The CPS advocacy committee that physicians occupy a unique trust role in society.

As noted, health advocacy is a consistent approach across Canada at the training and maintenance of competence level for all Canadian physicians. The key elements of this CanMEDS Health Advocate Competency are directed at physicians responding appropriately to the health needs of the community they serve and promoting the health of individual
patients, communities and populations. The CanMEDS definition as well as the definitions from Family Medicine would suggest that teaching about Health Advocacy could facilitate the operationalization of social responsibility and thus help address health inequities. However, the challenges associated with defining this Competency, understanding its scope in practice as well as actualizing the social responsibility mandate were also a prevalent theme in the literature.

Since a review of the literature has not identified any consistent approaches which could be used as a framework to address social responsibility, health inequities or the Health Advocate Competency, there appears to be a vacuum in this area.

1.2 The Research Question

The first step is to understand if and how the topics of health inequities and health advocacy are being addressed in socially responsible medical schools. It is important to address this question in light of the stated commitment to social responsibility of all seventeen medical schools in Canada. Therefore my thesis question is: How is the teaching of health inequities and the Health Advocate Competency incorporated into the undergraduate medical education curriculum of two self-defined socially responsible medical schools? As part of my research, I explored the historical origins of health inequities in Canada, and tried to understand what has been done to address this issue. I also explored the literature on social responsibility of medical schools as well as health advocacy to ascertain the level of commitment of medical schools to these concepts. I distributed a questionnaire to course directors in a few undergraduate medical schools in Canada to obtain baseline data on this subject. Once the data from the questionnaire was analyzed, I conducted semi-structure interviews to enhance the information gathered in the questionnaire. And finally, from all this information, I hoped to be able to develop an approach to enhance the teaching of the Health Advocate Competency and social responsibility in medical schools.

My research question is an important practical question which needs to be addressed as it establishes baseline data which does not exist about teaching of these important topics. It also establishes a program of research linking the areas of health inequities, the Health Advocate Competency and social responsibility which may result in the development of a conceptual model that will prove effective at addressing social responsibility. Such a model may provide a basis to contemplate curricular changes to support the development of socially responsible medical practitioners who incorporate health advocacy into their medical practice.
to support health equity initiatives. Research in this field is justified because curricula interact with powerful agendas in society and can shift understanding, interpretation and action thus becoming significant change agents.

The definition of health equity that this paper will use is that of the Health Equity Council (2005) which calls the following a “living definition” of health equity. This definition is also synchronous with the intersectional lenses which will be applied in this research:

Fair and equitable health outcomes across diverse communities will result from utilizing an inclusive health framework for publicly funded and other universally accessible health services. This requires policies, planning, education and training, funding, and research that clearly recognize racism/racialization and all forms of exclusion and oppression as fundamental social determinants impacting health and wellness. We further recognize the intersecting and compounding impact of various forms of marginalization, including, but not limited to, race, national or ethnic origin, class, spirituality or faith, sex, gender, sexual orientation, age, mental or physical disability (visible and invisible), immigration or family status, and identified arising from these, on individuals’ and communities’ state of health and well-being.

1.3 Situating Myself

I am on a journey which likely began in 1968 when as a young staunch Roman Catholic, I read about Pope Paul VI’s encyclical Human Vitae on birth control and the impact that this pronouncement was having on poor catholic families in Latin America. Women who were beginning to listen to health care professionals and social workers regarding the use of contraception to control the number of children and provide the necessities of life to a smaller number of children immediately stopped listening to this advice and ceased to use contraception. The outcry in the popular press had a very deep impact on me as I saw article after article indicating that children would die as a result of this papal edict. I was stunned to see that the leader of the Catholic world would put religious doctrine before the lives of children. I had grown up in a Catholic boarding school from kindergarten to grade 13 and had attended mass every single day. I loved my faith but found that I could no longer be part of a faith whose leader’s ideology ensured structural inequities for the poor. I took a University of Ottawa course entitled “The Great Religions of the World” to guide my next steps and having studied eight religions, decided to convert to another religion. Over the years I undertook a variety of volunteer works in various capacities, including building houses for Habitat for Humanity, to help those less fortunate than me. However, I was
cognizant that my efforts were somewhat of a “window dressing” and not addressing core issues which created the inequities.

In 1974, in the early years of my career as a member of the senior executive team at a teaching hospital, I adopted a style of management known as “management by walking around”. This management style meant that on a regular basis, I walked through different departments/nursing units in the hospital to observe how the hospital was treating its patients and their families. Within 6 months of my tenure at this hospital, as a result of these walkabouts, I proposed that the hospital establish the first Patient Representative program in Canada. The purpose of the program was to provide patients and families with a knowledgeable advocate to investigate their concerns and address the root causes of some of the challenges they were experiencing. For the first two years, to ensure its success I personally “manned” this program. After the program was well established, I staffed it with handpicked individuals who reported on program activities on a monthly basis to senior management and quarterly to the Board. Many changes were implemented to improve the patient/family experience in the hospital as a result of this program which has been emulated across Canada. Two examples of changes that were made to structural processes as a result of the Patient Representative program include the following. When I learned that an Aboriginal patient wanted to burn sweet-grass and that this ritual was a very important part of the healing process, I worked with the hospital’s Building Services to develop policies and find a room where this traditional custom could be safely discharged. When the hospital began to perform sex re-assignment surgeries, I worked with the surgeons and the Admitting department to ensure that these patients would be automatically assigned a private room at no cost to them during their hospital stay.

In the early 1990’s I read the report, Educating Future Physicians for Ontario (EFPO, Ontario Medical Review, 1992). I was very influenced by this report which recommended that medical students spend a significant component of their training in communities in order to be exposed to the problems and resources of communities and underserved populations. At the time, as a result of my deep and long standing commitment to medical education, The Faculty of Medicine at The University of Toronto had asked me to chair a committee whose mandate was the creation of an ambulatory experience for final year medical students. As an individual with graduate training in health care administration but not a physician, I was thrilled with this mandate. The EFPO report became a foundational reference in the development of both the objectives and the course which was inaugurated in 1995 as the
Ambulatory Community Experience (ACE). I was privileged to be the Course Director for the entire 16 years of ACE’s existence.

A number of rural and under-served communities were integral to student placements for ACE from day one. As part of the requirements of the course, students were asked to assess the community in which they spent their ACE experience (which varied from 4- to 5 weeks) to see how physicians could contribute to the health of individual patients as well as the population served in this community. Students were also asked to reflect on their social responsibility as physicians and to discuss this reflection in a written assignment. The Course, which was core curriculum for 16 years until 2011, was extremely successful as students in their yearly evaluations consistently referred to ACE as “awesome” “amazing” and “the best experience in medical school.” A study that I conducted with colleagues at The Wilson Centre in 2011 on the ACE reflective paper indicated that students did grasp the concept of health advocacy. This concept deemed in the literature to be difficult to understand, recognize and teach (Frank, 2003; Verma, Flynn & Seguin, 2005; Walsh, Herold-McIlroy & Ginsberg, 2006; Girard-Pearlman Banack, 2008) was described by students with great clarity and deftness.

During the summer of 2000, another significant event profoundly influenced my thinking. I took a course at OISE entitled “Cultural and Racial Differences in Education: Philosophical Perspectives.” This course opened my eyes to the privileged world that I had assumed was my right because I was well educated, worked extremely hard and was competent and, therefore, ‘entitled’ to these privileges. This aforementioned course introduced me to the fact that visible minorities might be just as educated, work just as hard, be just as competent but probably never achieve my privileged life. One article in particular educated me to the multiple ways in which White privilege is experienced while being invisible to and unacknowledged by White people. This article described an invisible knapsack filled with assumed privileges and advantages that I as a White woman enjoyed and took for granted (McIntosh, 1990). This embarrassingly late awakening is indicative of how well educated, well intentioned individuals can be blind to the privileges we enjoy and take for granted, blind to the structural inequities that surround us as well as the overwhelming positive impact of our white privileges in every aspect of our life. It is easy to be blind because we are socialized into our White world of privileges through the neighborhoods we live in, the schools, churches and synagogues we attend, the television, newspapers and magazines we are exposed to as well as the friends and family that surround us.
My interest in health inequities was further spurred by the 2003 United States Institute of Medicine groundbreaking report entitled: Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare. This report showed that: “racial and ethnic minorities tend to receive a lower quality of health care than non-minorities even when access-related factors such as patient insurance status and income are controlled” (p. 1). This 738 page report gave evidence, that, if you were a visible minority in the United States, your diagnostic and therapeutic experience was not equal to that received by White Americans. The report acknowledged the many issues contributing to this disturbing finding, including racism and stereotyping.

The year after this disturbing report was published, I organized a course on diversity and human rights for physicians at the hospital in which I worked as a Senior Vice-President whose portfolio included the Medical Staff and Medical Education. Although not a physician, during my entire career as a health care executive, I was responsible for four major portfolios of which two portfolios were Medical staff and Medical Education. The course I organized was sanctioned by the hospital’s Medical Advisory Council, the medical leadership committee of the hospital. It was also accredited by The Continuing Education Department at The University of Toronto and therefore eligible for maintenance of certification points, a consideration for physicians in practice. I had ensured physician input in the planning and development of the course and had engaged physician faculty. Despite making every accommodation to assure success, the response to the course was very revealing. A minority of medical departments responded very positively to the course, attended and participated in the sessions. However, the majority of medical departments reluctantly attended while insisting there was no need for this course as diversity was embraced in Canada’s multicultural environment and situations such as those described in the US report were rare in Canada. This reaction supported my inclination to one day contribute in a meaningful way to health equity at the systemic level.

Having been involved in the health care field and medical education both at the hospital and Faculty of Medicine for most of my career, it seemed obvious that this was the domain in which I should try to make contributions to address inequities. Furthermore, I have always had the utmost respect for the medical profession, which is why I devoted so much of my career to the field of medical education.

The realization that all Canadian medical schools acknowledged that they had a social responsibility suggested that an exploration of the actualization of this commitment was an
important first step. (Health Canada, 2001; Association of Faculties of Medicine of Canada [AFMC], 2009).

I was fortunate that as I began this thesis journey, a number of opportunities presented themselves which not only helped to evolve my thinking but also immersed me in literature and life experiences which were helpful to my development. In 2007, I retired from my position as a health care executive and became a Fellow at The Wilson Centre, a centre dedicated to health professional education research. The support I received in this Centre to make the transition from health care executive to health education researcher cannot be overestimated. The following year, I was involved in developing a Train-the-Trainer workshop on the Health Advocate Competency. This workshop, organized by The RCPSC, was aimed at medical educators working in undergraduate and post-graduate medical education programs across Canada. This experience demonstrated the low level of understanding that medical educators had for this particular Competency. Even after the two day workshop, the feedback was that these educators were still not confident about their expertise or skill set related to this Competency. Additionally, many expressed the concern they may not be able to secure the necessary resources from their Faculties of Medicine to teach this Competency. The following year I was commissioned to do a report on the social responsibility of medical schools for The Association of Faculties of Medicine of Canada and to speak on this subject at an all-day symposium at the annual Massey Grand Rounds. I was also approached that same year by one of the Associate Deans at a Faculty of Medicine with a request to Chair a Community Engagement Committee to bring the community perspective into The Faculty of Medicine. I suggested that this would be a perfect opportunity to actualize and demonstrate The Faculty of Medicine’s social responsibility. I proposed that social responsibility be core to the mandate of this expected new committee. Four years later, I am still awaiting the go-ahead to establish this committee, and those who were instrumental in speaking to me about this committee have all moved to other roles. These experiences suggest that although medical schools believe they should be responsive to society and address health inequities in their communities, most are unclear and even perhaps unwilling to discharge that responsibility in a tangible and accountable manner.

My journey also involved profound changes in how I view the world. When I started this journey, I did not like labels such as “feminist.” Although I did appreciate the initial foray and work for gender equality by the first-wave feminist movement, I associated “feminism” with white women burning their bras and other similar images of the 1960s
second-wave feminism and could not identify with this movement or these works. However, my readings took me in the direction of works by Crenshaw, Collins, Bannerji, Robertson, Dua, Dill and Zambrana to name a few, and these authors spoke of White privilege, systems of oppression and intersectional analysis. Although I was cognitively aware of these realities because of the 1990 article by McIntosh’s on the invisible knapsack of white privileges, these new authors deepened my understanding of these realities and helped me to internalize this viewpoint. I saw in my daily life examples of Mohanty’s (2003) statement that “privilege nurtures blindness to those without the same privilege” (p. 231). These new readings were not about the privileged White women’s feminism but the profoundly disturbing intersectionality of identities related to race, gender, ethnicity, and class which together compound oppression and mutually reinforce inequities.

Through personal changes that I was undergoing in relation to status, I began to reflect on the power of identities and how the convergence of specific identities could profoundly impact on a person’s life. I also began to understand that time, place and circumstances can alter the impact of identities. As a small example, as my life as a senior executive became more remote and my life as a student became my new reality, my old self-identity as a powerful and successful woman also became more remote and my confidence in my abilities to do many previously routine activities waned considerably. My self-perception changed and it was not a positive change. This experiential understanding gave me an appreciation for the powerful role our different identities play in our lives and how their intersections in various circumstances impact on all aspects of our lives. It also made me realize the privileged intersectionalities under which I have lived most of my life.

Therefore, intersectionality, a theoretical model which came from Black feminism spoke to me. I understood about different identities and how they were not merely additive but could simultaneously impact an individual. I saw intersectionality as a holistic approach to looking at health inequities and at the historical systems of oppressions which are, in many instances, the root causes of inequities.

Thornton Dill and Zambrana (2009) explain that intersectional analysis sees inequality as derived from race, gender, ethnicity and class, and their intersections place some groups, based only on membership, in privileged positions with unearned benefits with respect to other groups. They define intersectionality as follows:

…an innovative and emerging field of study that provides a critical analytic lens to interrogate racial, ethnic, class, ability, age, sexuality and gender
disparities and to contest existing ways of looking at these structures of inequality, transforming knowledges as well as the social institutions in which they have found themselves (p.vii).

In my case, to use McIntosh’s (1990) analogy, my knapsack was slightly less privileged because of gender but my White race, my social class, my cultural heritage and ability to fluently speak the ‘two imperial’ languages of Canada was a solid platform to obtain further privileges such as a higher education, a good income, access to the best health care and a high profile occupation. Although I worked hard to earn the education, income and excel at my profession, the original privileges that allowed me automatic access to these were unearned. Quite simply, I was fortunate to have been born White and to an affluent family.

Our previous Prime Minister, Paul Martin also indicated that he had an understanding of the discourse on privilege although he does not refer to it with that terminology. In an interview in the National Post (September 26, 2011) he paints a vivid picture of the positive difference the unearned privileges previously described brings to the life of an individual. Explaining his ongoing interest in working with aboriginal youth, establishing *The Martin Aboriginal Education Initiative*, as well as a $50 million Capital for *Aboriginal Prosperity Entrepreneurship Fund*, he states the following:

> It really started when I was a teenager. I worked a number of summers as a deckhand north of 60 on the Mackenzie River and made friends with members of the First Nation, the Metis Nation and the Inuit. The fundamental difference that struck me then is that at that age you’re full of hope and excitement—for the guys I grew up with in Windsor, Ont., life was just one great prospective of excitement looking ahead---and a lot of the young guys {Aboriginal youth} I worked with were every bit as smart and hard working as I was. They just did not have that same hope because life didn’t have those same opportunities (FP 4).

Although Mr. Martin does not attribute this lack of hope to intersectionality, in fact, those young men were dealing with, at a minimum, the legacy of colonialism and intersections of race, ethnicity and social class which was already painting, in their minds, a less than hopeful future.

It is important to clarify my standpoint as I approach this research question. I am a White woman of privilege. Although marginalized by gender and my status as a working mother when I first entered the male domain of senior management in the early 1970’s, I was able to overcome these structural barriers to achieve a career with power and prestige. However, I am cognizant that there were barriers and I was disadvantaged. Despite this fact, I
am still privileged by race, social class, culture, language, nationality to name a few unearned privileges. Therefore, it is important to note that I am exploring this question not from the perspective of an insider but rather from the perspective of an outsider who has been a member of the privileged majority whose actions have created the structures which support systems of oppression. I do not speak on behalf of those who have been touched by these systems as I am aware of how much my subject position would limit my understanding. The ultimate purpose of my research is to make an appreciable difference in how medical students are presently sensitized to health inequities, the Health Advocate Competency and to social responsibility and to identify barriers and strategies to improve these teachings. In other words, I want to do more than acknowledge my position of privilege and the social capital that it carries. I want to use these to begin a process of addressing systemic oppressions through meaningful changes in the education of medical students. As Sir Michael Marmot (2004) suggests: “There will always be inequities in society but the magnitude of their effects on health is within our control. Why not make things better? It is in all our best interest” (p. 266).

This thesis is organized as follows. Chapter 1 introduces the thesis question and situates me. Chapter 2 describes the literature review undertaken which answers the question about whether health inequities exist in Canada and studies their historical roots. Having established that there are health inequities in Canada, the literature review turns to the role of medical schools in addressing health inequities. The literature review continues with a section on the CanMEDS Health Advocate Competency as a potentially effective tool to address health inequities. Chapter 3 discussed the methodology, the theoretical lenses used, the study sites, the study participants, the challenges which were met during the study, the study period, the study design, sample size as well as data collection. Chapter 4 analyses the data from the questionnaire which is used as an environmental scan as well as the data from interviews with equity leaders. Chapter 5 summarizes what has been learned and makes suggestions regarding going forward.
Chapter 2

Literature Review

2.1 What is the Nature of Health Inequities in Canada?

In order to ascertain whether similar inequities exist in Canada to those in the United States, a search of the literature was undertaken. The search engine used was Scholars Portal (which includes Web of Science, ERIC, MEDLINE, CSA Illustrata, PsycINFO, AgeLine, ProQuest, Applied Social Science Index and Abstracts) with the following keywords “health disparities and Canada” or “health inequities and Canada” and the time frame was 1990 to the present. This search was enhanced with books and other materials.

Although the terms health disparities and health inequities are used interchangeably in the literature, a definition of these terms is pertinent. Adelson (2005) defines health disparities as indicators of a relative disproportion of a burden of disease on a particular population, and, health inequities as the underlying causes of the disparities directly or indirectly associated with or related to social, economical, cultural and political inequities (s45). Spitzer (2005) defines health disparities as the marked difference or inequality in health between two or more population groups defined on the basis of race or ethnicity, gender, educational level or other criteria, and she adds that disparities reflect a gradient in socioeconomic status and power. Further she comments that these disparities are engendered by inequity in access to income, social support, good housing, clean environments etc. (s78). Whitehead and Dahlgren in their 2006 WHO report also use the term health inequities and comment that the United Kingdom and other European countries use the term health inequalities to describe health differences that are unfair or unjust and beyond an individual’s control.

This study will use the term health inequities and the definition from the Toronto Central LHIN Health Equity Discussion paper (Toronto Central LHIN, 2008) which defines health inequities as the differences in health outcomes that are avoidable, unfair and systematically related to social inequality and disadvantage.

The literature reviewed here provides ample evidence that, despite Canada’s commitment to universally accessible health care and social justice, health inequities and
disparities are clearly part of the Canadian healthcare landscape. For example, an analysis by Lasser, Himmelstein and Woolhandler (2006), of a population-based Joint Canada/US Survey of Health indicated that both countries had health disparities related to race and immigrant status, although these disparities were greater in the United States. The authors note that, while Canada’s universal coverage may attenuate health disparities; it is insufficient to eliminate these disparities.

The literature search revealed no articles written prior to 2004 on the topic of health disparities in Canada. However, the grey literature referred to a number of government reports going back to The Lalonde Report (1974); The Epp Report (1987), and The International Think Tank on Reducing Health Disparities and Promoting Equity for Vulnerable Populations Report, (2003); all articulating a vision of reducing health inequities in Canada. More recently, The Unequal City, Toronto Public Health Report (2008); A Healthy, Productive Canada: A Determinants of Health Approach from the Standing Senate Committee on Social Affairs, Science and Technology (2009); and The Wellness Institute Report (2008, 2009) continue on the theme of the need to reduce health inequities.

However, starting in 2004, there is mounting sensitivity in the Canadian literature to equity issues in health care as evidenced by the number of articles on this topic. In fact, The Canadian Journal of Public Health devoted the March/April 2005 publication to the topic of ‘Reducing Health Disparities in Canada’. The papers included in that publication were originally commissioned for The 2003 International Think Tank on Reducing Health Disparities and Promoting Equity for Vulnerable Populations which took place in Ottawa in September 2003. Specific articles discussed absolute homeless and health (Frankish, Hwang & Quantz, 2005); the health of immigrants and refugees (Beiser, 2005); health disparities in aboriginal populations who are the embodiment of inequities according to Adelson (2005); gender and health disparities (Spitzer 2005); and, finally, the impact of intellectual disability (Ouelette-Kuntz, Garcin, Lewis & Minnes, 2005); and literacy (Rootman & Ronson, 2005); on health equity. In the preface of The Canadian Journal of Public Health March/April 2005 issue, Beiser and Stewart, the Canadian national co-leaders for the Reducing Health Disparities Initiative, identified many points of convergence in the articles listed above which they summarized as follows: Canada must expand the knowledge base that informs relevant policies and practices to address health disparities. Research must be undertaken to understand the mechanisms which produce health disparities, to document these health inequities, to design and test interventions that reduce inequities and, finally, to evaluate
existing programs. They suggest that this research must be multidisciplinary (going beyond the social science framework), and international in nature. Baum (2007) agrees noting that since many of the determinants of health are influenced by mechanisms across sectors; cross sectorial action is needed with a focus on reducing inequities. Mackenbach and Bakker (2003), suggest international collaboration such as exchange of policies, methods and their effectiveness, to help policy makers in different nations adopt more evidence-based strategies to address health inequities.

Many writers focus on the health of Aboriginals in Canada, noting that their health status is worse than that of other Canadians on almost every measure of health (Bramley et al., 2004; Adelson 2005; Frohlich et al., 2006; Towle, Godolphin & Alexander, 2006). Geiger (2001) notes that in almost every nation, increased burdens of mortality and morbidity afflicts racial and ethnic minorities and new immigrants: “In Canada, the health status of the Aboriginal population and a number of immigrant groups is equal cause for concern” (p. 1699). Frohlich and colleagues (2006) note that: “…the most egregious health disparities in Canada are those existing between aboriginals and the rest of the Canadian population” (p. 32).

Other recent Canadian government reports also state that Aboriginals and individuals of low economic status bear a disproportional burden in terms of health inequities (Reducing Health Disparities, 2004; Standing Senate Committee on Social Affairs, Science and Technology report, 2009; Wellness Institute report, 2009). Adelson (2005) as well as Frohlich et al. (2006) consider Aboriginals to be victims of colonialism and oppressive regimes, who are also impacted by issues of income (inadequate income results in inequity in access to material resources such as food, housing, etc.) and place (certain neighborhoods have less access to parks, health and education services, are more dangerous etc.). When addressing aboriginal health disparities, many (Adelson, 2005; Frohlich et al., 2006; Towle et al., 2006), include racism, colonialism, loss of indigenous culture as reasons for these health disparities. These descriptions are analogous to the experiences of the Maori in New Zealand who also lost land, culture and language when European colonizers arrived (Woodward & Kawachi, 2009). Frohlich et al. (2006) strongly suggest that to remedy these structural inequities requires a focus on addressing the determinants of health disparities rather than the disparities themselves. Casas-Zamona and Ibrahim (2004), as well as Frohlich et al. (2006), suggest the use of targets for reduction of health disparities. However, Mackenback and Bakker (2003) urges caution in the selection of targets to reduce health inequities to ensure
that these provide more than a motivational focus but actually focus on the outcomes of policies and interventions.

Frohlich et al. (2006), as well as Collins and Hayes (2007), suggest that, despite Canada’s legacy of governmental reports on health inequities spanning a number of decades, there is no evidence that concrete strategies have been developed to address these inequities in Canada. Culyer (2007) states that for the past 75 years, equity is always discussed along with healthcare policy and notes that: “it is undoubtedly equity that drives four of the principles of the Canada Health Act (comprehensiveness, universality, portability and accessibility)” (p. 25). He goes on to say that despite this overt commitment, neither the federal or provincial governments have developed clear definitions of equity and inequity, databases for measuring these, or policy targets and mechanism for promoting and achieving equity.

The 2009 Standing Senate Committee Report recognizes that 50% of population health is attributable to the social and economic environment and that population health policy must be implemented to address health inequities (Keon & Pepin, 2009). This report makes a number of recommendations which include a reorientation of government policy (a national plan) which might include establishing health goals, and a focus on an Aboriginal population health strategy. The report also suggests further research on this issue which is an acceptable recommendation as long as further research is not just a delaying tactic.

Davis, Schoen and Stremikis (2010) in The Commonwealth Fund Study entitled Mirror Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally looks at the US in relation to 6 other countries who have universal health insurance coverage. Canada performs abysmally in this report with an overall ranking in this study and on the equity question of 6, just ahead of the last placed US health care system. The equity ranking was based on the findings that below-average income respondents in Canada were more likely to report problems accessing timely care. This report declares that there is a consistent relationship between how a country performs on equity and how patients rate other dimensions of quality care. The lower the performance scores for equity, the lower the performance on other measures. They go on to say that: “this suggests that when a country fails to meet the needs of its most vulnerable, it also fails to meet the needs of the average citizens” (p. 18).

Mackenbach and Bakker (2003) reviewed the experience of a number of European countries struggling with mechanisms to reduce socioeconomic inequalities in health and
suggest that part of the problem is that policy makers are working in isolation and efforts to address this issue are largely intuitive. Boelen (1999) advises that to solve health inequities requires partnerships amongst key stakeholders including researchers, policy makers, health professionals and medical schools.

It is clear from the above that there are pervasive health inequities in Canada and that many groups are marginalized from the mainstream of health services. This admission about health inequities resonates with other admissions around the world (Mackenbach & Bakker, 2003; Casa-Zamora & Ibrahim, 2004; Bramley et al., 2004; Hays, Stokes & Veitch, 2003), that not all populations are treated in an equitable manner in terms of health care access and treatment. Aboriginal peoples are discussed more frequently in the Canadian literature, although other groups are also at risk including women, immigrants and refugees, those of lower economic status, and individuals with intellectual disabilities.

*The Lalonde Report* (1974) mentioned earlier was the first to discuss the idea that there are factors outside of science which influence good health. The report also introduced the idea of health promotion and disease prevention and the concept of health inequities. Almost five decades after *The Lalonde Report* and despite other government reports spanning these last decades, Canada still has health inequities. What are the historical roots of health inequities that render these so persistent?

### 2.2 Historical Roots of Inequities in Canada

Canada is a country which is recognized for its strong commitment to social justice. And yet, Canada has acknowledged that as a country it harbours inequities which impact on health. How are these two irreconcilable positions possible? What are the historical roots of these inequities? Although this first quote refers to the United States, the same colonialism discussed below was present in Canada which has also privileged White European English-speaking (and French speaking people) at the expense of others.

Tejeda, Espinoza and Gutierrez (2003) define:

…the dominant condition characterizing social existence in what today constitutes the United States as a colonial one because there continues to be a structured relationship of cultural, political and economic domination and subordination between European Whites on the one hand, and indigenous and nonwhite peoples on the other. What more, this relationship (which was imposed and institutionalized throughout the seventeenth, eighteenth and nineteenth centuries and has been maintained, in essence, up to the present)
continues to serve primarily the interests of the dominant White, English-speaking and Christian populations (p.15).

Byrd and Clayton (2003), note that: “the roots of American racial and ethnic health care disparities are more than 2,000 years old. The adverse effects of health experiences of Native Americans and African Americans are the oldest...” (p. 508). Canada has many of the same historical perspectives despite our constitution which speaks of accessibility and equity for all. This is because our historical origins are also based on mainstream Eurocentric beliefs and values. Omi and Winant (1986), note that when Europeans arrived in America they “wondered if the natives of the New World were indeed human beings with redeemable souls (p.19)”. Further in the same article they note:

The expropriation of property, the denial of political rights, the introduction of slavery and other forms of coercive labor, as well as outright extermination, all presumed a worldview which distinguished Europeans-children of God, human beings etc.,- from ‘others’ (p.19).

Later, during the nineteenth century when White immigrants from non Anglo-Saxon roots started coming to America, new challenges faced the founding Anglo-Saxon immigrants. Although White, these new immigrants were different and these differences had to be acknowledged in some way. Henderson and Tickamyer (2009) suggest that whiteness does not always result in privilege and power since race may define whiteness but class and culture strongly influences the limits of privilege. Thus “there are Whites that are privileged and Whites that are marginalized and defined as other” (p. 59). Carty (1999) agrees and suggests that in Canada, these new white immigrants were categorized as ‘others’ and were considered inferior on the grounds of social class. However, she states that the characterization of Africans as “others” was particularly derogatory and that Black people in the East were considered “commodities” and seen as “backward and less than human” (p. 41). In these statements we can see a simple example of the effect of intersectionality as Black people were considered “other” on the basis of race and class which compounded the negative treatment they received.

The racist views described by Omi and Winant (1986) were essential in order to be able to condone the subjugation and control of the indigenous population by the colonizers. As Bhopal (2001) observes: “Racism is the belief that some races or ethnic groups are superior to others, which is then extended to justify actions that create inequality” (p. 1503).
Beginning with the European conquest of indigenous people, many more examples of Canadian racism can be listed, such as the head tax imposed on potential Chinese immigrants after the completion of the Canadian Pacific Railway, the expulsion and internment of Japanese immigrants and citizens, and the refusal to accept Jews fleeing the Nazi persecution in Europe prior to and during World War II (National Anti-Racist Council of Canada Report, 2002).

A local example of racism in the form of anti-Semitism in Toronto is described by Barsky (1998) who quotes from demographer Louis Rosenberg’s 1939 statistical study of Jewish life in Canada:

It is in the economic life of Canada that anti-Jewish discrimination is most marked and most serious in its results. In seeking employment by public bodies, a Jew must be so outstandingly brilliant that his qualifications swamp the obstacles raised by his birth. It is taken for granted that for a Jew to secure an appointment in a competition with non-Jews, he must be ten times as good as the average applicant in order to have a tenth of the average applicant’s chance (p.15).

Barsky notes that when Jews were admitted as patients to hospitals, they were treated with indifference by those who could not understand them. This treatment and the climate of bigotry which created serious road blocks for Jewish physicians to access hospital privileges were the impetus for the founding of Mount Sinai Hospital in Toronto. As she notes, although there were 12 medical internships available in Toronto, none were accessible to Jews despite their high academic achievements.

2.2.1 Racism

Ahmed, Mohammed and Williams (2007) define racism as:

…an organized system undergirded by an ideology of inferiority that categorizes population groups into ‘races’; assigns hierarchical status to these ‘racial’ groups, and uses this ranking to preferentially allocate societal goods and resources to those that are regarded as inherently superior.

Derman-Sparks and Phillips (1997) define racism in a similar manner and note that racism is an “institutionalized system of power” which encompasses a: “…web of economic, political, social, cultural structures, actions and beliefs that systemize and ensure unequal distribution of privilege, resources and power in favor of the dominant racial group at the expense of all other racial groups” (p.9).
They further note that in the United States, racism is found in all aspects of life and that the ideology constructed by the dominant group normalizes the systemic inequality thus making racism not an aberration but a basic part of normal American society. Further, there are no neutral observers in this discourse and the lack of intentionality does not change the objective consequences for people of colour. They suggest that racism operates at the institutional, cultural and individual level. They note that institutional racism impacts mission, policies, organizational structures and behaviours. Sometimes there is conflict between the stated mission and some of the actions of organizations which may reveal some covert racism. They describe cultural racism as consisting of beliefs, symbols and underlying cultural rules that teach and endorse the superiority of the dominant Western culture. They further note that cultural racism is so subtle that it can feel invisible and yet it plays a significant role in socializing individuals to participate and maintain institutional racism. In describing individual racism, the authors note that this type of racism, while specific to the person, exists because institutional and cultural practices permit it to do so. They describe racism as racial prejudice plus institutional power.

Another definition of racism is a system of advantages based on race. I like the analogy used by Tatum (1997) that passive racist behaviour, can be described as standing on a moving sidewalk. No overt racist actions are undertaken but one arrives at the same destination as those who are overtly racist. Unless we are walking in the opposite direction, that is addressing structural issues that permit racism, we are not contributing to the destruction of racism.

Omi and Winant (1986) write that the social sciences have come to reject biological notions of race in favour of a social concept of race. Essed (1990) notes that from a biological perspective, there is only one race and that is the human race. She agrees that the discussion of racial groups is a social and not a biological construct. She suggests that a deterministic attribution of specific behaviour and specific human possibilities is at the core of racial thought and racism is the attribution of inferiority to a particular racial/ethnic group which justifies unequal treatment. She also describes cultural, institutional and individual racism and provides examples of each level of racism as they have been observed in the Netherlands. Cultural racism is how people are portrayed through the media, books, art, cultural festivals etc. including early tales of travels by Europeans who encountered Native peoples and Africans. Euro-American culture is portrayed as the best the world has seen so far and thus colonialism is justified by saying that Europeans brought civilization. She notes
that society reproduces racism from one generation to another although it may not be as overt. Essed further suggests that to fully understand cultural racism it must be linked to institutional racism. She defines institutional racism as when organizations responsible for legislation, policy, education, social and health services as well as other frameworks of society function in such a way as to limit certain racial/ethnic groups from opportunities for growth or are organized in such a way as to be less accessible. Active individual racism can be described as excluding or inferiorizing individuals because they are not White. Passive individual racism can be as simple as laughing at a joke that humiliates or “not hearing” racist comments. According to Essed, power and domination are essential to racism.

Ahmed et al. (2007) discuss the link between poverty and race noting that White poor families tend to be dispersed throughout the community while poor Black families are more likely to be concentrated in poor neighborhoods with lower quality of schools leading to differential educational opportunities, fewer public parks and other recreational facilities, higher levels of environmental hazards leading to poorer health outcomes and fewer jobs thus re-enforcing the marginalization cycle. These variables cannot be treated as separate as they all interlock to create worsening outcomes. For example, the authors suggest that employment opportunities are restricted for those individuals living in these racialized communities because there are few role models of stable employment and no real social network that could provide leads for potential jobs. With limited employment comes limited income and low housing and less access to good education, good recreational facilities etc. and thus the cycle is perpetuated.

According to the National Anti-Racism Council of Canada 2002 report, discrimination based on race or skin colour is a common occurrence in Canada. Language is one example where racism is embedded as the term Black has accrued a number of negative and pejorative connotations. Boler and Zembylas (2003) illustrate the point quoting from an essay by Robert Moore entitled Racism in the English language. In it Moore provides this example:

I may become a black sheep (one who causes shame or embarrassment because of deviation from the accepted standards) who will be blackballed (ostracized) by being placed on a blacklist (of undesirables) in an attempt to blackmail (to force or coerce into a particular action) me to retract my words (p.119).

Few Canadians would be conscious of the underlying racism in the individual words used in this sentence. In fact, Canadians are loath to admit there is racism in this country and few
studies about racism of the type done in both the United States and Great Britain, have been undertaken to explore the issue of racism and the roots causes of health inequities. Canadians seem to be more comfortable with euphemisms, which when analyzed critically, can still imply disapproval. For example, Bannerji (2000) suggests that the term 'visible minority' can be construed negatively as it focuses on being non-White and a minority player.

Block and Galabuzi (2011) write about the intersection of race and poverty in Canada calling it the racialization of poverty which they define as follows: “The racialization of poverty refers to a phenomenon where poverty becomes disproportionately concentrated and reproduced among racialized group members in some cases inter-generationally” (p.15). They note that racialized Canadians face not only barriers to job but also significant gaps in pay. Additionally, the intersection of gender further compounds the connections of race and poverty with racialized women earning less than racialized men and considerably less than non-racialized men. The Block and Galabuzi article is one of the infrequent instances when the concept of intersectionality, although not named as such, is discussed in the Canadian context.

McMurtry and Curling (2008) in their report entitled “Review of the Roots of Youth Violence” note that racism in Ontario is worse than it was a generation ago: “We were taken aback by the extent to which racism is alive and well and wreaking its deeply harmful effects on Ontarians and on the very fabric of this province (p.39).” They also note that the Supreme Court of Canada has made it clear that there is pervasive racism in Canada stating in R. v Spence (2005): “The courts acknowledge that racial prejudice against visible minorities is….notorious and indisputable… {it is} a social fact not capable of reasonable dispute (p. 238).” They state that Aboriginal peoples experienced persistent health and income disparities which are exacerbated by discrimination described as “virulent and entrenched (p. 239).”

### 2.2.2 Racism and Health Inequities

Bhopal (1998) notes that although most health care workers and researchers are humanitarian, this is not sufficient to guard against racism as health professionals follow the ethos of their time. Although we do not know the exact contribution of racism to health inequities, we know enough to know that it is a contributing factor. A recent example can be found in a study of Sheets et al. (2011) who searched a widely used pathology textbook for assertions that African Americans have a different disease profile than individuals from other
races. They found that two-thirds of the statements about different risk factors for African Americans in this textbook were not supported. In fact, some statements were contradicted by the published literature.

Geiger (2001) when discussing the health of racial and ethnic minorities and new immigrant populations’ in the United States states:

…although the poorer health status of these populations is primarily attributable to poverty and related environmental factors- social, physical, biomedical, economic and political- as well as lack of access to health care, a significant contribution may be made by the racial and ethnic disparities in the quality of medical care, specifically by differences in the diagnostic work-up and treatment of minority patients still in the system (p.1699).

He goes on to comment about the relevant peer-reviewed literature in the United States and notes that it has:

…provided overwhelming evidence that African-Americans, peoples of Hispanic origins and American Indians are strikingly less likely to receive coronary angioplasty or bypass surgery, advanced cancer treatment, renal transplantation or surgery for lung cancer compared with White patients matched for insurance status, income, or education, severity of disease, co-morbidity, age, hospital type, and other possible confounders. Even more disturbingly, these differentials were found in basic elements of clinical cares such as the adequacy of physical examinations, history taking and laboratory tests (p. 1699).

Ahmed et al. (2007) describe internalized racism as “the acceptance, by marginalized racial populations, of the negative societal beliefs and stereotypes about themselves” (p. 323). In other words, it is the acceptance as true of the dominant society’s view of their inferiority. The authors quote a number of studies showing the adverse effect of internalizing negative racial and cultural beliefs about one self on academic performance. They also speak to a number of studies linking internalized racism to unhealthy levels of alcohol consumption and psychological stress. These authors also speak of the negative impact on health when individuals perceive discrimination. This impact includes adoption of health-damaging behaviours, as well as changes in the neuroendocrine, autonomic and immune systems.

Jones et al. (2008) explored the relationship between socially assigned race, (how do other people usually classify you) and self-identified race/ethnicity and the impact of these classifications on self-reporting of health status. The study results indicated that being perceived by others as White is associated with a large and statistically significant advantage in health status, no matter how one self-identifies. This article provides a compelling
example of the power of race and racism on health when the perception of others can alter your own perception of your health status.

*The United States Institute of Medicine Report, Unequal Treatment* (2003) was replete with examples of racism in health care giving evidence that: “racial and ethnic minorities tend to receive a lower quality of health care than non-minorities even when access-related factors such as patient insurance status and income are controlled” (p. 1). In 738 pages, this landmark report provided ample examples that if you are a visible minority in The United States, your diagnostic and therapeutic experience is of considerably lower quality than that received by White Americans. This report included an extensive review of articles from the ten previous years (1992-2002) which yielded studies showing racial and ethnic disparities in the following health care categories: analgesia, asthma, cancer, cardiovascular disease, cerebrovascular disease, diabetes, children’s health care, emergency services, eye care, gallbladder disease, HIV/AIDS, maternal and infant care, medical imaging, mental health, peripheral vascular disease, pharmacy, rehabilitative services, renal care and transplantation, use of services and procedures, women’s health as well as physician and patient perceptions. The report acknowledged the many issues contributing to these findings included racism and stereotyping.

Finally, The American Medical Association recently felt compelled to apologize for its history of racial inequity (Aluko, 2008), a noteworthy indicator that this history must be long and pervasive. As Boler and Zembylas (2003) write: “no one escapes internalizing dominant cultural values, even though these values take different forms in different individuals” (p. 115).

Crampton, Dowell, Parkin and Thompson (2003) in writing about how medical education can address racism in medicine cautions that racism may be more insidious if it does not flow from ideological conviction but “non-consciously through inherited mores and institutional structures” (p. 595). This is a very important statement. Medical schools are not intentionally racist institutions. However, they are social organizations and as such, reflect the subtle biases existing in society. There is ample evidence that just because Canada does not speak of racism, it exists in our society and continues to be transmitted in subtle and unintentional ways in all our institutions including universities.
2.2.3 Aboriginal Peoples

Knowledge of colonialism and its impact on the Aboriginal peoples of Canada highlights the fact that Aboriginal peoples have been, and continue to be, subjected to racism. Unfortunately, few seem to make the link between Aboriginal peoples and racism. Lawrence and Dua (2005) in their article on *Decolonizing Antiracism* speak extensively of the exclusion of the Aboriginal perspective within antiracism movements. They note for example that: “at the core of indigenous survival and resistance is reclaiming a relationship to land. Yet within antiracist theory and practice, the question of land as contested space is seldom taken up” (p.126). They further note that indigenous presence and ongoing colonization is not included in analysis of races and racism, thus systematically excluding Aboriginal peoples and erasing their ongoing struggle from the ways that racism is articulated. Lawrence and Dua continue to say that the few scholars who include Aboriginal peoples in their theoretical frameworks equate decolonizing politics with antiracist politics and while their intent may be good, the result is marginalization of the decolonizing struggles. The two most contentious areas where people of colour and Aboriginal peoples have conflicting interests relates to immigration and multiculturalism. Regarding immigration, people of colour although marginalized, participated and benefited from settlements of land and the colonial domination of Aboriginal peoples. In terms of multiculturalism, the language policies in Canada fund the “official languages” followed by “heritage” languages and whatever is left over is than distributed among the 50+ Indigenous languages in Canada. From the perspective of these two authors, one from the Mi’kmaw people and the other of Indian descent, ongoing colonization and decolonizing struggles must be core to understanding racism and antiracism. This is an example of intersectionality as theorized by Crenshaw (1991) when she states: “when one discourse fails to acknowledge the significance of the other, the power relations that each attempts to challenge are strengthened” (p.1282).

A review of the history of Aboriginal people would suggest that they were, and continue to be, victims of overt racism. Adelson (2005) refers to Aboriginals in Canada as the “embodiment of inequity” (p. s45). Aboriginal people in Canada include First Nations, Métis and Inuit people. It is perhaps illustrative to go back in Canadian history to look at how overt systems of oppression in the form of governments and religion can systematically tyrannize and marginalize a group. Seeing the origin of some overt systems of oppression
may help not only to understand root causes but also to identify the more subtle systems of oppression in existence today.

Stevenson (1999) writes that the 1869 Gradual Enfranchisement of Indian Act marginalized Aboriginal women by excluding them from participating in local First Nation governance, voting, running for office and any form of decision-making including disposition of goods, chattels and reserve land. Further, Stevenson (1999) states that the Canadian government through the Indian Act of 1876 did the following:

1. It marginalized First Nation women (Stevenson’s nomenclature) by defining “Indian” through patrilineage rather than the traditional matrilineage which existed in many tribes.
2. It disenfranchised any First Nation individual who received a University degree, was admitted to the Bar as an Advocate or Barrister, became a priest or became licensed by a Christian denomination.
3. It disenfranchised illegitimate children unless the newly minted male Chiefs and Council accepted them and agreed to give them equal shares of band revenues.
4. It removed the sexual autonomy previously enjoyed by First Nations women by removing their rights to divorce and remarry thus imposing Judeo-Christian values.

Looking at these historical facts through intersectional lenses highlights the impact of gender, culture, class and race which mutually reinforced the negative behavior of privileged white people towards Aboriginal peoples.

Missionaries, and therefore religion, were complicit with this change in the role and stature of First Nations women because they supported all government initiatives. As Stevenson (1999) notes, missionaries upheld the European ideal of a woman as fragile, weak, confined to affairs of the household, chaste and dependent on men. Missionaries deliberately misrepresented the image of First Nations women whom they vilified because they were hard working, strong, economically independent, actively involved in the public sphere with personal autonomy and control over their sexuality. Brand (1999) sees the strength of First Nations women as similar to the strength of Black female slaves who were seen as having no physical limitations at a time when White women were seen as weak and dependent.

Missionaries were very vocal in representing First Nations women as savages since this form of rhetoric supported the increasing colonization and justified land seizures. Thus the government/missionary dyad combined the missionary ideology with government coercive cultural transformation strategies to rationalize governmental behaviour towards indigenous peoples (Stevenson, 1999). An intersectional lens reveals how gender, culture,
class, race and because of missionary involvement, religion resulted in interlocking systems of oppression for Aboriginal peoples which were manipulated to the benefit of the dominant White group.

The history of colonialism, discriminatory practices, unjust laws, economic, health and political disadvantages that the Aboriginal peoples have suffered is overwhelming. The tenor of early 20\textsuperscript{th} century Canadian society is well captured in this 1920 quote from Duncan Campbell Scott, Superintendent of Indian Affairs: “Our objective is to continue until there is not a single Indian in Canada that has not been absorbed into the body politics, and there is no Indian question and no Indian department” (Stevenson, 1999, p. 70). His message is clear: the intent is to destroy the social and familial relations, worldview, customs, languages, culture, communities, and ultimately, the identities of Aboriginal peoples.

The subjugation of Aboriginal peoples, from whom land and resources have been removed, has resulted in their marginalization in many aspects, from education to health to economics. The authority by which this was accomplished was first the 1867 \textit{British North American Act (BNA)} followed by \textit{The Indian Act} of 1876 both of which were seminal in the colonizing process (Stevenson in Dua \\& Robertson, 1999). This Act effectively abolished the right of the Aboriginal peoples to determine their own lives. For example, this Act gave power to the State to relocate entire communities, not for the benefit of the community, but for Federal economic resource management reasons. Once the Indian Act was in place, other oppressive rulings abounded such as the definition of “Indian” by patrilineage imposed on First Nations peoples in contradiction of the traditional matrilineage practiced by many tribes. This change effectively elevated the power of men at the expense of women. Stevenson (1999) notes that in each phase of colonization of First Nations people there was a different agenda: “Mercantilists wanted our furs, missionaries wanted our souls, colonial governments and later Canada, wanted our lands” (p. 49).

Warry (1998) attributes the poverty of Aboriginal communities directly to their marginalization within the economic structure of Canadian society and to the impact of racism and discrimination. He further notes that a causal relationship between colonialism, poverty and ill health has been documented by many studies over the last 30 years.

The health of the Aboriginal communities was not addressed by the government until after World War II when health and social services were systematically provided to Aboriginal peoples. The provision of these services was due, in part, to the concerns for the safety of the non-Aboriginal population who might be exposed to infectious diseases such as
tuberculosis which was widely prevalent on the reservations. Thus, these services were provided predominantly to protect the dominant White class. Aboriginal peoples still continue to experience a greater illness burden and a substantially lower level of service in their communities because of many structural reasons including insufficient health care resources, unsanitary water, inadequate housing and access issues related to geographical isolation.

2.2.4 Multiculturalism

As has been demonstrated through this chapter, racism is only one system of oppression. Gender, social class, and religious affiliation are also aspects of oppression which results in inequities. As McDowell and Hernandez (2010) note: “the lens of intersectionality assists us to transcend conceptualizations of oppression organized around single axis of identity” (p. 94).

Crenshaw (1991) who writes through an intersectional lens as she discusses the rape of Black women suggests that problems are created when concerns about racism and gender are dealt with separately. The danger in focusing on one marginalized group is that it may serve to elevate that group at the expense of another. In fact, Collins (2002) suggests that when it comes to social injustice, marginalized groups may have competing interests that could generate conflicts: “our ethnicity, gender, class, sexual orientation, ability, age and nation of origin afford us certain privileges…” (p. 102).

An example of the potential competing interest between two marginalized groups is discussed by Hudson and Hunt in the book The Making of the Northern Ontario School of Medicine (Tesson et al., 2009). This book describes the social mandate of this school as well as its focus on serving the needs of the various communities in Northern Ontario. Tensions between two of the marginalized communities, the Francophone and the Aboriginal communities have often surfaced as this school tries to meet the needs of these and other underserved communities. Gupta (1999) also provides an example of this competing interest when she writes that established ethnic organizations in Canada disapproved of using “multicultural” funds to deal with “racism and human rights issues”.

Multiculturalism was a government policy launched in 1971 with four tenets which included 1- assist all Canadians to develop culturally, 2- overcome cultural barriers to full participation in Canadian society, 3- arrange cultural encounters to promote unity and 4-assist immigrants to learn one of the two official languages (Gupta, 1999). Gupta comments
that the multicultural policy was launched largely in response to the separatist movements in Quebec, the French-English question, assertions by First Nations people and to address immigrant issues. She further notes that the interpretation and the practical reality of the concept and the resources allocated to it have changed depending on government funding and pressure from various minority groups. The multicultural policy was subsequent to the Bilingualism and Biculturalism Commission report which: “…reconfirmed the special status of the British and French in Canada by defining them as ‘official minorities’ (read separate and superior to other minorities) and by defining Canada fundamentally as a bilingual and bicultural country with a multicultural component” (Gupta, 1999, p. 191). Further, according to Gupta (1999), First Nations people were not mentioned in the Bilingualism and Biculturalism report and have never been involved in discussions about multiculturalism or anti-racism. Gupta (1999) deducts from this that there is a hierarchy in Canada based on ethnicity and race with, in descending order, British and French, other ethnic groups and First Nations people as last.

Since *The Multicultural Act* of 1988, Canada has made multiculturalism a key focus of its state vision, and mechanisms of that vision are embodied in legislation and diversity and human rights offices in many sectors including hospitals and universities. However Gupta (1999) suggests that multicultural policies have not addressed issues of power and structural barriers, limiting themselves to attitudinal changes to discrimination. Nevertheless, she does acknowledge that since the inception of *The Multicultural Act*, gradually, there have been more First Nations issues discussed and an acknowledgement that institutional racism exists in Canada. On the other hand, Gupta (1999) suggests that the lack of clarity about “racism” and “anti-racism” contributes to the fact that these concepts are discussed with negligible changes in practice.

It is important to reflect about the context of the times when discussing the birth of multiculturalism. Canada was a land of Aboriginal peoples, which was overtaken by White European colonizers. Subsequent to this takeover and until the 1960’s, except for small pockets of Black people in specific areas, Canada was largely a country of White people. Bannerji (2000) suggests that multiculturalism was introduced in light of the substantial third world immigration of the 1960’s as a potential “ideological coping mechanism”. She suggests that multiculturalism is in fact an ideology of containment and management of immigrants and a “euphemistic expression for racial labour and citizenship policies” (p. 4).
She further states that multiculturalism has engendered cultural politics and changed the focus of dealing with problems of class and patriarchy.

Tester (2007) declares that “racism in Canada is often hidden behind the edifice of multiculturalism” (p.3). Gupta (1999) supports this notion saying that multiculturalism: “…has provided a political climate in which overt racism and discrimination has been made illegal. However it has also produced a particular brand of “Canadian racism” described by many as “polite”, “subtle”, “systemic” and even “democratic” (p.187). Mohanty (2003) offers a more philosophical comment. She states that: “While multiculturalism itself is not problematic, its definition in terms of an apolitical, ahistorical cultural pluralism needs to be challenged” (p. 208).

Multiculturalism is often held up as a shining example of Canada’s leadership in respectfully incorporating multinational immigrants into a vibrant, productive society. However it is important to acknowledge that although more subtle because of the multiculturalism discourse, a covert form of racism exists in Canada. Multiculturalism, the ideological concept of a beautiful mosaic has not resulted in a more equitable distribution of resources or power and the systemic issues which cause health inequities are still present. There is a chasm between the idea of multiculturalism and its reality in Canadian society.

2.2.5 Immigration

Beiser (2005) informs us that Canada preferred White immigrants from Britain, Northern Europe and The United States and that: “…selection and settlement policies militating against non-White immigrants remained in effect until 1967, when they were replaced by a colour blind system based on points assigned according to the applicant’s human capital” (p. s32). Canada, until the 1960s, appeared to have immigration policies that were overtly racist. Beiser further notes that nations are always cautious about admitting strangers who could be a menace to the health of the population or its economic well-being. As recently as post World War II, there were still medical leaders, notably Charles Kirk Clarke, former Dean of the Faculty of Medicine at The University of Toronto (after whom The Clarke Institute was named in 1966, now The Centre for Addiction and Mental Health, in Toronto), who cautioned against the “influx of the genetically weak” who would “impair the quality of Canadian stock” (Beiser, 2005, p.s32). Clark, a xenophobic and a strong proponent of eugenics, was influential in the enactment of Canada’s exclusionary immigrant act of 1919 (Dowbiggin, 1997). He was predisposed in his approach to the immigrant
question by his observation that many of his psychiatric patients were of non-Canadian origin. Rather than look at the conditions that these new immigrants experienced including social and cultural isolation, poor working and living conditions which might be the underlying cause of their illness, he saw them exclusively through biomedical lenses as genetically unfit. In addition to his role in the development of The Faculty of Medicine at the University of Toronto, Clark was also influential in the development of the department of psychiatry at this same medical school. He and his colleague Dr. Clarence Hincks (also honoured by the naming of the Toronto Hincks-Dellcrest Treatment Centre) co-founded the Canadian National Committee for Mental Hygiene in 1918 and were actively involved in the eugenics movement (Court, 2010). Their ‘achievements’ show how society and structural elements such as Federal policies can be influenced by biomedical ideology and are a clear marker of the power of medicine. Furthermore, the fact that these two health care centres could be named after known eugenics supporters is a problematic statement about Canadian society in the 1960s.

Canada’s immigration policies are a good indicator of our prejudicial approach to different races and illustrate why intersectional frameworks should also include national identity/status. Dua (1999) speaks of Canadian immigration policies which she states were based on creating a White settler nation. Only in the late nineteenth century, when economic circumstances demanded low-wage labour were Asian men admitted as temporary workers. However, these men were not allowed to sponsor wives and children until 1947. Carty (1999) also notes that when immigrant laws where relaxed it was not to make Canadian society “more colourful and diverse” but “to bring cheap labour to capital” (p. 44). An example to illustrate this point is the federal government’s Domestic Workers Scheme of 1955 to bring Caribbean women to work in the homes of prosperous Whites. Brand (1999) notes that initially Black women were considered to be breeders who produced free labour. In Canada, emancipation did not markedly alter the status of Black women as they were excluded from White women’s traditional occupations of clerical, secretarial and sales work until the late sixties and seventies, continuing to work in agriculture, domestic service and low paying industrial jobs. She further notes that “Black Women’s’ Work” is historically rooted in slavery, is devalued, unacknowledged and gendered and has an ad hoc quality because the relationship between employee/employer is flexible, disadvantaging and destabilizing Black women.
Arat-Koc (1999) observes that before the 1960’s, Canada’s immigration policy was racist and that “immigration of women of colour was very contentious as women of colour were seen as threats to the racial and cultural purity of the nations” (p. 208). She informs us that single women of colour were allowed to immigrate for their “labour only” to solve labour shortages in domestic work and were considered a commodity. This was in contrast with single women from Britain who came as domestic workers with the expectation that they would eventually marry and be the “mothers of the nation”. This overtly racist view was attenuated in the 1960’s when immigration policies shifted to a points system which decreased (but did not eliminate) the relevance of race and sex to the immigration process. The reason for the change was economic. European immigration was reduced because of a flourishing economic growth in Europe, and, as a result, Canada with its own thriving economic expansion had difficulty accessing skilled labour. The ‘objective’ points system looked at age, formal education and training, occupational skills and experience, and knowledge of Canada’s official languages. Arat-Koc suggests that this system was a commodification of immigrants which evaluates potential immigrants predominantly on their expected place in the labour market. Those that can contribute are included and those that can’t are excluded or marginalized (Arat-Koc, 1999).

When one looks at the point system criteria it is easy to see how immigrants from developing countries could be marginalized, especially women from these countries with “low market value”. Arat-Koc explains the family class immigrants and refugees categories, both of which have differential status and treatment, and comments that females are overrepresented in the less beneficial Family class category for two reasons. First, until 1974, single women were not allowed to enter Canada as the principal immigrant applicant. Secondly, although this is changing, women have more difficulty meeting the requirements of the point system as they lack opportunities for advancement or have experienced gender inequalities and thus fall short of the necessary qualifications in the points system. Arat-Koc also quotes Roxanna Ng who argues that there are structural inequalities in the immigration process which cause one spouse to be dependent on the other and the dependent spouse is usually the wife. Despite many changes in Canada’s immigration policies, these policies continue to be problematic for certain individuals and groups. Arat-Koc explains that there is a difference between policies that are non-racist and non-sexist versus those that are anti-racist and anti-sexist. She characterizes the differences as: “the former set of principles are often limited to elimination of formal and explicit discrimination but may be perfectly
compatible and co-existent with unequal and exploitive treatment” (p. 230). Anti-racist and anti-sexist approaches challenge problems and examine policies and structures that impact on the basis of gender, race, ethnicity, language, class, sexuality, etc.

Immigration restrictions in Canada have continued at different times for different nationalities causing disruptions for potential immigrants. Immigration laws reviewed critically can be understood to be part of a structural system of oppression as individuals and groups can be marginalized because of their immigration status.

A specific example of an ongoing systematic barrier for immigrants is related to finding work. In May 2009, Oreopoulos published a study that highlighted discrimination in the Canadian labour market. The discrimination was based on foreign-sounding names and Oreopoulos described the difficulties faced by individuals with these names in being prioritized for work by employers.

As we have seen in an earlier section, Ahmed et al. (2007) describe other difficulties faced by disenfranchised individuals in finding work. These include access to social networks that are not necessarily present in neighborhoods where immigrants cluster. As we who are privileged know, often finding work is not about what you know but who you know.

Block and Galabuzi (2011) note that between 2001-2006, the racialized population in Canada grew at a rate of 27.2%, a rate five times higher than the 5.4% increase for the Canadian population. However, their study showed that ongoing discrimination maintains barriers to good paying stable jobs, supports higher levels of unemployment and significant income gaps between racialized and non-racialized Canadians and this is further exacerbated for women when gender is interlocked with race. Additionally racialized groups are disproportionately represented in the economic sectors where contracts, temporary work, limited job security and no benefits are the norm. For individuals in these situations, the lack of employment security is a substantial stressor.

Gupta (1999) reminds us that “the state is a historical phenomena; it is the product of human association” (p. 188). The state receives its power through consensual means and she goes on to give the example of the Harris government which was elected in Ontario in 1995 on a ‘common sense revolution’ plan. Subsequently this anti-equity platform allowed the Harris government to dismantle almost all anti-racist initiatives undertaken by the previous government. A more recent example is that of the majority election in May 2011 of the Harper government on a platform that included an omnibus bill with much tougher crime processes as well as more restrictive immigration policies. These proposed immigration
changes, which were slowly divulged, are a blatant commodification of potential immigrants. The reason I express this position is that the new immigration policies will favour individuals who can satisfy an employment need in Canada and therefore the result of these policies is to view immigrant applicants as if they were a marketable item. These polices will also undoubtedly disservice female applicants who are usually less educationally qualified or have less work experience. It will also negatively impact the ethnic diversity presently in Canada and support homogeneity because of the higher language proficiency requirements which will privilege applications from English (and French) speaking countries. Dianne Francis (2012), a Canadian economist who lauds these new immigration proposals, notes in a recent Financial Post article that the immigration system should be “the human resources and recruitment department for the economy” (p.2). Although a country’s immigration policies must balance many factors including economic growth, the immigration proposal details that are being released suggest that this focus will come at the expense of family reunification and other humane aspects of immigration. The fact that business leaders will be involved in the selection process of new immigrants is a clear indicator of the privilege the state is according to the dominant class. The fact that more transient work will be offered to those that meet the ‘human capital’ requirements of the new policies is also worrisome as the benefits offered to this class of immigrants will not be equitable with those given to the rest of the Canadian population.

The federal election followed the Toronto municipal election which saw the Ford brothers attain power, one as Mayor of Toronto and the other as a Counselor and trusted insider/advisor. Some of the planned budget cuts for the 2011/12 Toronto municipal budget include a series of proposal that will profoundly impact marginalized people. These include, amongst others, the removal of lunch programs in inner city schools, charges for recreational programs and the closure of evening bus services in areas where marginalized groups live thus removing their basic transportation to and from work. These proposals would certainly ensure that many hungry children will not benefit from their education, that access to recreational facilities will be negatively impacted and many individuals relying on bus services to and from their jobs could become unemployed thus further diminishing their prospects for an improved economic outlook. Despite his lack of commitment to the marginalized and underserved populations in Toronto, according to the media, Mayor Ford’s popularity remains high.
Gupta (1999) declares that although Canada has implemented some progressive reforms, because of struggles led by women, people of colour and minorities, the diluted nature of these reforms “show they are more façade than genuine attempts to remove inequities” (p. 189). The proposed changes to the immigration policies is another indicator of this façade as these policies are being introduced under the guise of ultimately assisting immigrants by selecting only those who can succeed in Canada.

It is important to reflect on how we can counter this historical legacy and the dominant cultural values which have led to health inequities to produce medical students who are knowledgeable about these inequities, understand their social responsibility and are committed to addressing these issues within the scope of their medical practice. The first step in this process is understanding that these health inequities exist. Closely following this realization must be an understanding of the historical processes which created these inequities. Acknowledging the unearned privilege the dominant group (including physicians) have heretofore enjoyed is also an essential step in the transformation. Perhaps the silence in the literature until 2004 about health inequities is simply that the dominant group could hide behind the façade of multiculturalism and universal health care. Unless we in the dominant group are willing to critically review our privilege, we are unlikely to understand the unearned nature of these privileges. Without this knowledge and understanding, it is unlikely that the dominant group will want to address the unfair systems which continue to maintain our unimpeded access to these unearned privileges.

What is the role of socially responsible medical schools in terms of understanding and addressing health inequities?

### 2.3 Social Accountability/Responsibility of Medical Schools

As previously noted, the topic of health inequities was not part of the Canadian literature prior to 2004. However, whenever health inequities are discussed, the importance of a multi-pronged approach involving key players, including medical schools, is always stressed. What does the literature tell us about social responsibility of medical schools? To answer this question, a literature review was undertaken using Scholar’s Portal and the key words “social responsibility and medical school” and “social accountability and medical education”, searching the database from 1990 to the present. Additional articles were found by reviewing the bibliographies identified in the original search. This literature review provided the following information.
The World Health Organization (WHO) defines the social accountability of medical schools as follows: “…the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve” (Boelen & Heck, 1995, p.3). They note that medical schools whose programs address the “…obligations for which they are socially accountable could be said to be socially responsible” (p. 3). Boelen (1999) suggests that social accountability: “…goes beyond social responsiveness. It implies that the school consults society and jointly identifies priority health issues and expectations…” (p. 17).

2.3.1 Social Contract

Numerous authors discuss the fact that medical schools, by accepting society’s resources and support, enter into a social contract and thus should be responsive to their community/public (Boelen & Heck, 1995; Butler, 1992; Foreman, 1994; McCurdy et al., 1997; Peabody, 1999; Ayers, Boelen & Gary, 1999; Faulkner & McCurdy, 2000; Lewkonia, 2001; Gadon & Glasser, 2006; Freeman et al., 2007). Kamien (1996) speaks to the notion of a social purpose.

The most prevalent theme of the literature on social responsibility/accountability and medical education is the notion that medical schools must be socially responsible or accountable to society. This is discussed by Flexner (1910), Waugh (1990), Butler (1992), Foreman (1994), The WHO (1995), Hennen (1997), Peabody (1999), Cappon and Watson (1999), Boelen (1999), Faulkner and McCurdy (2000), Lewkonia (2001), Gadon and Glasser (2006), Woollard (2006), Freeman et al (2007), AFMC, (2009); Aretz (2011), Lindgren and Karle (2011), Gibbs (2011), Dharamasi, Ho, Spadafora and Woollard (2011). Nation, Gerstenberger and Bullard (2007) call medical education a public good. The long term commitment to society was initiated by Hippocrates (Gadon & Glasser, 2006) and further demonstrated throughout history by events such as the establishment of the first Academic Chair of Medicine in 1497 in Aberdeen, Scotland, with the mission “…of the pursuit of health in the service of society” (Lewkonia, 2001, p. 1). Abraham Flexner (1910) over 100 years ago published a report entitled Medical Education in The United States and Canada which revolutionized how medical education is organized and delivered. The report galvanized the focus on the scientific reductionist approach of medicine and organized the first two years of medical school with a science focus followed by the next two years of guided clinical exposure. But Halperin, Perman and Wilson (2010) point out Flexner’s belief
that physicians had an obligation to do more than treat individual patients but also had a societal obligation. In fact they note that Flexner believed that the physician was a social instrument because medical schools were a public corporation which used public funds.

Further evidence of social responsibility abounds in the literature. For example, Waugh (1990) informs us that the social responsibility of the academic complex (medical schools and their teaching hospitals), was the theme of the 1990 joint annual meeting of The Canadian Medical Colleges and Association of Canadian Teaching Hospitals. Butler (1992) writes that social responsibility has been a fundamental interest of the medical profession ranking among the top 10 topics in The Association of American Medical Colleges addresses for most of the last century. In 1998, The Educational Commission for Foreign Medical Graduates and The World Health Organization co-sponsored a conference entitled “Improving the Social Responsiveness of Medical Schools”. Cappon and Watson (1997) discuss a 1997 survey of the existing 16 Canadian medical schools conducted to ascertain their experiences in promoting social responsiveness. The results indicated an enhanced interest in the issue of social accountability although the application was variable.

Health Canada in 2001 produced a document entitled Social Accountability: A Vision for Canadian Medical Schools suggesting a set of principles that should guide Canadian medical schools in their quest to achieve social responsibility. These principles include responding to the changing needs of the community and establishing partnerships with organizations, the community, professional groups, and governments to develop a shared vision of sustainable health care. Gadon and Glasser (2006) discuss the 2001 commitment of The Association of Faculties of Medicine of Canada (AFMC) to social accountability charging medical schools to develop measurable standards for programs which address the social determinants of health. As part of the commitment to social responsibility, AFMC in 2003 developed a data base of activities related to social accountability to both raise awareness of the work done in this area and also to stimulate similar activities in Canadian medical schools. The Northern Ontario School of Medicine (NOSM), the newest Canadian medical school, launched in 2002, was the first to adopt a social accountability mandate (Strasser & Lanphear, 2008). The Josiah Macy Jr. Foundation released a report in 2008 entitled Revisiting the Medical School Educational Mission at a Time of Great Expansion (AAMC, 2008). The report states that the core mission of medical schools is as follows: “All medical schools have an obligation to educate future physicians who are prepared both to assess and to meet health needs of the public” (p. 4). Part of this obligation entails:
“…ensuring that medical students retain their enthusiasm for medicine and remain committed to its societal mission” (p. 4).

In 2009, The Association of Faculties of Medicine of Canada (AFMC) launched a project entitled *The Future of Medical Education in Canada* (2009). The first recommendation of ten reads as follows: Address Individual and Community Needs. The explanation for this recommendation has been previously quoted in an earlier section of this thesis but I will repeat it again because it is of key importance:

Social responsibility and accountability are core values underpinning the roles of Canadian physicians and Faculties of Medicine. This commitment means that, both individually and collectively, physicians and faculties must respond to the diverse needs of individuals and communities throughout Canada, as well as meet international responsibilities to the global community (p. 5).

Further into the report, the following statement appears:

The link to social accountability is not only longstanding but foundational to medical practice and education. It is embedded in the Hippocratic Oath taken by physicians and was identified by Flexner 100 years ago when he undertook a review of medical education in Canada and The United States. Not surprisingly, the importance of social accountability emerged as a cross cutting theme in this project. Universally seen as a fundamental, social accountability connects medical education to the diverse needs of society and requires vigilance to ensure that high quality health care is available for all Canadians (p.16).

All 17 Faculties of Medicine in Canada have indicated their support for this report and view as fundamental this first recommendation on social responsibility and accountability. The 2010 *Global Consensus for Social Accountability of Medical Schools*, an association of 130 organizations and individuals from around the world with responsibility for health education, professional regulation, and policy-making, participated in a process to develop strategic directions for medical schools to become socially accountable. Canada is a member of this organization and contributed to the document.

### 2.3.2 Mission/Goals of Medical Schools

A number of articles define the mission of medical schools as tripartite: education, research and clinical service (Boelen & Heck, 1995; Foreman, 1994; Hennen, 1997; McCurdy et al., 1997; Ayers et al., 1999; Boelen, 1999; Lewkonia, 2001). Two articles change the nomenclature of this third mission as follows: Peabody (1999) suggests it should
be to develop health policy reform, while Lewkonia (2001) suggests it should state explicitly to provide service to society. A number of articles comment that the application of the mission should not remain institutionally-based, nor should planning be focused on the interests of faculty, university and hospitals, but both mission and planning must be immersed and framed by community/societal expectations and needs (Boelen & Heck, 1995; Hennen, 1997; McCurdy et al., 1997; Ayers et al., 1999; Cappon & Watson, 1999; Boelen, 1999; Lewkonia, 2001; Woollard, 2006; George, 1999; Kaufman, 1999; Eckenfels, 1997; Eckenfels (1997) speaks of John Evans’ supply/demand approach, describing institutional demand-side thinking as “…from the perspective of the patient and population of the community” (p 1045), whereas; supply-side thinking is “driven by new knowledge and technology…” (p. 1045). Boelen (1999), Faulkner and McCurdy (2000) as well as Hays et al. (2003) suggest that a valuable framework for medical education is to assume responsibility for the welfare of the community, and a population based approach to education.

The literature further speaks of medical school goals which must be defined and prioritized through a public discussion, be clearly articulated and linked to fulfillment of social objectives which must be measurable (Peabody, 1999; Faulkner & McCurdy, 2000; Lewkonia, 2001; Sanson-Fischer et al., 2008). Boelen (1999), discusses The WHO social accountability grid which can be used by medical schools to articulate their mission and priorities in the domains of education, research and service and assess the social responsiveness of these priorities in terms of values related to relevance, quality, cost effectiveness and equity. Within each domain, three phases are included (planning, doing, implementing) allowing medical schools to trace their trajectory in all areas of the grid. Sirisup (1999) discusses a medical school in Thailand which has begun using the social accountability grid in a systematic way to assess social responsiveness. He notes that other medical schools are exploring mechanisms to measure responsiveness and community satisfaction. In the United Kingdom, George (1999) notes that The Education Committee of the General Medical Council produced, in 1993, a set of 13 recommendations for undergraduate training, 5 of which are targeted at improving the social responsiveness of medical schools. Regular progress reports from medical schools as well as visits from The Education Committee are mechanisms to monitor progress towards meeting these recommendations. Hays et al. (2003) write about a new medical school in Northern Australia which explicitly stated its strong community orientation by adopting a socially accountable mission statement stating that it will improve the health of rural and remote indigenous and
tropical populations. To ensure that the school meets the stated goal, in addition to participating in the national accreditation process, this school has an external evaluation committee that reports on how local expectations have been met. The Northern Medical School (NOSM) is the newest medical school to be built in Canada and the first to be established with a social accountability mandate (Strasser, et al., 2009). Opened in the fall of 2005, the mandate of the school is to train physicians to practice in Northern Ontario or in other rural/underserved populations in Canada. The school is steeped in social accountability principles which are reflected in its curriculum, its experiential long term community placements, and its special student selection criteria (Pong, 2009). The NOSM Academic Council constitution articulates that deliberations and decisions must be undertaken in light of the primary focus on students and the healthcare needs of the people of Northern Ontario. The Board of Directors is also socially accountable with membership comprised of appointments from its stakeholder groups including local municipalities, representatives from various medical and health communities, Aboriginal and Francophone groups (Hudson & Hunt, 2009).

A brief review of the mission statements of a few Canadian medical schools, done outside of this literature review, reveals that some of the mission statements of these medical schools limit their mission to a dual role of education and research with a stated expectation of an improved societal health outcome. One Canadian medical school limits its mission statement to only the dual roles of teaching and research with no mention of outcomes related to society. It is understood that all medical schools partially fulfill their duties to society with respect to providing research which advances health care as well as training physicians. However, if these medical professionals do not understand their role in addressing health inequities in society, than one can surmise that medical schools have not filled their entire mandate with respect to society.

A mission statement should clearly and succinctly define an organization’s purpose for existence. If some Canadian medical schools do not explicitly include a clinical services/service to society role as part of their mission statement (instead of listing this as a desired outcome), could this structural omission impact their actions related to their social accountability agenda?
2.3.3 Medical Schools and Communities

A number of successful examples of medical schools integrating with communities to address health inequities and provide care for the underserved are discussed in the literature such as: The Area Health Education Centers involving 37 states and 55 medical schools in The United States (Butler, 1992); Parkland Memorial Hospital’s community oriented programs; New York’s Montefiore Medical Center drug treatment programs and community centers; The John Hopkins Health System urgicentres located in poor and largely minority communities (Foreman, 1994). In Canada, examples of such programs are The University of Ottawa “bus rounds” (service to individuals who are dying or in continuing care facilities) and The University of British Columbia interdisciplinary course to serve individuals with HIV infections or AIDS (Cappon & Watson, 1999). In terms of community based training of health professionals, The Dartmouth Medical School and The University of Minnesota programs expose medical students to the social, environmental and cultural influences which impact health (Foreman, 1994). Thailand also boasts a medical school which has developed, since 1978, a progressively more sophisticated community oriented/targeted curriculum which has received input from the community (Sirisup, 1999).

A new school in Northern Australia established a conceptual framework for the entire curriculum focused on rural/remote health and community orientation. Clinical learning takes place not only in large hospitals but in health facilities dispersed throughout the region with web-accessible Internet resources, a key element supporting this program (Hayes et al., 2003). Worley and Murray (2011) speak of the partnership between the Australian Federal government and medical schools, which has resulted in the establishment, in the last two decades, of undergraduate rural and remote medical education programs throughout Australia focused on the needs of rural/marginalized communities.

A required placement in an Aboriginal Community for all first year students at The Northern Ontario School of Medicine (NOSM) is an innovative social accountability initiative for this Canadian school founded with the mandate of social accountability (Tesson et al., 2009). Making The Links (MTL) is a program at The College of Medicine, University of Saskatchewan which exposes students to service-learning in remote marginalized communities. Working with community partners, students are exposed to three different settings: the northern experiences, the urban underserved experience, and an international experience (Meili, Fuller & Lydiate, 2011). Dharamsi et al. (2010) describe a pilot
international service-learning experience offered at The University of British Columbia (UBC). In their evaluation of this experience, students indicated a deeper appreciation of the vulnerabilities of marginalized groups as a result of this exposure.

### 2.3.4 Intake Policies

The intake policies influencing medical school student selection are an important factor when considering social responsiveness (Butler, 1992; Cappon & Watson, 1999; Faulkner & McCurdy, 2000; Kaufman, 1999; Freeman et al., 2007, Frenk et al., 2010; Lunn & Sanchez 2011). In fact, according Frenk et al. (2010) in *The Global Independent Commission Report*, criteria for admissions are indicative of institutional purpose. For example, merit based admission policies indicate the goal of recruiting the best and brightest in contrast with pro-active recruitment criteria of students based on rural, ethnic or social consideration which indicate an institutional goal of advancing health equity. Mitka (2009) in reviewing the 2009 *Joshua Macy Jr. Foundation Report, Revisiting the Medical School Mission at the Time of Expansion* notes that the aforementioned report recommends a more balanced set of admission criteria to create a more diverse student population while avoiding the issues related to affirmative action. Freeman et al. (2007) suggest that preadmission screening for medical schools might include a selection bias that would identify students with characteristics that will result in the likelihood that an applicant will care for the underserved after graduation. Sanson-Fisher et al. (2008) note that schools with a commitment to social equity should have clear selection policies and procedures which aim to increase the numbers of medical students from disadvantaged groups or communities.

According to Waitzkin (1989), medical education continues to produce physicians who come from upper middle class and upper income families. More than a decade later, Dhall et al. (2002) conducted an Internet survey of all students at Canadian universities, with the exception of Quebec, which was excluded for technical access reasons. Their findings were that Canadian medical students differ from the general Canadian population. Although there were more visible minorities in medical schools than the percentage in the Canadian population, Black and Aboriginal students were underrepresented whereas Chinese and South Asians were overrepresented. Students were less likely to come from rural areas and more likely to have a higher socioeconomic status compared to the general Canadian population based on their parent’s education, occupation and income. Freeman et al. (2007) report that sixty percent of medical students in medical schools in The United States come
from families in the top 20% of income. Carrasquilo and Lee (2008) report that despite 30 years of initiatives in The United States to increase physician diversity, the proportion of underrepresented minorities in medical schools remains in the 10–15% range. The report of The Association of American Medical Colleges entitled Medical Education Costs and Student Debt: A Working Group Report to The AAMC Governance (2005) states that: “for the past two decades, over 60% of medical students come from families with total incomes in the top quintile of all American families while only 20% of medical students are from families with incomes in the lowest three quintiles” (p. 3). Frenk et al. (2010) in Education of Health Professionals for the 21st Century, A Global Independent Commission, note that rising costs of medical education leaves graduating students with debts of about $200,000 dollars which can “hinder them from pursuing socially important but less lucrative careers” (p. 1939).

Cappon and Watson (1999) note that in Canada, a number of medical schools (Queen’s University, The University of British Columbia, McMaster University, Dalhousie University, University of Alberta, University of Manitoba, University of Western Ontario, and Memorial University) have adopted mechanisms to improve the representation of disenfranchised social groups in their student body. In New Mexico, promising secondary school students, representative of the community economic and ethnic background, are tracked, receive mentorship and field experiences to sustain their interest in health care. This affirmative action was being challenged at the time the article was published (Kaufman, 1999). A challenge of this nature should be interpreted as an overt indication of the desire to continue White dominance. Preferential admission policies for rural students from underserved areas have been adopted by one Health Sciences University in Nepal as part of their plan to respond to societal needs (Chapagain, Boelen, Heck & Koirala, 2000). Since the mid 1990’s, all medical schools in Australia are offered incentives to both recruit more rural students and orient curricula towards more rural health care issues, with one new medical school in Northern Australia having a specific focus on these issues (Hays et al., 2003). Strasser and Lanphear (2008) report that The Northern Ontario School of Medicine (NOSM) actively seeks to recruit students from the surrounding rural/remote, Aboriginal and Francophone communities. There is an Aboriginal subcommittee which makes recommendations for admission to the Aboriginal stream. This subcommittee reports to the admissions committee which has community representation including Francophone and Aboriginal representatives who participate in interview panels. NOSM has worked with The
Association of Faculties of Medicine of Canada to develop an Aboriginal admission tool kit available to all medical schools in Canada (Tesson et al., 2009). Cognizant of the high tuition costs of medical school, NOSM also works with communities across Northern Ontario to raise money for student bursaries, some of which are targeted for specific groups such as Francophone applicants.

Saha, Guiton, Wimmers, and Wilkerson (2008) studied a cohort of more than 20,000 United States medical school graduates and found that White students who attended medical schools with a less homogenous student body rated themselves as better prepared to deal with racially diverse patients and the needs of the underserved than students attending less racially diverse schools.

Higginbotham (2009) studied the experience of women of colour entering the field of law over a few decades. She notes that the practice of law is a public service as well as an occupation and notes that larger changes in the field impact who receives representation and the quality of that representation. A similar comment can be made regarding medicine which is also a public service and an occupation. Without increased diversification of the groups who obtain a medical education, the homogeneity of the medical profession can impact who receives health care and the kind of health care received. As Hobbs (1998) notes:

…if student, residents and faculty represented an ethnic, socioeconomic, gender, political and religious cross section of our society, then the environment would exist to allow a broader discussion of the health and welfare of all patients, regardless of background as a legitimate part of all patient evaluations and management (p.84).

2.3.5 Altruism and Idealism

Woollard (2006), a Canadian family physician who writes extensively on Social Responsibility suggests that there is unease from medical educators about the waning of the transmission of the fundamental values of healing and human concerns to technically competent practitioners. He and Foreman (1994) recommend that medical schools have programs to support the inclination of medical students to serve society. Woollard (2006) further notes that, in the Canadian experience, many initiatives focused on community engagement and marginalized populations are student initiated and driven. An example of this is IMAGINE (Interprofessional Medical and Allied Groups for Improving Neighborhood Environments) a University of Toronto student initiative to address health issues and foster partnerships in marginalized communities. It is a non-curricular, volunteer-based program
which was inaugurated in 2007 to create opportunities for social accountability, civic engagement and interprofessional experiences (Dugani & McGuire, 2011). The program has three pillars to address health needs: an afterhours health clinic, health promotion activities and community awareness. Eckenfels (1997) describes three programs which focus on social responsibility, one at Rush Medical College in Chicago and two others across The United States, which importantly, were all student initiated.

Becker, Greer, Hughes and Strauss (1961) in the classic study *Boys in White* noted that students don’t lose their idealistic long-range perspective but develop a cynical concern with the details of getting through medical school and their idealism is subordinated to their immediate situation. A few decades later, Peterdorf and Turner (1992) suggested that the structure and organization of medical education fosters a focus on grades and class standings which overtakes all other considerations including commitments to caring and altruism. Seaberg, Godwin and Perry (2000) state:

Students often begin their training with considerable empathy and altruism; however, they are taught in medical school to focus on more objective aspects of patient care; to cure and rule out disease. The emotional distance between doctor and patient becomes worse during residency. The isolation, long hours of service, chronic lack of sleep, fear of failure and constant exposure to tragedy serve to extinguish any empathy and altruism that may be left (p.1433).

Coulehan and Williams (2001) asked an outstanding applicant to medical school who had a profound and pronounced humanistic approach to reflect on her experience at the end of her undergraduate medical education. They used excerpts from her narrative to expose the process which happens to most medical students and may result in the loss of compassion and idealism. Although they acknowledge the student’s assessment of the “utter drain” of medical school, the long hours, and the “brutality” of the clinical years, their explanation for the loss of humanity focuses on the socialization process of medical school. They suggest that the inherent conflict between the explicit commitment to traditional values of medicine (empathy, compassion and altruism etc.) and the tacit socialization process with its commitment to detachment, self-interest and objectivity is the reason for the loss of compassion in some medical student during their education. The socialization of medical students to the culture of medicine and the “hidden curriculum” will be discussed further in chapter three.

Okie (2003) states: “medical students come into medicine because they are caring, compassionate people who want to help-it gets bred out of them by third year” (p. HE01).
O’Toole, Harvey, Switzer (2002) did a study to ascertain the influence of medical school on the attitudes of students towards under-serviced/vulnerable populations. They found that medical students were influenced by their medical education experience including the degree of community outreach and exposure to physician role models.

Crandall, Volk and Loemker (1993) conducted a study to investigate whether there was a change in attitudes to caring for indigent patients associated with years of training in medical school. They found that fourth year medical students were less favorably inclined to care for indigent patients than their first year counterparts. More than a decade later, Crandall, Reboussin, Michielutte, Anthony and Naughton (2007) conducted a longitudinal study spanning medical school education in schools using Problem Based Learning (PBL) versus the traditional curriculum to ascertain if different curricular models influenced the attitude of medical students towards the underserved populations. The study showed worsening attitudes towards marginalized people irrespective of curricular approach. They suggest further studies of a qualitative nature to ascertain what changes in medical school maintains, changes or improves medical students’ attitudes towards marginalized groups.

Woloschuck, Harasym and Temple (2004) note that attitudes influence behaviours and the attitude of medical students can impact on the quality of patient care. They studied a cohort of 3 consecutive classes from The Faculty of Medicine at The University of Calgary as they progressed through medical school. They found that positive student attitude scores towards social issues in medicine declined as they progressed through medical school although female students maintained a higher attitude. They suggest that the reasons for this loss may be related to loss of idealism and the impact of the hidden curriculum amongst others.

Hojat et al. (2004) studied the decline of empathy in medical school in The United States and with different co-authors; Hojat et al. (2009) did a longitudinal study of changes in empathy in four hundred and fifty-six U.S. medical students. Both studies found a significant decline in empathy occurred during the third year of medical school. They clearly defined empathy as a cognitive attribute (the ability to understand the patient’s experience and the capacity to communicate this understanding). They also note that this definition is important because cognition and understanding can be substantially enhanced by education. Based on these studies and a review of the literature, they suggest that the erosion of empathy can be attributed to many causes such as; lack of role models, high volume of material to learn, an intimidating educational environment, negative educational experiences, partial sleep
deprivation, fear of making mistakes, time pressures, and malpractice insurance. They also note that reliance on computer-based diagnostic and therapeutic technologies also clouds the vision of medical students as to the importance of human interactions. The importance given to physician detachment and the focus on the scientific/biomedical model also impact on this situation. They provide a number of suggestions for the curriculum to address this erosion of empathy.

Wear (1997) writes about the overwhelming amount of knowledge that must be imparted and retained and the competitiveness to achieve success as a major challenge for medical students. She writes that medical training: “promotes such fact grubbing and hyper competitiveness that the goals of caring for anything other than grades and class rank are lost in the medical school scramble” (p.1058).

Newton, Barber, Clardy, Cleveland and O’Sullivan (2008) administered a Balanced Emotional Empathy Scale at the beginning of each academic year at The University of Arkansas to four entering medical student classes. Their findings indicated a loss of what they termed vicarious empathy (a visceral response) which they attributed to the medical education process. Stratton, Saunders and Elam (2008) studied changes in emotional intelligence and empathy and found that for many students, the challenges of balancing personal happiness and professional training can be overwhelming. Furthermore, they suggest that physician attributes deemed important by society are not reinforced in medical education. Spencer (2004) refers to this waning of idealism as the pre-cynical and cynical period. Brazeau, Schroeder, Rovi and Boyd (2011) conducted a study of graduating medical students from four classes and found that mean empathy scores were higher for students who participated in service activities compared to those who did not.

Wen, Greysen, Keszthelyi, Bracero and de Roos (2011) suggest that the strong ideals that students have when entering medical school must be fostered such that education moves students to be change agents to address the health care needs of marginalized populations.

It is of concern that in almost all of the studies quoted above, the dramatic decline in empathy occurs during the first clinical year when students are initially involved with patients. It would seem that this phenomenon requires critical attention. A more detailed discussion of the role of the hidden curriculum and the socialization of medical students to the culture of medicine and the impact of these intertwined processes will take place in Chapter 3.
2.3.6 Faculty

Developing a faculty dedicated to pursuing a social responsibility agenda is vital and may involve: developing innovative linkages between the academic centre and the community to encourage research questions; educational opportunities in the scholarly community; and an increase in structures that assure prestige and stature for those involved in this agenda (Butler, 1992; Foreman, 1994; Hennen, 1997; Faulkner & McCurdy, 2000; Woollard, 2006; Sanson-Fisher et al., 2008; Lunn & Sanchez, 2011). Faulkner and McCurdy (2000) also suggest that Faculty development programs may also be needed.

At NOSM, hiring Faculty with a social responsibility outlook is very important and a specific question which probes for this attribute is part of the standard interview questions. The question is:

The Northern Ontario School of Medicine was created in part to address the needs and interests of the people of Northern Ontario. How would you define socially accountable education and to what degree do you believe it is relevant to a career at the School (Tesson et al., 2009)?

Woollard (2006) and Lunn and Danchez (2011) recommend changing the recognition and reward systems to link these to a new definition of scholarship which incorporates solving pressing social and ethical problems. Many recommend that health service research should be encouraged (Foreman, 1994; Peabody, 1999; Ayers et al., 1999; Cappon & Watson, 1999). In Canada, according to some of the literature, research in population health, and specifically Aboriginal people’s health, as complementary to biomedicine is being promoted (Hennen, 1997; Gadon & Glasser, 2006). This type of research is of particular interest to NOSM. However, to date, there is no evidence that health care inequities have been positively impacted by this research.

The profound impact of Faculty as role models of social responsibility and the need for Faculty Development and commitment to this concept will be discussed in chapter five.

2.3.7 Between the Idea and the Reality: Social Responsibility and Accountability of Medical Schools

From the above, it is clear that medical schools do have a social responsibility to their communities, and, that, across the world, medical schools are struggling to address this mission. Some are being proactive, joining with other constituents in shaping a more socially
accountable and equitable health system, and see the education of physicians as a vital piece of the solution to societal health inequities (Cappon & Watson, 1999; Boelen, 1999).

However, Palsdottir, Neusy and Reed (2008) note that since the Alma Ata Declaration committing to health care for all by the year 2000, only scattered efforts to establish social responsibility in medical education in pursuit of that goal have been undertaken and health disparities continue to grow throughout the world. Their study found no systematic international evaluation of socially accountable medical schools and, further, that current tools to measure social responsibility require more rigour. The authors also note that unfortunately, few schools have taken up the call of The WHO to develop specific indicators and benchmarks and to evaluate progress towards social responsibility using the grid described in the Boelen and Heck 1995 article. Through their study they identified eight medical education programs throughout the world, one of which is Canada’s Northern Ontario School of Medicine (NOSM), whose mission statements clearly state their purpose of training socially responsible physicians to deal with marginalized populations. These eight schools seek input from their communities and key stakeholders to determine their educational methodologies and curriculum content. These eight schools are now cooperating to develop a common evaluation framework to measure the performance and impact of their programs on marginalized communities.

As Whitcomb (2003) notes in an editorial for the prominent Academic Medicine Journal:

…medical schools face major challenges in designing educational experiences to help students learn how to develop effective relationships with patients who differ from them racially, ethnically and in other ways. The magnitude of the challenge relates primarily to the fact that is not yet clear how best to teach students how to begin to acquire the knowledge, skills and attitudes to accomplish this (p. 547).

The preceding pages indicate the complexity of the issue and how merely changing curricula is inadequate and embracing a social responsibility mandate will require revolutionary changes to medical education. Despite good intentions, social responsibility, a long standing commitment in medicine, from the time of Hippocrates, supported by Flexner in 1910, central to The Educating Future Physicians for Ontario project in 1992, re-affirmed by The World Health Organization (WHO) in 1995, Health Canada in 2001, the CanMEDS project in 1996 and 2005, The Association of Faculties of Medicine of Canada in 2009, and The Global Independent Commission report in 2010, is still not a foundational value in medical
school. However, recently, the literature on social responsibility and social accountability seems to be more profuse and the call to address this agenda more urgent. For example, the August 2011 issue of *Medical Teacher*, another prominent medical education journal, was devoted to this topic. Gibbs (2011) comments that the articles in this special issue on social responsibility do not hold the final answer but sees them as part of the discussion and reflection needed to advance social responsibility. This statement is a very strong indicator of the progress (or lack thereof) of the social responsibility and social accountability agendas when one reflects on the centuries of commitment, on paper, to this idea.

Many writers, led principally by Boelen and Woollard (2009, 2011), have moved from the concept of social responsibility to the higher order concept of social accountability. The definitions remain the same as when these two concepts were introduced in 1995. However, Bolen and Woollard now enlarge on these concepts and infer an incremental process as follows:

…a socially responsible school might offer courses in public health and epidemiology related to the determinants of poverty and disparity in health but offer limited exposure to real life situation in the field. A socially responsive school would move beyond this point and engage students in community-based activities throughout its curriculum, assess their competence to care for the most vulnerable people and encourage graduates to settle in underserved areas……In case of a socially accountable school, “social needs” are an integral part of the managerial loop: the school participates in needs identification, justifies action programmes accordingly and verifies whether anticipated outcomes and results have been attained in satisfying social needs via their graduates (p.616).

In their 2009 article, Boelen and Woollard state: “Social accountability requires that the actions of a medical school begin and be grounded in the identification of societal needs. The meeting of those needs is the desired end” (p. 890). They emphasize that measurement tools such as the social accountability grid previously discussed are core to success in this area. They urge accreditation systems to adapt standards that incorporate social accountability.

In 2006, Woollard reported that only Canada has explicitly incorporated a social accountability framework into its accreditation standards. Lingren and Karle (2011) suggest that social accountability of medical schools must be included in all accreditation processes at every level. Sanson-Fischer et al. (2008) state the undergraduate medical education curriculum should be seen to contribute to decreasing health inequity through a number of mechanisms including working with disadvantaged groups. Faculties/Schools of Medicine should be measured on the achievement of that goal.
It is obvious from the above that although most medical schools internationally and all medical schools in Canada espouse the principles of social responsibility and accountability, the reality falls short of the anticipated intention.

The concern with the ongoing discourse on social accountability and responsibility is that it may give the appearance of advancement while masking the truth of the shortfall between the idea and the reality. While all medical schools can argue that they meet some of their responsibilities to society by producing physicians as well as research which is beneficial to society, it appears that few, if any, can show that they actually meet the needs of the marginalized in that same society or that they produce socially responsible physicians.

2.4 The CanMEDS Health Advocate Competency

My interest in the Health Advocate Competency lies in the fact that this Competency and social responsibility have similar outcome goals, suggesting that health advocacy is an approach which can operationalize social responsibility. The Association of Faculties of Medicine of Canada have incorporated the following quote from Boelen and Heck (1995) in their 2009 report: “…direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or the nation they have a mandate to serve” (p. 3).

The Health Advocate Competency states that: “…physicians responsibly use their expertise and influence to advance the health and well-being of individuals, patients, communities and populations (Frank, 2005).” Presumably, a school which prepares its graduates to be health advocates has actualized its social responsibility mandate.

As previously described, while exploring the literature for potential solutions to health inequities, The Royal College of Physicians and Surgeons of Canada (RCPSC) CanMEDS Health Advocate Competency came to the forefront. This Competency is one of seven RCPSC CanMEDS Competencies (called roles in the first iteration) deemed necessary for all Canadian specialty physicians-in-training (Frank, 2005). These Competencies are also integral to The RCPSC maintenance of certification programs for specialists in practice. Health advocacy is also incorporated in The 4 Principles of Family Medicine of The Canadian College of Family Physicians (College of Family Physicians of Canada, 1993). Within the 4 Principles there are statements that physicians are seen as advocates for their patients including advocating for public policy which promotes their patients’ health. The 4
Principles apply to all family physicians in-training and are considered essential for family physicians in practice.

The discourse of health advocacy in medicine could be argued to have started in 400 BC at the time of Hippocrates who discussed the notion of beneficence and altruism. In this more recent re-emergence, the discourse is only a few decades old and a discussion about how it operates as a discourse in Canadian medicine and American medicine follows.

2.4.1 Background Information: Canada

The term health advocate first formally emerged in the lexicon of Canadian medicine in May 1992 through a brochure entitled “Summary: What people of Ontario Need and Expect from Physicians,” published by The Educating Future Physicians for Ontario (EFPO) project (EFPO Interim Report, 1992). The goal of this project, launched in 1990, was: “…to modify the character of medical education in Ontario to make it more responsive to the evolving needs of Ontario society” (Neufeld et al., 1998, p. 1136).

The result of this project was the development of 8 roles which were seen as the expectations expressed by the public and supported by the literature regarding the anticipated roles of physicians. The role description of health advocate was described as follows: the health advocate is aware of all determinants of health and how to promote healthy public policy. The educational implications of this role were: educate students about the determinants of health, cost-effectiveness of public interventions, how policy decisions are made, and how physicians can contribute. Encourage students to take direct advocacy responsibility for some public health issues. (Neufeld et al., 1998).

Sometime after EFPO was inaugurated in the late 80’s and early 90’s, at the national level, The College of Family Physicians of Canada (CFPC) and The Royal College of Physicians and Surgeons of Canada (RCPSC) were engaging in their own review of their educational processes. As a result of these reviews, both licensing bodies, responsible for all physicians training in Canada, incorporated the Health Advocate role originally developed by EFPO into their essential physician competency framework. For The CFPC, health advocacy is implicit in three out of the four principles which form the competency framework for all family physicians. Under one of the principles listed on their website, it is explicitly stated that: “Family physicians have the responsibility to advocate public policy that promotes their patient’s health” (http://www.cfpc.ca/principles).
In 1996, after completing their review, The Royal College of Physicians and Surgeons of Canada adopted a framework of core competencies for all specialty training entitled the CanMEDS roles. Seven roles were described, one of which was the Health Advocate role. A decade later these roles were reviewed, revised and revalidated and a new edition of the CanMEDS roles (which now referred to roles as competencies), was released as CanMEDS 2005 (Frank, 2005). According to the preface in their 2005 framework document The RCPSC is “…committed to meeting the needs of society”. In this latest iteration, the role/competency of the Health Advocate is described as follows: As health advocates, physicians responsibly use their expertise and influence to advance the health and wellbeing of individual patients, communities and populations. The key competencies of the role are:

- respond to individual patient health needs and issues as part of patient care;
- respond to the health needs of the communities that they serve;
- identify the determinants of health of the population that they serve;
- promote the health of individual patients, communities and populations. (Frank, 2005)

The Medical Council of Canada (MCC) oversees the licensing examinations for all medical school graduates in Canada and their Objectives for the Qualifying Examination clearly spells out the necessary attributes of competent medical school graduates. In 2009, these objectives were reviewed by The MCC and revised based on the CanMEDS competencies. The Health Advocate rationale and objectives are defined as follows:

Rationale:

Physicians have a role in disease prevention and in protecting and promoting, through advocacy, the health of the individual patient, communities and populations. The physician may advocate individually, or collectively. Advocacy can influence patient care, public health and health policy. To achieve this goal, physicians need to understand the determinants of health, principles of health system organizations, and their economic and legislative foundations.

Acting in the patient’s best interest, physicians are obliged to make appropriate health care available to their patients in a fair and equitable manner (distributed justice). There is a growing number of effective treatments, an increasing array of expensive technologies, but only finite health care resources. This means that physicians may have to make decisions based on ethical principles as patients’ interests are balanced.

Objectives:

1. Identify the important determinants of health, the risk factors for illness, the interaction between the population and their physical, biological and social determinants and personal attributers including:
Employment
Income
Social status
Culture
Social support systems
Education
Housing
Diet and exercise
Lifestyle issues
Gender
Genetics

1.1 Access and respond to the specific determinants of health relevant to the individual, the community, and/or the population.

1.2 Identify, respond to, and resolve conflicts between ethical, legal and professional issues, including economic constraints and commercialization of health care and scientific advances.

1.2.1 Identify and propose fair means of resolving issues within their context of available resources (www.mcc.ca, accessed November 2010).

The Canadian Medical Association (CMA) in its code of ethics (2004) focuses on the core activities of medicine which it states in the following order are: health promotion, advocacy, disease prevention, diagnosis, treatment, rehabilitation, palliation, education and research. The order of the activities listed suggests a focus/prioritization of health advocacy as both health promotion and disease prevention are part of health advocacy. Diagnostics and treatment are intrinsic to medicine’s function and power through the special knowledge required to practice the profession of medicine.

A number of medical schools in Canada have framed their medical school objectives at both the undergraduate and postgraduate level using the CanMEDS Competencies and The Four Principles of Family Medicine, both of which include health advocacy.

It is clear from the preceding that the major organizations influencing Canadian medicine appear to view health advocacy as an important role for physicians to discharge. It is also interesting to note that the definition itself of the competency acknowledges the power of medicine as it states “…physicians use their expertise and influence…. And yet, almost two decades after the introduction of the original Health Advocacy Competence, Beiser and Stewart (2005) note that health care disparities are a pressing national concern. The Health Advocate Competency, if fully embraced, could be an important contribution to meeting the health inequities challenge.

Yet it has much potential, since it is a Competency that is required for all Canadian physicians in training at both the undergraduate and postgraduate level. It is also integral to
the maintenance of certification programs for all Canadian physicians in practice. When compared to the ‘cultural competency’ programs proposed in The United States as a mechanism to address health inequities, the Health Advocate Competency has many advantages. The Competency does not focus on ‘others’ but on the physician as the individual with the expertise (and the responsibility) to improve the health of the individual patient, community and population. The Competency does not infer that the root cause of problems is lack of information about the ‘others’ nor does it set up a dualistic position or perpetuate stereotyping as is the potential in ‘cultural competency’ programs. The Health Advocate Competency presents the possibility of a systemic approach to health inequities, spearheaded by physicians, a body of people who have held positions of power, prestige and privilege for more than a century. Baum (2007) notes that a powerful influence on a government’s desire to be socially just is pressure from the economically higher gradient members of society and physicians are a significant component of this potential lobby group.

To understand the professional discourse on the physician health advocate, a literature review was undertaken using the terms “physician,” “advocate,” “advocacy,” and “health” in various combinations, and a number of search engines were used including Pub Med, Ovid Medline, Web of Science, and Scholars Portal. To supplement the sparse findings from the initial searches, the references gleaned from these articles were also reviewed and substantially added to the literature review. Although the review was methodical, it cannot be considered exhaustive for two reasons. First, one of the early findings in the literature review was that the term “advocacy” is not necessarily used, especially in The United States, to describe activities undertaken by physicians which would fit the health advocate role description. Other terms include “social medicine,” “social accountability,” “community responsiveness,” “social responsibility,” “health activism,” “public roles,” etc. Secondly, a significant component of the health advocate role is “health promotion.” This literature review did not include a search using the term health promotion which is understood at the individual level and well ensconced in the medical literature. The review also focused on physicians and, therefore, does not include advocacy literature from other healthcare professions such as nursing, nor does it include literature about consumer advocacy or physician assistants who function as patient advocates, both of which are discussed in the American literature.

Although no limitations were placed in terms of countries, all but three of the relevant articles gleaned were either Canadian or American publications. Therefore, this literature
The literature review which follows is presented to increase understanding of how the term operates as a discourse in Canadian and American medicine.

2.4.2 Defining the Physician Health Advocate in the Canadian Literature

Although the CanMEDS Health Advocate Competency has a specific definition and key competencies, there appears to be a struggle to further define/clarify this role and the articles which follow illustrate this point.

Oandasan and Barker (2003) conducted a case study on eight community responsive physicians to identify characteristics of these physicians in order to provide an operational definition to inform the development of an advocacy curriculum. They found that the major way in which these physicians were responsive was by undertaking advocacy work on behalf of their communities. The authors speak of the difficulties of defining and thus teaching the physician advocate competency and further note the paucity of information in the literature on this subject.

Bandiera (2003) writes about a curriculum developed for emergency medicine residents on the role of health advocate. He references Health Canada as well as The Ottawa Charter to develop his 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” (p. 337). He further notes that: “…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” (p. 337). He then gives examples of health advocacy activities at the individual level (smoking cessation); on a general population level (lobbying for stricter tobacco advertising legislation); and at the organizational level (public education to decrease trauma deaths in the community). A curriculum on the health advocate role for residents in emergency medicine is important as it highlights that even in the brief interactions in an emergency visit, there is a place for advocacy.

Oandasan (2005) writes that there are many interpretations of the meaning of advocacy and proposes an “operational definition” to assist in teaching this role. She wants to create an “…integrated understanding of health advocacy” which she suggests will help
avoid dichotomous thinking about the role. She states that “advocacy is an activity that one does” and further it is “…leveraging physicians’ societal power in order to speak for individuals who are not heard or are silenced” (p.S40). She references The Ottawa Charter to help with her definition for health advocacy which is:

Purposive action by health professionals to address determinants of health which negatively impact individuals or communities by either informing those who can enact change or by initiating, mobilizing and organizing activities to make change happen, with or on behalf of the individuals or communities with whom health professionals work (p. s41).

Oandasan (2005) stresses being evidence-based when advocating for a cause and urges that the voice of physicians advocating for patients never be stifled.

I really like the definition of The Ottawa Charter about health advocacy because it is action oriented (purposive action), and provides a range of choices from the more passive (informing those who can enact change) to the more assertive (initiating, mobilizing and organizing activities to make change happen) and even incorporates team work.

Herbert (2005) notes that providing responsible advocacy at the individual and population level is clearly a responsibility for all Canadian physicians. She quotes The CFPC Declaration of Commitment from 2004 which states:

…we are a resource to our practice populations---promoting health to prevent illness, providing and explaining health information, collaborating with and facilitating access to other caregivers, and advocating for patients throughout the healthcare system (p. 578).

### 2.4.3 Physician Advocacy and Political Activities in Canada

Some authors are very explicit about the need to lobby government and policy makers as part of the advocacy agenda. For example, Senn (1988), the earliest writer identified in the literature using the term advocacy, discusses the increasing demands on the Canadian healthcare system and the complex issues in health policy formation and resource allocation. He argues that because physicians are constantly faced with making decisions in the best interest of their patients, in times of uncertainty and ambiguity, the “good” (read competent) physician is more than qualified “to act effectively in health policy formulation as an advocate for all patients (considered as a social group)” (p. 2). He cites a number of objectors to this involvement who argue that physicians have too personal or role related interests to qualify them to work in health policy formulation. He counters these objections by saying that physicians, because of their patient care work, bring “compassionate objectivity” to
healthcare policy discussions. This allows them to “represent the interests of all in an objective way in matters of resource allocation and policy formulations” (p.4). Physicians are thus a valuable source of health knowledge, experience and advocacy for all patients.

Morris and Butler-Jones (1991) discuss community physician advocacy as an essential factor in addressing community health issues. They give a few examples of successful advocacy projects such as physicians taking the lead, along with pharmacists, to address the illnesses and deaths of children caused by poisoning. Their lobbying efforts resulted in the adoption of child resistant medication containers. Another example involves an orthopedic surgeon who became frustrated dealing with victims from multilane highway accidents. He successfully lobbied for a barrier between lane directions which, when constructed, immediately reduced the accident toll in the area. And, finally, a radiologist spearheaded all aspects of a successful campaign to build a detoxification center in his community. The authors recommend that physicians examine their areas of specific interest and act on health issues in their community to have a positive health impact.

Spears (1996) discusses the actions of some physicians practicing in Northern Ontario who have advocated reducing the high trauma rate in their communities. One of these physicians was featured in advocacy mode using a local newspaper to write an open letter to The Crown Attorney’s Office expressing his concern about a court challenge to The Snowmobile Trail Officer Patrol (STOP) program. This is a program which conducts spot checks, on snowmobile drivers, for drinking and driving. This physician, along with other physicians, has been successful in working with local snowmobile clubs to inform them about the impact of speed as well as drinking and driving. Their efforts have resulted in fewer accidents.

Mackie and Oickle (1997) note that physicians are seen as community leaders in matters of health. Because of this, the role of physicians does not end in the office but extends to the community. They suggest that physicians should be part of community leadership to advocate policy and program changes to incorporate Comprehensive School Health Programs in their community. These programs, which deal with issues such as tobacco, drug use and sexuality, are designed to not only impact the health behaviour of individual students but also their community. They provide an example of a smoking cessation program in the Comprehensive School Health Program outlining the program and how physicians can participate in it.
Herbert (2000) writes that, although advocacy is implied in the principles of Family Medicine, she suggests it should be explicitly stated as follows: “The family physician must be an advocate for fairness and equity in healthcare and for responsible choice” (p. 2442). She further states that family physicians must become more political and involved in all aspects of healthcare in its broadest sense – from smoking issues, to nuclear waste, to seat belt legislation, gun control and clean water. Family physicians must also defend the underdog, and support a health research agenda which promote equitable health.

Bandiera (2003), in addition to providing a definition of the physician advocate in the previous section, also encourages physicians to politically lobby institutions, social organizations and various levels of policy makers and the Canadian public as part of their health advocacy activities.

A Canadian Medical Association Journal editorial (2005) discusses a recent situation in the media where a physician was admonished for alerting the media about a significant issue in a hospital. In doing so, the physician breached the media policy of that institution. The editorial suggested that physicians in these situations must weigh the responsibility to their institutions against their Hippocratic duties to patients and the public. It goes on to say that the public expects physicians to advocate for individual and collective wellbeing and that the trust extends beyond the patient to research, education and patient care.

Baerlocher and Asch (2006) discuss the positive health advocate role that interventional radiology can have on public health. They write that the incidence of a particular complaint or disease might suggest the need for a screening program. They mention, as an example of this, a US program started by The Society of Interventional Radiologist (SIR) called “Legs for Life” which screens for peripheral artery disease, abdominal aortic aneurysm, carotid disease, stroke and venous disease. They further suggest that health advocacy should not be limited to issues like screening programs but could also include lobbying government through professional organizations (SIR or The Canadian Interventional Radiology Society CIRS). This lobbying would address issues such as increased access to interventional radiology procedures, healthcare coverage for new procedures and funding for screening programs.

Link and Issenman (2007) discuss The Canadian Paediatric Society (CPS) advocacy work. The group has developed an advocacy tool kit to help members lobbying governments, politicians and bureaucrats. The CPS has also developed a biannual report card rating governments (provincial and federal) on health measures for children and youth. The poorer
results are used to encourage legislative changes. Link and Issenman suggest that, in addition to supporting these CPS initiatives, individual pediatricians can contribute to *The CPS Foundation* which supports worthy initiatives. They also note that, politicians often remind *The CPS Advocacy Committee* that pediatricians occupy a unique trust role. Therefore, the authors suggest that pediatricians donate time and their influence lobbying government to promote public policies that reduce poverty. A case in point is *The Paediatric Child Health Journal* which devoted the October 2007 issues of its journal to poverty and its impact on child health. In the editorial by Guyda and Williams for this specific journal issue, they note that despite our economic wealth as a nation, Canada is ranked by *UNICEF* as 19 out of 26 *Organizations for Economic Cooperation and Development* countries in terms of percentage of children living in relative poverty. They suggest that colleagues continue to lobby/advocate all levels of government to address this issue.

It is apparent that the role of health advocate is strongly supported in the few Canadian articles about this role. Only one article, Ogle (1997), expresses concern about the “blanket adoption” of this role and proposes a more contextual and individualized approach. He is concerned that the advocacy role is poorly defined and it is unclear if patients want their doctors to be advocates and whether they are entitled to advocacy services. He continues to say that physicians are trained in science and work in a scientific environment. The appropriateness of the advocacy role is subject to changing social concepts of health care and, further, that the external perception of need is not enough reason to embark on advocacy. Other than this concern, all other Canadian publications promote the idea that advocacy requires the physicians to engage in activities beyond the office. Each author implicitly or explicitly also acknowledges the need to enhance the health of the individual patient through enhancing the health of the communities in which they live.

### 2.4.4 Teaching Health Advocacy in the Canadian Literature

Given the profile of the *CanMEDS* roles/Competencies, it is surprising that there is so little in the Canadian literature on curriculum design for the Health Advocate Competency. Oandasan and Barker (2003) speak of the difficulties in defining and thus teaching the physician advocate role and the scarcity of information in the medical literature about the role. Their study identified characteristics of physician community advocates which can be used to plan educational strategies to teach this role. These characteristics include awareness of issues of power and privilege; awareness of the determinants of health, exposure to
marginalized groups, and motivation to do the right thing. They suggest that medical students should be exposed to marginalized populations and that medical schools should tangibly profile advocacy as an important educational domain. They further suggest that medical schools should create a clear link between existing areas of study (determinants of health, medical ethics, and community electives) and the knowledge, skills and attitudes essential to be a community advocate. And finally, they note that there should be a continuum of these activities from undergraduate, through postgraduate education and into practice.

Bandiera (2003) addresses the issue of developing curriculum for emergency medicine residents in their role as health advocates. He notes that although an ER environment may not seem ideal for health advocacy activities, it lends itself well to specific activities of this nature which have been validated as effective. These health advocacy activities include smoking cessation counseling, vaccination, and alcohol abuse interventions. A selected example of the curriculum content is provided. It is important to note that the examples used in the curriculum came from the residents themselves. Relevant examples and personal reflections are key elements of this program which has been well received by the residents.

Pottie and Hostland (2007) write that there is a need to attract and train medical students and physicians to work with and advocate for under-serviced and marginalized populations. They focus on one such group, refugees, and propose an educational program to meet the needs of this group. Specific objectives of this educational program included “appreciate the value of advocacy for vulnerable populations” (p. 1923). The health advocacy activities focused on facilitating communication, providing information, and access to primary healthcare and exchanging knowledge. The program, which took place at a government shelter, met the needs of all three target groups: the refugees, health professionals and medical students. Many students reported that this program was the first time in medical school that they felt they actually made a difference in someone’s life. Families who participated in the program were more interested in preventive services and more trusting of physicians.

Tuhan (2003) provides a psychiatry resident perspective on teaching the CanMEDS roles. Regarding the health advocate role, she suggests working with community agencies which can help highlight issues in the community which can inform advocacy needs. Awareness of structures of governance, legal, economic and societal perspectives on mental illness can also help inform about deficits which would benefit from advocacy activities.
Borgaonkar, Pace and Jeon (2007) found that writing an essay on health advocacy improved knowledge about this CanMEDS role as measured by an Observed Structured Clinical Exam (OSCE).

Frank and Langer (2003) discuss the teaching of the CanMEDS roles to surgeons. They explain how these roles were developed to meet the needs of society and that by the end of 2003, all the specialties and subspecialties in Canada will have rewritten their core educational objectives and evaluations to reflect these Competencies. Excerpts from the final in training evaluation report for pediatric general surgery are provided. They note that implementation of these roles has been flexible so that each national specialty committee can decide what emphasis to place on the specific core competencies. This in itself can be problematic as it infers that some Competencies/roles can be prioritized at the expense of others. It is also tacit acknowledgment of a hierarchy of knowledge as the only Competency deemed essential is that of the Medical Expert Competency which is considered “central and integrative” (Frank, 2005, p.7). Further, the Medical Expert Competency is considered central as it is the “role which most distinguishes physicians from other professionals” (Frank, 2005, p.7).

Given the intent that these CanMEDS Competencies should be part of the core educational goals of all specialties in Canada, it is important to evaluate how this implementation is proceeding throughout Canada. A few surveys provide a glimpse into the challenges of teaching the Health Advocate Competency. Verma, Flynn and Seguin (2005) quote a 2001 RCPSC survey where faculty reported that the two most difficult roles to teach and evaluate where those of manager and health advocate. Additionally, their Medline search of the literature found no studies discussing health advocate residency curriculum and very little literature on the physician’s role as health advocate. These authors also studied faculty and residents at Queen’s University in Kingston Ontario, Canada, with respect to their understanding of the health advocate role. Their study consisted of four focus groups, two faculty (n=14) and two residents (n=15). Study results revealed that most participants in both groups were not familiar with The RCPSC health advocate role and thought the definition of health advocate required clarification. Faculty were concerned that there was no curricula or defined objectives for teaching advocacy. Resident participants could not delineate the boundaries of the roles. Teaching, learning and evaluation of the health advocate role was reported by both participant groups to be a challenge. Some participants also saw a conflict between the advocate and manager role.
It is interesting to note that this perceived conflict between being the patient’s advocate and healthcare system costs is discussed in this literature review by many American authors dealing with HMOs and managed care.

Participants in the Verma et al. (2005) study did acknowledge that the health advocate role involved going beyond the care of the individual patient into communities and society at large. However, both Faculty and residents thought this role had low value relative to other CanMEDS roles and considered advocacy as charity work and therefore, not much valued. The study also found a disconnect between the faculty’s perception that advocacy was part of their daily work, and residents lack of awareness of advocacy behaviors in their preceptors. The study authors saw this difference in perspective as an indicator that role modeling for this competency was effective only if combined with a specific curriculum.

Walsh et al. (2006) reported on a pilot study conducted with 151 final year residents of eight residency programs to assess resident perceptions and preparedness in the CanMEDS roles. Program Directors were also surveyed. Residents were asked to rate each of the 7 roles under the headings of:

- Understanding
- Preparedness
- Importance for practicing physicians
- Importance as an objective of residency education.

Fifty-two percent of residents (n=78) and eighty-six percent of program directors (n=6) participated in the survey. The results indicated that the perceived preparedness of residents was the lowest for the manager, scholar and health advocate roles. In terms of the health advocate role, although residents acknowledged that this was an important role, a significant number did not feel prepared in terms of the specific competencies of this role. They felt the least prepared in two of the four health advocate competencies:

- knowing how to contribute effectively to improving health in their communities and also
- how to recognize and respond to issues where advocacy is appropriate.

Residents reported that staff physicians were the most important group to act as teachers of this role (75.6%) and the next most important teacher group were patients/families (34.6%). The preferred venue for learning about the health advocate role was in the clinical environment (48.7%) followed by observation/role modeling (44.9%).
Program Directors felt that the health advocate role was very important but acknowledged that residents might not be prepared in this role at the end of their residency. Six of the eight Program Directors noted that this was the hardest role to teach.

There is an interesting contrast between the findings of Verma et al. (2005) regarding role modeling as a teaching strategy and the expressed desires of the residents in the survey conducted one year later by Walsh et al. (2006). As noted above, in the Walsh et al. (2006) survey, residents stated role modeling was their second choice of an acceptable teaching strategy for this competency. However, the Verma et al. study (2005) reported that according to their study participants, role modeling was not an effective strategy unless accompanied by a specific curriculum.

Freiman, Natsheh, Barankin and Shear (2006) did a survey of dermatology residents in Canada (n=48) to evaluate the effectiveness of the implementation of the CanMEDS roles. The participants believed that the roles were taught adequately in varying percents. For example, in their opinion, the medical expert role was taught adequately 78% of the time whereas the health advocate and scholar roles were taught adequately 48% of the time. The manager role was the least well taught at 28%. They conclude that the challenge is to develop new teaching and evaluation methods to ensure that trainees acquire the knowledge, skills and attributes required by their specialty within the framework of all the CanMEDS Competencies.

Bandiera and Lendrum (2008) did a study to evaluate whether daily encounter cards could address the limitations of the existing feedback mechanisms within an emergency department with respect to the seven CanMEDS roles. Results showed that teachers selected an average of 3 CanMEDS roles per daily encounter card to discuss with the residents. The overall frequency with which each CanMEDS Competency was selected for trainee evaluation ranged from 85% for the Medical Expert to a low of 25% for the health advocate role.

Flynn and Verma (2008) followed up their 2005 research about the Health Advocate Competency with a new study whose purpose was to develop a curricular framework for training residents in health advocacy. Modeling a Delphi technique they involved a panel of health care providers and faculty experts to develop six attributes of a health advocate along with means to teach these attributes. The attributes identified through this process were: knowledgeable (about the determinants of health), altruistic, honest, assertive, resourceful and up-to-date. Desirable and undesirable behaviours related to each of these attributes were
also identified. They suggested that teaching should be based on established objectives and clear expectations combined with role modeling. Evaluation should include both formative and summative components and all members of the health care team should contribute to the assessment. The program was organized to support skill development in a graded fashion throughout training from advocating for an individual to advocating for society.

Dharamasi et al. (2010) in their phenomenological study of international service learning note that medicine has a responsibility to society and the Health Advocate Competency is an effective tool to meet that responsibility. However, they note: “What is lacking is a clear sense of how the health advocate role can be effectively integrated into medical curricula: taught, learned, and evaluated” (p. 978).

In another article, Dharamasi et al. (2011) re-iterate the difficulty of teaching and evaluating the Health Advocate Competency. They suggest that advocacy is linked to social responsibility and should be integrated into medical curricula and accreditation standards. Medical students need to be in a community of practice and the recent inclusion of service-learning opportunities in medical schools is a good first step in that direction. The authors further suggest that it is important for preceptors to model the behavior they wish to see in future physicians.

Gill and Gill (2011) note that several American schools have incorporated health advocacy in their curricula but Canadian schools have been lagging behind. They go on to describe a University of Alberta and a University of Calgary two day course focused on a Political Action Day whose purpose is to engage students in advocacy and educate them about how to influence policy development. They found that there are vast opportunities for medical students to engage and learn about political advocacy.

In my own study with colleagues, (Girard-Pearlman Banack et al., 2011) we reported on a successful model for teaching health advocacy and social responsibility based on 16 years of experience at The University of Toronto Faculty of Medicine. The model was derived from a course entitled Ambulatory/Community Experience (ACE) and had three elements: 1- vetted ambulatory/community placements; 2- individual pedagogical approaches and 3- narrative/reflective assignments. All final year medical students (range over 16 years from 165/year to 224/year) were assigned to an ACE experience which was considered core curriculum.

To vet the ambulatory/community placements used, preceptors completed an application based on the ACE learning objectives to ensure that they were aware of the
fundamentals of their commitment prior to taking on an ACE student. The individual pedagogical approaches consisted of two elements. The first was a dynamic individualized curriculum the result of a distributed medical education program with over 100 ACE placements. Secondly, both students and preceptors signed a learning agreement based on the 5 ACE learning objectives which allowed guided customization under each objective to meet student needs and site conditions. Additionally, two of the objectives clearly listed health advocate activities and objective #5 unmistakably addressed social responsibility (develop an awareness of the physician’s social responsibility with respect to the environment and community issues which impact on health care). The last element of the model was the narrative/reflective assignments in which students had to analyze the Determinants of Health in the community of their ACE placements, and present a case write-up clearly explaining how the 5 learning objectives could be applied in everyday medical practice. In the analysis of the narrative/reflective paper, the Health Advocate Competency deemed in the literature to be difficult to define, understand, recognize and teach was well described by students. Ninety-three percent (93%) of students in community placements (community, rural settings) commented on health advocate activities they witnessed, participated in, or identified as part of their future. In ambulatory settings (ambulatory clinics in partially or fully affiliated teaching hospitals), this percent dropped to seventy-three percent (73%). The paper provided multiple quotes which were thematically presented as evidence of the understanding and internalizing of health advocacy by these final year medical students. To summarize the model, it suggests that the social responsibility mandate of the undergraduate medical curriculum is addressed through ACE where students are immersed in ambulatory/community placements having customized their individual learning agreements based on the ACE learning objectives as they reflect in their narrative/reflective assignments about health advocacy and social responsibility, providing tangible evidence of their understanding of these concepts. The model explicitly links health advocacy and social responsibility. This study will be further discussed in Chapter 5.

2.4.5 Background Information: The United States

There is a substantive body of American literature on advocacy by physicians. This is an interesting finding since there does not appear to be a mandate from the American licensing bodies for a specific advocacy role for physicians. In The United States, advocacy
is considered part of professionalism. Pediatrics is the only specialty which has recently mandated advocacy as part of its requirements.

The review of the American literature was organized in a similar fashion to that of the Canadian literature with one important difference. An additional subheading is included in the American literature which deals with issues of financing and financial barriers—topics which were not discussed in the Canadian literature on health advocacy. This is understandable as the healthcare system in The United States leaves millions of Americans without coverage. It is also interesting to note that the examples of advocacy in the American literature are more eclectic and far more numerous than in the Canadian literature.

2.4.6 Defining the Physician Health Advocate in the American Literature

It is not surprising to see that in the early 1990’s discussions about the professional roles of physicians were taking place in jurisdictions other than Canada. As a group, The European Federation of Internal Medicine, The American College of Physicians-American Society of Internal Medicine (ACP-ASIM) and The American Board of Internal Medicine (ABIM) were all working on a physician charter to address changes in the healthcare delivery systems (AAMC, Medical Professionalism Project, 2002). The Charter document called for a “renewed sense of professionalism, one which is activist in reforming healthcare systems” (p. 244). As previously noted, in The United States, advocacy is defined as part of professionalism whereas in Canada, the CanMEDS project has divided professionalism and advocacy into two distinct roles and given each role specific key competencies.

The Charter’s developers were concerned about the medical professions’ ability to maintain its social contract with society as well as its public trust. To maintain these, they urged physicians to commit not only to the welfare of their patients but also that of society. They emphasize that physicians are seen as experts for society in matters of healthcare. They write that:

The medical profession must promote justice in the healthcare system, including the fair distribution of healthcare resources. Physicians should work actively to eliminate discrimination in healthcare whether based on race, gender, socioeconomic status, ethnicity, religion, or another social category (p. 244).
The issue of cost effective care is also discussed and physicians are encouraged to review their own practices to ensure that they practice cost-effective medicine as well as to advocate for a cost-effective system.

Sandroni (1991) states that “…a persistent committed physician can have profound impact on the glacial movements of government bureaucracy and that actions taken outside our offices can improve the health of far more patients than we could ever reach as individual physicians” (p. 374). He gives the example of two successful physician advocates: former 1980’s Surgeon General, C. Everett Koop and Dr. Rudolph Virchow, a pathologist who lived in the 19th and 20th centuries. Koop focused on anti-smoking campaigns, AIDS as a public health issue not a discrimination issue, as well as the rights of disabled people. In Virchow’s case he worked tirelessly to deal with overcrowded housing leading to epidemics, proper sewage, as well as food inspections and food distributions issues. Sandroni found common threads in their advocacy efforts. First, they were patient men as most serious social problems impacting healthcare are multifactorial and require efforts over many fronts, over extended periods and in many settings. Second, they had sound evidence based research to support their causes.

Tervalon and Murray-Garcia (1998) discuss physician training outcomes in multicultural education. As they discuss critical elements of this education, they comment that competency in advocacy is mandated by The American Academy of Pediatrics. They quote Evans (1992) who states that a small part of each physician’s responsibility extends beyond the individual patient to advocacy for changes in the community to improve the determinants of health and the effectiveness of healthcare services. Advocacy is a professional skill to be learned by residents to prepare them for their future role as health advocates, not just for underserved children but for all children. They further suggest that this advocacy should be community informed thus inferring a partnership with community members and organizations.

Genel (2000) used the Abraham Jacobi address to remind his colleagues of the advocacy work of Dr. Jacobi as well as their own advocacy work as The American Academy of Pediatrics (AAP). He speaks of the effectiveness of their advocacy which permitted development of the childhood vaccine compensation program and other legislative victories for American children. He deplores the failure of their efforts to date in obtaining universal access to quality healthcare for all children and pregnant women but urges that advocacy for these causes continue. He urges The APP to follow suit with U.S. Surgeon-General David
Satcher who has made eliminating health disparities based on race and ethnicity his number one priority. Genel suggest that The APP should also take this challenge as their number one advocacy focus.

Horton (2002) cautions physicians that they can no longer stay silent and leave advocacy to others. He urges all physicians to become involved and defines advocacy activities as: writing a letter to a newspaper, posting a comment on a website, or asking a question at a meeting. Advocacy only means taking the problems one faces day to day and pursuing their resolution outside their usual presentation (p. 458).

Gruen, Pearson, and Brennan (2004) note that physicians must provide clear and visible leadership in the interest of the public’s health if the medical profession is to regain and retain the diminished public trust. They must have a role in healthcare outside of their offices. They quote Geraghty and Wyma (2003) who wrote a 3-part series on the social role of physicians in community and advocacy work in which these latter authors note that physicians have been involved in solving problems in their communities for the last 1,000 years. Gruen et al. (2004) note that there exists a social contract between society and medicine in which:

…society grants the medical profession-comprising individuals and their collective associations-special social status and certain privileges, such as monopoly use of knowledge, practice autonomy, and the right to self-regulate. In return, the medical profession is expected to promote society’s health (p. 95).

Despite the increased demands and declining reimbursements, physicians must take on public roles which improve the aspects of communities that affect the health of individuals. In answer to questions related to the limits of professional obligations/boundaries in this arena, they provide an excellent conceptual model of health advocacy. In the inner circle is giving advice to a patient regarding smoking or weight-gain, etc. Helping a patient to access needed care is the second concentric circle. The third circle is concerned with direct socioeconomic influences on health such as: taking a public stand on smoking cessation, the use of bicycle helmets, or the availability of clean needle exchange programs to prevent blood borne transmissions. In the fourth concentric circle are factors clearly associated with health status but “…the evidence of causality of illness in individual patients is weaker and the feasibility of efficacy of physician action is less clear” (p. 96).

These include, amongst others, disparities of income, education, housing and exposure to environmental pollutants. The authors acknowledge that these broader
determinants of health may have a greater overall impact on the health of communities. The last concentric circle is concerned with global health influences. The authors argue that all physicians have responsibilities for the first three circles including promoting healthcare system changes to reduce barriers to access as well as addressing the determinants of health. However, the last two circles are areas where physicians may choose to extend their role but, given the open-ended and limitless nature of these areas, this is a matter of choice. They comment that in these areas, societal expectations may not demand that these be included as professional obligations.

In framing an advocacy agenda for all physicians, key activities include: promoting a healthcare system which offers access to all; reviewing individual practices as well as system practices to ensure a cost effective system; and addressing direct socioeconomic issues. These socioeconomic issues may be more relevant if related to the physician’s fields. For example, cardiologists may choose to work with smoking cessation programs, pediatricians for prevention of child abuse or immunization programs, trauma surgeons for bicycle helmets and seat belt use; dermatologist with skin cancer prevention, etc. Physicians working in lower socioeconomic areas can be supported by physician organizations and through these organizations physicians in more affluent practices can support the work of their colleagues. This model provides a range of strategies for physicians to practice advocacy. Collective action through professional organizations is highly encouraged. Like others, (Oandasan, 2005; Sandroni, 1991), they suggest that advocacy is effective when there is a clear goal and message, good supporting evidence, collective action and participation in the public process. Physicians have special knowledge and perspective on health issues as well as public influence and power which can all facilitate advocacy.

Gruen, Campbell and Blumenthal (2006) discuss the ongoing debate as to whether or not physicians have a professional responsibility to address healthcare issues beyond the care of their patients. They surveyed U.S. physicians to determine whether they saw a public role beyond the care of their immediate patients. Ninety percent of the respondents (n=1662) felt that community participation, political involvement and collective advocacy were important. The definition used for a public role was: “advocacy for and participation in improving the aspects of communities that affect the health of the individuals.” (p. 2467).

The advocacy activities ranged from advocating for health insurance for the uninsured, reduction in obesity, better nutrition, reduction in unemployment, air pollution, and prevention of teenage substance abuse, to tobacco control, seat belt use, gun control and
more. Community participation, individual political involvement as well as involvement through professional associations were all cited as useful mechanisms. An interesting finding of that study was that physician involvement in any particular issue appeared to be linked to individual patient concerns in their practices. They suggest that clarifying causative links may be an important factor in physician advocacy.

Kakoza (2006) offers a reflective piece about an experience she had as a third year medical student when she failed to advocate on behalf on an in-patient who received bad news in a very humiliating manner. She notes that in medical school she was taught to advocate for patients whose needs should be identified, valued and prioritized by physicians. However, the challenges in advocating were not discussed. These include balancing personal and professional needs with patient needs. She comments that the role of patient advocate is often pushed to others in the healthcare team. She states that it takes courage to be an advocate and this role may not be a priority for all her medical colleagues. She ends by saying that she hopes to develop the courage to be an advocate. As suggested by Kakoza’s previous comment, the role of health advocate is often pushed to others.

Earnest, Wong, and Frederico (2010) note the widespread acceptance of advocacy as a professional obligation but note that it is still undefined in concept, scope, and practice. To address this, they highlight the need for the design and delivery of programs in advocacy and suggest the changes needed to the curriculum are modest. However, they stress that practice opportunities are essential and provide examples of practicing physicians and their advocacy work. These include physicians who reorganized their practices to see more uninsured patients, those who worked with school boards to change nutrition policies in schools to address growing obesity of children, physicians providing advice to politicians or being advisors on health matters to local reporters. They define advocacy for physicians as: “Action by a physician to promote those social, economic, educational, and political changes that ameliorate the suffering and threats to human health and well-being that he or she identifies through his or her professional work and expertise” (p.63). They reinforce that physicians have social standing that permits access to policy makers and leaders which allows them to leverage public processes and priorities.

2.4.7 Physician Advocacy and Political Activities in The United States

Kleinman (1991) remarks that physicians have a tradition of social advocacy and service to the poor. He goes on to describe a framework for an advocacy role which includes
lobbying the professional societies to take an advocacy position in favour of social services and healthcare for the poor. He provides specific examples of how to deal with indigent patients (for example, give them drug samples). He urges physicians to support sound planning for housing, community mental health centers, and drug rehabilitation programs. He suggests that advocacy includes writing letters as well as publicly supporting legislation and political candidates who commit to public policies that promote human values. He encourages physicians to provide cost effective healthcare to protect these finite resources and to participate in reviews about health system to ensure their cost effectiveness.

Ganz (1993), in an editorial discussing *The American Society of Clinical Oncology Committee on Patient Advocacy*, defines the role of this committee very clearly as focusing on issues related to insurance and employment of cancer survivors because health insurance and employment are interdependent in The US healthcare system. Physicians are urged to take a more proactive role in helping shape health policy for cancer survivors at the local and national level. The committee itself plans to develop policy statements to influence health legislation. The committee quotes *The American College of Physicians* ethics manual regarding the social responsibilities of physicians and the expectations of the public about the profession’s function in society. They further speak of the duty physicians have to ensure healthcare access for all and to work on correcting deficiencies in availability, accessibility, and quality of health services in their community.

Schonfeld (1993) is concerned that physicians are not involved enough in advocating activities. He urges physicians to become active by joining relevant patient advocate organizations. According to him, an example of the deficit in activism is evidenced by public hearings regarding biological response modifiers for cancer patients. At these hearings, not a single physician appeared before the committee to speak for or against this product.

Flynn (1995) discusses the health climate in The United States and how it pits physicians against CEO’s of insurance companies, healthcare plans and hospital management companies. He reminds his colleagues that “the high public esteem of the medical profession of the past was largely due to patient advocacy and altruism” (p. 408). He notes that physicians must become engaged in the socioeconomic process and suggests that in the future, *The Society of Head and Neck Surgeons* must focus on socioeconomic and political issues to aid both the medical profession and its patients.

Richards (1995) discusses the concern about advocacy for patients in the era of managed care. She also speaks of the work of The Wisconsin Medical Society which has
advocated for many decades and recently successfully achieved a reduction in the malpractice costs of all physicians in that state.

Murray and Livingston (1995) recall that physician advocacy played a significant role in ensuring mandatory head and facial protection for hockey players. He urges his medical colleagues to lobby for further changes in the rules and behaviours in hockey to prevent the new injuries that have surfaced in the game subsequent to the use of this protective equipment.

Melvin (1995) suggests that physicians, despite the little training they receive in dealing with battered spouses, are still in a unique position to advocate for them. This can be done by helping to detect volatile situations or dealing with battered spouses by being advocates who make the necessary referrals to help address these issues. LaCrosse (1996) also encourages physicians to become patient advocates in situations of domestic violence. He suggests that screening for abuse should be part of every physician’s routine exam. He gives tips about how physicians can display, in a safe manner, information about hotlines or tips to help patients who are being abused.

Achkar (1998) questions whether the pursuit of a group’s interest, in this case The American College of Gastroenterology, and society’s welfare are compatible. He then reviews the political activity of the college which has centered on lobbying for colorectal cancer issues and reimbursement for endoscopic services. He notes that the intense lobbying on this issue should result in improved patient access and, therefore, is a positive force for the public good. He gives another example related to a reimbursement system where the public interest would have been best served had the medical community not accepted the proposed system. He concludes that as a professional society, it is the duty of The American College of Gastroenterology to invest resources in actions to support the advancement of health issues.

Rudolf et al. (1999) studied the clinical diaries of nine British pediatricians who participated in a study to identify the scope of advocacy activities faced by this specialty group. The study identified 60 issues requiring advocacy, both at the individual and community level, of which many required political action but very little required national level politics. Since the media can be an important ally, working effectively with this group to highlight and resolve local issues was seen as important. The issues were organized under themes and include: highlighting the benefits of high quality nursery provision in disadvantaged areas, promoting school based clinics, etc. The article refers to The American
Society of Pediatrics, who like their Canadian sister organization, provide an active website for advocacy information (http://www.aap.org/advocacy/).

Genel (2000), in the Jacobi lecture, describes the work of The American Academy of Pediatrics which was founded and continues to work as advocates for children. To support their advocacy mission, they are deliberately involved with policy makers in government. This strategy has supported a number of their legislative victories for children.

Meyer and Regenstein (2000) urge physician advocacy for durable medical equipment. They note that the debate over managed care has focused on the inability of patients to access specialist or emergency care. However, there is also a need to advocate with managed care for appropriate equipment for patients. Managed care companies bulk purchase equipment (for example, wheelchairs) with total disregard for special needs of patients. They also resist reimbursing patients for electric wheelchair or newer models of updated technology. Since physicians are strong advocates for patients in gaining access to payment for treatment, they should include better equipment on behalf of their patients in their advocacy work.

Thompson (2001) suggests that regional societies could be extremely useful in advocating to various regulatory and legislative groups both locally and nationally. He makes it very clear that these societies must advocate for their physician members if they are to survive. He further suggests that this advocacy for the members of the regional society would greatly improve patient-physician interaction which would result in improved patient care.

Weisfeld (2001) speaks of the advocacy work of The Medical Society of New Jersey with the state, Health Maintenance Organizations (HMO’s), and healthcare plans. These efforts have resulted in decreasing the administrative burdens for New Jersey physicians, as well as improving the claim processing for patients. While proudly discussing the gains that have been made, he speaks of other areas which still need to be addressed related to the limits on individual practice autonomy and practice related compensation.

Johnson (2004) notes that most doctors already function as patient advocates in their daily lives, addressing HMO coverage issues and other disputes over medical necessity. However, he addresses his remarks to a new phenomenon: physicians who are accepting a paid role in a hospital as a patient advocate and discusses liability issues when functioning in that role.

Kirby and Kirby (2005) propose that urologists must become advocates for men’s health. They describe 10 interventions which urologists might make to enhance the health of
their male patients. These include mostly health promotion activities such as promoting exercise, healthy eating, work/life balance, sexual health, diabetes prevention, lipid profile, etc.

Jaff, Arnold and Bousvaros (2006) discuss advocacy for patients with inflammatory bowel disease. There are many hurdles for these patients under the American healthcare system, such as denials of coverage from third party payers. The authors provide information through case studies of how to successfully advocate for these patients with insurance companies, schools and employers.

The one dissenting voice re political advocacy came from Huddle (2011). In a recent article, he argued that political advocacy should not be part of either medical professionalism or medical education. He suggests, amongst other things, that physician advocacy will lead to medicine becoming less of a profession and more of a political interest group providing society with less clinical work and more political pressure. There was a very spirited response to this article from physicians, many of whom were trainees, and from medical educators who rejected Huddle’s views (Sud, Barnet, Waters & Simon, 2011; Kuo et al., 2011; Schickedans, Neuhausen, Bennett & Huang, 2011; Palfrey & Chamberlain, 2011; Halliday, 2011; Gottlieb & Johnson, 2011; Stull, Wiley & Brockman 2011; Girard-Pearlman Banack & Byrne 2011). These responses argued in favour of universal training in health advocacy and mentioned a number of areas where advocacy by physicians was important. Examples mentioned included advocating for safe places for children to play, quality food choices in cafeterias, safety caps on medications, infant car seats, etc. They lauded the advocacy work of physicians which resulted in tobacco control, safer highways because of seat belt legislation and drunk driving laws. Schickedans et al. (2011) in their rebuttal, reference an article from Farmer and Sen (2005) who speak of Virchow, a physician who advocated for better sewer system and food safety who they quote as follows: “If medicine is to really accomplish its great task, it must intervene in political and social life” (p.323).

2.4.8 Advocacy and Financing

A number of authors deal with the issues of healthcare financing. The articles which follow are an indication of the severity of this issue and the many ways in which it impacts both patients and physicians.
Kleinman (1991) is concerned with healthcare financing for the poor while Ganz (1993) are concerned with cancer survivors and issues related to their health insurance and employment status and the connectivity between the two.

Priester (1990) like Flynn (1995) bemoans the fact that that the healthcare delivery system in The United States has created major conflicts for physicians. Priester is concerned with the loss of physician autonomy and the fact that control has shifted from providers to purchasers and payers. Flynn speaks of physicians who are now being called upon to represent interests strongly motivated by commercial interests. He notes: “Traditionally advocates of patient wellbeing, we are now called upon to represent the interests strongly motivated by commercial profit, regardless of the consequences to health care delivery” (p. 407). Flynn wants The Society of Head and Neck Surgeons to engage with other medical societies to become more involved in the socioeconomic process to fight this situation. He sees this type of advocacy as part of the professional role of physicians.

Heilman (1994) discusses the issues he is having with physicians who are working in prepaid systems. He describes incidents where the healthcare needs of patients were secondary to the cost containment directives of managed care organizations. As a radiologist, he has had to intervene and advocate on behalf of these patients. He sees a role for radiologists to be dispassionate advocates for these patients whose “gatekeeper” providers are keeping the “gates too tightly closed.”

Slomski (1998) describes the situation of a gastroenterologist in the US, who was fired, allegedly, for incompetence. However, the gastroenterologist’s lawsuit victory was the result of proving that the firing was based on inadequate contributions to the managed care bottom line. This physician saw himself as an advocate for appropriate care for his patients and admitted not doing things “the managed care way.” After the victory, there was much press coverage linking the protection of physicians from managed care with the protection of patients. The article notes that medical groups must be aware that they may be acting as agents of HMOs when focusing on the bottom line instead of quality of care. Dr. Slomski urges medical groups to be wary of interfering with a physician’s medical judgment when treating patients.

Li (1998) notes that the healing power of medicine is not self-appointed. He states that:

…the authority of medicine derives from the principle of patient advocacy— that is, for 3,500 years society has identified, separated and commissioned
physicians for the sole purpose of providing care to sick and suffering patients. If we physicians compromise on patient advocacy, we will severely surrender this commission (p. 1023).

He argues that part of this advocacy includes helping patients to obtain health insurance and needed treatment from managed care organizations. He quotes The National Bill of Rights of Patients which states that physicians have a responsibility to act as advocates for patients when care is denied by managed care organizations. He asks each physician to ask themselves whether or not they are their patient’s advocate and who they serve. He speaks of the issues in the healthcare system which leave physicians overworked and underappreciated and of the clash between business ethics of managed care organizations and patient advocacy.

Pearson (2000) speaks of the growing tension between care and costs and how the physician is caught in the middle of this tension. He uses a hypothetical case to illustrate his “proportional advocacy” which has the physician still advocating in the best interest of the patient but in the context of boundaries that respect the finite resources of the healthcare system.

In discussing advocacy related to healthcare financing, some authors mention the duty of the physician to examine their own practice to ensure that it is cost effective. (Gruen, 2004; Medical Professionalism Project, 2002; Kleinman, 1991)

2.4.9 Teaching Health Advocacy in the American Literature

Lozano, Biggs, Smith, Marcuse, and Bergman (1994) wrote that advocacy training was not mandated in pediatric residency programs which they felt was a serious shortcoming. They described a pediatric program which introduced voluntary child advocacy training in the form of child advocacy projects. They suggest that to be a successful training modality, projects should not interfere with clinical learning; should emphasize learning advocacy skills and techniques; and should have a tangible final product.

A few years later Tervalon and Murray-Garcia (1998) note that advocacy competency training is now mandated by The American Academy of Pediatrics as a skill that must be acquired during residency. This skill is taught in structured educational experiences provided in the community to prepare the residents for their future work as advocates. Pediatrics was the only specialty in this literature review which stated that advocacy was a core competency for resident training.
Poehlman and Kolosa (1999) begin their remarks by noting that physicians are viewed as having “esteemed opinions” (p.39) on almost every subject and they marvel at how much influence a physician’s opinion carries. They note that the proper use of this expert status can be a powerful tool for the practicing physician in changing the health of communities and influencing policy. It is based on this premise that they propose that teaching advocacy skills is an important part of professionalism. They go on to describe a successful program developed at East Carolina College which starts in the first year of the Family Medicine residency program and continues throughout the residency. The core of the program involves teaching residents how to make advocacy assessments, interventions in marginalized communities and also how to make political presentations to influence policy. A list of advocacy topics taken on by residents include, a sexuality program at a local school board; advocating before the accrediting body of the state capital; assisting The United Way in bringing a fledgling domestic organization under the agency’s umbrella; working with low interest loans for senior citizens, etc.

Wright et al. (2005) note that although paediatric training programs are now mandated to teach health advocacy to trainees, there are few guidelines on how to do this and there is not a standardized definition of advocacy. They did a study to identify resident and faculty attitudes to advocacy training, advocacy curriculum and learning methods. Both residents and faculty felt that advocacy training was important. Based on the findings of this study, an advocacy curriculum was designed focused on experiential projects covering 45 issues identified in the study as being an important focus for advocacy efforts. These include adolescent issues such as teen pregnancy, access to immunization and universal healthcare for children.

Chamberlain, Sanders and Takayama (2005) describe a child advocacy curriculum involving three pediatric residency programs. The program involves two, 3-hour workshops, independent field work, and a formal presentation to peers and faculty describing an advocacy project which each resident must complete. The projects include work in the areas of obesity, healthcare access, adolescent pregnancy, oral health, injury prevention and others. Residents also evaluate the program at its conclusion and, to date, they experience high satisfaction with the curriculum. The program does pose some challenges for the organizers including scheduling time for the residents to participate, faculty resources and ensuring that projects are of a manageable scale.
O’Toole, Kathuria, Mishra, and Schukart (2005) discuss the fact that medical professionalism is being challenged by the corporatization of healthcare delivery, disengagement of physicians from critical decision making roles, and financial incentives and disincentives in patient care. They report on a national demonstration project teaching professionalism in a community-based curriculum which includes sensitizing students to activism. This curriculum is seen as the application of professionalism instead of the abstract concept of that term. The curriculum involves structured seminars, weekly case presentations of relevant issues as well as conducting a site specific project meant to address a need within the community. These projects include development of health brochures, administration of health surveys, and evaluations of programs within the community. In the evaluation of the project, students responded that learning health advocacy and general approaches to and issues involved in working with a community or underserved group were two components that they would not have learned in the traditional curriculum. Students felt that these were important omissions in medical education. It is interesting to note that both O’Toole et al. (2005) and The Medical Professionalism Project define advocacy and activism as a significant component of professionalism. In Canada, as previously noted, CanMEDS has separated these into two roles: the Professionalism role and the health advocate role, each with their own key competencies.

Cha, Ross, Lurie and Sacajiu (2006) note that physicians must work as patient-centered advocates for each individual as well as engage in advocacy to improve healthcare systems to address unmet societal needs. They describe a curriculum offered to fourth year medical students to teach them the research and advocacy skills necessary “…to pursue socially equitable health policies in The U.S. healthcare system “ (p.1325). Students spend one month on the advocacy curriculum, developing a research question and writing and presenting an advocacy plan. They are supported by lecture based sessions on health policy, research methods, and advocacy and physician activists as role models. The advocacy section concentrates on giving students the concepts and techniques of activism, such as public speaking, coalition building, and issue based campaigning, etc. The students respond well to the curriculum and leave with a cohort of colleagues who are enthusiastic about advocacy work. However, the authors note that these students: “…unfortunately return to the culture of medicine at large, noted to be an atmosphere not supportive of activism” (p. 1328).

Earnest et al. (2010) write that since advocacy is a professional imperative, this competency must be well defined and all physicians must meet it at a basic level. They
suggest minor tweaking of the curriculum to incorporate instruction on the determinants of health, theories and policies of leadership and social organization change. Opportunities to practice advocacy through service learning is essential. Accrediting bodies must endorse competency training as a necessary component of medical training.

Duvivier and Stull (2011) write a plea as physicians-in-training that medical education incorporates advocacy training and the development of clear competencies in this area. They suggest that this type of training will allow them to become better doctors to serve their patients.

Stull, Brockman and Wiley (2011) also see advocacy as a core component of medical education. They suggest that advocacy may preserve trainee altruism and desire to help people and society. They suggest that this kind of training needs to be longitudinal providing education, grassroots organizing and policy analysis. Trainees must be exposed to opportunities to practice their advocacy skills.

2.4.10 Health Advocacy: Comparing the Literature in Canada and The United States

The principles of health advocacy are well ensconced in the American literature although the nature of this advocacy is somewhat different than in Canada. This difference is understandable given the different healthcare funding systems. This difference translates in advocacy for specific causes, cost effective care, equitable access to healthcare as well as changes in the funding system. The American literature also has articles related to advocacy to improve the remuneration or working conditions of physicians. This latter type of advocacy writing is not found in the Canadian advocacy literature. In fact, physicians in The United States are much more deliberate about using professional medical societies for lobbying/advocacy activities directed at their working conditions and remuneration. They also frequently publish their opinions on advocacy topics in their state professional journals, which is another interesting difference from the Canadian literature. Other differences are the discussions that advocacy is a tool to maintain or regain public trust from society. (Gruen, 2004; Flynn, 1995; Medical Professionalism Project, 2002). The Canadian literature speaks of responding to the needs of society and usually does not comment that there is, or has been, a loss of public trust. In fact, as stated earlier, Lynk and Issenman (2007) mention that politicians often remind their advocacy committee of the unique role that pediatricians occupy regarding public trust. One key element which is the same in both the Canadian and
American literature is the uncompromising support for health advocacy activities and the understanding that a physician’s role goes beyond the office into the communities where patients live.

It is interesting to see, that both in Canada and The United States, physicians are not shying away from using the political process to advance the health of their communities. In this context, the American literature speaks much more about working through professional societies to advance advocacy work. The Canadian Paediatric Society is to be commended for developing a tool kit to assist its members in lobbying government. In this, it joins its American counterpart, The American Academy of Pediatrics in concentrating advocacy efforts through a professional body. However, if various medical societies lobby for changes pertinent to their respective specialties, could this in itself lead to health inequities as the voices of the stronger medical societies successfully lobby for payment of specific intervention, or screening programs at the expense of another equally deserving but less endowed medical society? It is an interesting question to ponder.

American authors speak of advocacy to eliminate health disparities more frequently than their Canadian counterparts. On the one hand this is to be expected since according to Groman and Ginsberg (2004) more than 43 million Americans have no health coverage and, therefore, no access to healthcare. Additionally, in the same article, The American College of Physicians (ACP) states that minorities are disproportionally represented in the uninsured population because they tend to have higher unemployment, lower paying jobs and are not necessarily full citizens. In defining these causes for lack of health coverage, the ACP is de facto acknowledging the impact of the intersection of race, social class, poverty and immigration status on health status.

However, Canadians should not think that there are no disparities which need to be addressed in this country. Despite Canada’s high standard of living and universally accessible healthcare system, Beiser and Stewart (2005) note that the health disparities in Canada are a pressing national concern. These inequities are embodied in Aboriginal people, immigrants and refugees, individuals of lower socioeconomic status and women. They suggest that research is required to document and find solutions for these health inequities and to evaluate and promote programs that effectively deal with this issue. This recommendation directly supports Herbert’s (2000) comments that family physicians must endorse a health research agenda which promotes equitable health.
The flavour of the articles in Canada was much more explorative of the competency and its dimensions than those articles from the American literature. Some of the impediments to the actualization of the Health Advocate Competency in Canada appear to be related to its unclear definition as many articles offered their own definitions for the Health Advocate Competency. In fact, in a 2003 RCPSC survey, the Health Advocate Competency was reported as the one least used for setting learning objectives, developing instructional materials, choosing rounds topics and guiding evaluations (Frank, Cole, Lee Mikhael, & Jabbour, 2003).

The literature review also found a number of examples of physicians acknowledging their power and urging that this power be leveraged for societal good by lobbying government and policy makers as part of an advocacy agenda. The notion that advocacy was part of the professional/leadership obligation; part of the social contract with society and part of the public trust was also mentioned by a number of physicians.

It is important to re-iterate how few Canadian publications there are on physician health advocacy considering that it is a key competency mandated by both The RCPSC and The CFPC. The organization of the material chronologically by section did not show an accelerated progression in terms of number of publications over time.

It is understood that not all physicians will want to tackle large system problems such as root causes of health inequities in Canada. One reason to decide not to deal with this aspect of the Health Advocate Competency may be that it is not relevant to the individual practice setting. A conceptual advocacy model such as the one proposed by Gruen et al. (2004) is appealing because while making it clear that advocacy is a duty of all physicians, the model provides flexibility for physicians in determining the extent of their professional advocacy role within the continuum of advocacy activities.

The literature related to teaching/learning and evaluation of the Health Advocate Competency is relatively new. However, it is clear from the Canadian literature that the Health Advocate Competency is still creating challenges in terms of understanding the dimensions of the role as well as how to teach and evaluate it. I was a member of the faculty for the first RCPSC Train-the-Trainer Health Advocate Developmental Workshop in April 2008. Most of the 40 participants, all educators from across Canada, had a very fuzzy idea about the working definition of a health advocate and thus found that teaching and evaluating this competency was extremely difficult. This perception only marginally improved after this intensive two day workshop. What was more problematic is that after the workshop, a few
participants mentioned their concern at accessing the necessary resources to mount a health advocate program at their Faculties of Medicine. This is very problematic as within the multi-million dollar budgets of Faculties of Medicine, resources can be re-allocated. The problem may be more a lack of commitment to this Competency and therefore reluctance to take money away from the scientific endeavours of the Faculty to provide a budget supporting teaching of these softer skills. After all, scientific discoveries are what corporations support.

In January 2012, I participated in a local workshop on the Health Advocate Competency. During most of the three hour workshop, the participants, teachers, medical students and residents committed to social justice and activism, struggled with the concept and scope of the Health Advocate Competency and how to teach and evaluate it. Although I was incredibly impressed with the work these individuals did with marginalized groups, their struggles were further evidence of the difficulties in understanding the dimensions and of operationalizing this Competency. I came away with so much admiration for their work and so much respect for them as physicians. However, I was left with anxiety about the potential to embed this Competency in all physicians since the experts at discharging this Competency are finding it challenging to teach these concepts to medical students. This is another concrete personal experience that demonstrates the challenges of teaching health advocacy.

It is obvious from the ongoing discourse on health advocacy in the literature that research is needed on this topic to ascertain what adjustment in definition or curriculum delivery are needed to teach and evaluate health advocacy skills and make the Health Advocate Competency an effective tool against health disparities. Other important findings from the literature on curriculum are that, as Bandiera (2003) and Walsh et al. (2006) and others found, clinically relevant context is important in delivering a successful health advocate curriculum. Further general principles derived from the literature which could be considered as best practices when planning advocacy work include working in marginalized communities and showing the causal links, both in terms of the individual physician practice and the community served. In educating for this role, strategies to be considered include: reflection, writing and presenting projects, working with marginalized communities and relevant clinical experiences.

Physicians must be encouraged to be involved in advocacy work and to publish their experiences in this domain. Best practices must be promoted. Those involved in curriculum development must also publish in order to encourage further curriculum development and
address this deficit in the scholarly literature. Canadian authors should use the health advocate nomenclature in order to reinforce the use of the term and to firmly implant it in the medical culture. The overwhelming potential of this competency, which is part of the Canadian undergraduate, postgraduate and continuing education requirements, make it a prime tool to systematically address health inequities in Canada.

2.4.11 Understanding the Re-emergence of the Health Advocacy Discourse in Canada

It is interesting to note that before 1988, the medical literature in both Canada and The United States had few articles on health advocate activities by physicians. This is particularly interesting since the principle of advocacy dates back to the era of Hippocrates. As the literature in Medical Sociology often reminds us, the values and activities of the medical profession are congruent with the society in which they are located (Nettleton, 1995).

Why did the discourse on health advocacy arise both in Canada and The United States in the late 1980’s? To understand the re-emergence of this discourse at this time, a brief environmental scan of the health care landscape, focusing initially on Canada, is in order. It is important to understand the social context which encouraged the re-emergence of the health advocate discourse in order to interpret the underlying intent of this re-emerging discourse. In many ways, the health advocate discourse is a repositioning discourse for a profession which lost autonomy, trust and the respect of the public. However, as we shall see, the health advocate discourse has not made inroads to counter the biomedical discourse of science which has been prevalent in medicine for the last 100 years. The health advocate discourse is still one of smoke and mirrors.

In Canada in the 1980’s and 1990’s, Medicare was going through a turbulent period brought about by a number of factors including escalating health care costs, changing patterns of care and the establishment of The Canada Health Act in 1984. According to Lewis (2001) the escalating costs resulted in the federal government unilaterally decreasing transfer payments to the provinces thus further destabilizing provincial health care budgets. Another change in health care was that community care and drugs, elements not funded by Medicare, were becoming more prevalent as health care became less focused on hospital and physicians services, previously the core of the publicly funded health care system. Lewis further speaks of the fact that during the 1980’s, every province established a high level
review of the health care system which resulted in some provinces undertaking massive reforms such as regionalization. These provincial inquiries also resulted in recommendations on a shift from institution-based care to community-based care, recommendations which were largely left unimplemented in most provinces. Escalating costs, massive reforms, political pressures, changes in patterns of care, all occurring in a relatively short period can easily destabilize a system.

1986 was a busy year at the Federal level in terms of health care. First Jake Epp, the Minister of National Health and Welfare, published *Achieving Health for all: A Framework for Health Promotion* which advocated a population health approach including strategies to reduce health disparities. Secondly, Ottawa hosted *The First International Conference on Health Promotion*. This conference, according to the published information, was primarily in response to the growing expectations around the world for a new public health movement and resulted in the development of *The Ottawa Charter* (1986). *The Ottawa Charter* advocated health promotion and created an action plan focused on building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services. The notion of responding to the health gap within and between societies and to tackling the structural inequities in health is explicitly mentioned in the Charter. However, that same year, the Minister of Finance Michael Wilson capped health care expenditures, an action which seems to contravene the emerging momentum towards addressing health disparities.

Against this tumultuous background, physicians dissatisfied with their remuneration, had been opting out of provincial plans throughout Canada. Canadians over the years of the many previous iterations of the publicly funded health care system had begun to view health care as a right. However, they were now faced with the challenge of finding a physician who was not extra billing or opted out of the provincial plan.

To address some of these issues and to codify health care policy, *The Canada Health Act* was passed in 1984 stipulating that for provincial health insurance plans to quality for their share of federal transfer payments, the five principles of the Act had to be met in their entirety: public administration, comprehensiveness, universality, accessibility and portability. To meet the accessibility principles, extra-billing by doctors and hospital user charges, which had crept into the Canadian health care system, were to cease within a three year period of the Act.
Physicians did not react positively to the new federal legislation and in Ontario, in 1986; physicians began a strike that would last twenty-five days. Public support for this strike was almost non-existent, and the strike spurred the development of a number of national and provincial groups committed to defending the principles of the new Act such as The Canadian Health Coalition and The Ontario Health Coalition. Additionally, professional associations such as The Canadian Nurses Association voiced their strong opposition to the strike and re-iterated their support of the principles of Medicare. Therefore, the impact of this strike was largely negative as governments, understanding that Medicare was supported by the public, enforced their position and the doctor’s strike ended without any concessions to this group. Moreover, the most negative consequence of the strike was the resulting lack of respect for doctors and the loss of the deference they previously enjoyed.

I was very involved during the strike, working with the medical leadership of the hospital organizing medical coverage as these leaders undertook the duties of their departmental staff who were on strike. I, like many of the people of Ontario, felt a sacred trust had been broken when so many of my well-regarded medical colleagues chose to strike.

Kelly (2006) describes the Canadian health care system as very complex with services delivered privately to consumers who have freely selected their provider whose services are funded publicly. He speaks of the three built-in sources of tension in the Canadian health care model and list these as 1- the federal government commitment to universal care 2- consumers who have a free choice of providers 3- the professional autonomy of physicians. Further, he notes that these objectives come into conflict when governments exercise budget control over the resources which ultimately pay physicians while neglecting to address demand on services. Kelly states that up to the time of the precursors to Medicare in 1962, patient care was based on beneficence with the relationship limited to the patient and doctor. Subsequent to the introduction of Medicare, physicians are paid by the government, and a physician can no longer act as an entrepreneur and focus on the needs of the individual but must also consider the goals of society which sees health care as a right. Physician autonomy and freedom is thus threatened. Kelly posits that because extra-billing, although wide ranging was practiced by only a minority of physicians, the strike was not about extra-billing but about “…the erosion of the profession’s place in the health care system” (p.3).

Four years after the Ontario doctors’ strike, and no doubt in response to the lingering negative consequences of that strike and the previously mentioned erosion of professional
standing in the health care system, the five Ontario medical schools in existence at that time collaborated on a project to find out what the people of Ontario wanted from their physician and to develop programs in medical schools to meet those needs (Neufeld et al., 1998). The project was initiated and funded by The Associated Medical Services (AMS), a non-profit medical organization and was called Educating Future Physicians for Ontario (EFPO). Through broad public input, focus groups, literature reviews, review of major reports, surveys, and interviews, the people of Ontario, health professionals, educators and a number of marginalized groups were asked to comment on the current roles of physicians, and to suggest changes to these roles as well as ideas about how to teach medical students. EFPO was an explicit process to listen to the public and to try to mend fences with that public following the Ontario strike. As stated by Neufeld et al. (1998) the goal of EFPO was to “…modify the character of medical education in Ontario to make it more responsive to the evolving needs of society” (p.1133). The EFPO roles that were the result of this consultation and a brief comparison to the CanMEDS roles, which followed a few years later, make the connection between the two very clear as noted below:

Table 1: Comparison of EFPO roles and CanMEDS Competencies

<table>
<thead>
<tr>
<th>EFPO Roles</th>
<th>CanMEDS Competencies</th>
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</thead>
<tbody>
<tr>
<td>Medical Expert (clinical decision maker)</td>
<td>Medical Expert/clinical decision maker</td>
</tr>
<tr>
<td>Communicator</td>
<td>Communicator</td>
</tr>
<tr>
<td>Collaborator</td>
<td>Collaborator</td>
</tr>
<tr>
<td>Gatekeeper/ Resource Manager</td>
<td>Manager</td>
</tr>
<tr>
<td>Learner</td>
<td></td>
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<tr>
<td>Health Advocate</td>
<td>Health Advocate</td>
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<tr>
<td>Scientist/Scholar</td>
<td>Scholar</td>
</tr>
<tr>
<td>Person</td>
<td>Professional</td>
</tr>
</tbody>
</table>

The CanMEDS roles, designed by a Working Group on Societal Needs of The Royal College of Physicians and Surgeons and originally adopted in 1996, drew significantly on The EFPO roles (Parboosingh, 2005). The Working Group also widely surveyed both the population and health care professionals across Canada to obtain input into the CanMEDS Competencies. The similarity between The EFPO and CanMEDS Competencies/roles can be understood as confirmation and validation that as a society, across Canada, the population
valued the same competencies in their doctors which originally surfaced in the public consultations in Ontario.

Frank and Langer (2003) note that the impetus to reform medical education at the residency level was in response to a number of factors amongst which were; a rise in consumerism, changing roles for professions in society, greater demand for accountability, concerns about patient safety and quality of care, fiscal implications, evolving government control/regulations, breakneck pace of technological advancements and a move to ambulatory care.

Parboosingh (2005) in summarizing the proceedings of The AFMC-AMS symposium Celebrating the Legacy of EFPO and the Saskatchewan Connection, reports that these roles have been adopted internationally and are important because they focus on the outcome of care and not on the structure and process of medical education. The Four Principles of Family Medicine, developed in 1989 by a Task Force of the College of Family Physicians, contain elements of both EFPO and the CanMEDS roles/Competencies.

Interestingly, to my knowledge, none of the groups who worked on the development of the roles/competencies for EFPO, The RCPSC, and The CFPC referenced The Multicultural Act established in 1988. Since the impact of race and immigration status has a profound influence on health and health outcomes, this is an interesting omission worthy of future analysis.

The re-emergence in 1992 of the Health Advocate Competency in the medical lexicon appears linked to the context of the 1980 and early 1990’s when the medical profession was trying to re-establish its prominence in the health care system and recover the public trust it once held. The Health Advocate Competency seems to be the one which most closely embodies the aspiration of meeting the needs of the community, social responsibility and social accountability as well as addressing the “art” of medicine. It also appears to be the competency which could address what Woollard (2006) calls the waning of the transmission of fundamental values of healing and human concerns. It could be seen to function as a bridge between the focus on episodic/medicinal health care and the more desirable long-term improvements in health status. It is also the Competency that can be seen to be a balance to the Medical Expert Competency which is focused on biomedical ideology. In fact, the Competency may be seen as a challenge to the fundamental values of medicine and the hierarchal system which places medical knowledge at the apex of learning. This may be part of the explanation for the difficulties this Competency is experiencing in trying to embed into
the medical profession. As we will see in Chapter three, medicine seems to have difficulty incorporating subjects outside of the scientific realm into the curriculum. The lack of publications could also be linked to the profile of this Competency within the culture of medicine which values hard facts and scientific knowledge.

Hopefully, the few publications on health advocacy do not necessarily imply that these activities do not exist in Canada, but rather that they are either not written/published or are published using different nomenclature. In both instances this is problematic if the role is to become firmly ensconced in the Canadian medical culture.

A disturbing fact is that there is still a quest for an operational definition and mechanisms to teach and evaluate this Competency two decades after its original introduction into the lexicon of Canadian medicine. Frank and Langer (2003) wrote with confidence that by the end of 2003, all specialties and subspecialties in Canada will have rewritten their core educational objectives and evaluations to reflect the CanMEDS Competencies. In 2007, Frank and Danoff wrote that the CanMEDS Competencies, although challenging to implement, “…have successfully become part of the fabric of Canadian education at all levels” (p. 646). This literature review, and the analysis of the questionnaires which follows in chapter four, make it clear that for the Health Advocate Competency, there is still a gap between the idea and the reality.

2.4.12 Understanding the Re-emergence of the Health Advocate Discourse in The United States

What historical contingencies spurred the health advocate literature in The United States? As previously noted, in The United States, there is no universal coverage and 43 million Americans (more than the entire population of Canada) are without insurance of any kind to cover their health care costs and those with coverage still face challenges to accessing appropriate health care. A brief historical review highlights some of the events which may have supported the re-emergence of the health advocate discourse in that country.

In the 1980’s a prospective payment system called Diagnostic Related Groups (DRGs) was implemented by the government payment plan entitled Medicare, like its Canadian counterpart. According to Hirsh, Homer, McDonnell, and Milstein (2005), this new system paid hospitals and other providers a fixed amount for health care rather than reimburse for the actual costs of the care, thus ratcheting down payments for patients with government coverage. This reduction in payments caused providers to shift cost to private
insurers. This caused employers to start relying on forms of “managed care” such as *Health Maintenance Organizations (HMOs)* to control their insurance costs. An important difference in our two payment systems is that the cost of medical insurance coverage in the United States is relegated largely to employers and, therefore, having health care coverage is a function of being employed and receiving health care as an employment benefit. At about the same time, corporization of health care delivery also moved into this market place with large hospital consortiums emerging throughout the United States.

Against this background, a literature on health advocacy also emerged in the United States in the early 1990’s probably in response to the abrupt and severe loss of autonomy incurred by physicians as a result of “managed care”. William Osler predicted in 1903 that in the future, the practice of medicine would become big business and the traditional ideals which justified physician authority would be lost (Manson, 1994).

Through different historical processes, physicians in both Canada and the United States lost autonomy at about the same time period. However, an important difference is that physicians in the United States, through managed care, also lost authority to practice medicine in the manner they felt was most appropriate for their patients. These physicians may have been perceived as rupturing the long standing contract with society by being agents for cost-containment strategies of managed care corporations instead of being advocates and authorities on patient care. As a health care executive from 1974 on, I attended bi-yearly meetings in the United States of my professional association *The American College of Health Care Executives*. Meeting after meeting spoke of the criteria that patients had to meet to be eligible for certain diagnostic workups in the managed care world. Managed care policies dictated physician practice disallowing specific tests and treatments unless approved by the corporation. This led to a disfranchisement and loss of trust from the public who saw their physicians as agents of for-profit corporations.

In Canada, although physicians lost autonomy, they maintained their authority over medical matters. In ensuing years hospital budgets might impact physicians in terms of availability of OR’s, downsizing of hospital beds, and other cost-containment strategies, however no one told Canadian physicians how to practice medicine.

### 2.4.13 Between the Idea and the Reality: Health Advocacy

Wear and Kuczewski (2004) write about their concerns regarding professionalism discourse in the literature. The arguments they posit and the issues they raise in this article
could easily apply to the discourse of health advocate if this term is substituted for professionalism. For example, they note that:

Developing professionalism [read health advocacy] has become part of the academic parlance used by administrators, clinical faculty, residency programs and professional organizations with the expectation of shared meanings and goals. It is perceived to be a worthy educational project in all medical settings at all levels. Who after all can argue with its general tenets (p.2)?

However, they argue that the discourse is imbued with too many abstractions. The search for an operational definition and the comments about the difficulties teaching and evaluating the Health Advocate Competency would suggest that the same is true about health advocacy. Additionally the authors state:

Medical educators while saying how important professional [read health advocacy] values are and spreading them throughout admission and accreditation materials have failed to create pedagogical practices designed to enculturate the professional [read health advocate] values and just as important have failed to address headfirst the values being transmitted through the hidden curriculum that are decidedly unprofessional in nature (p. 4).

As we will see in Chapter three, the hidden curriculum is definitely an influence on the uptake by students of non-scientific subjects such as health advocacy.

We have also seen in the literature review that there is an almost universal struggle to create a curriculum to teach health advocacy at both the undergraduate and post graduate level. Wear and Kuczewski (2004) continue that in addition to the theoretical thinness of the curriculum with respect to professionalism [read health advocacy], there are issues around assessment and evaluations. These issues have also emerged in the literature on health advocacy. The authors suggest that to properly ensconce professionalism [read health advocacy], the subject must be comprehensively treated throughout the curriculum, be part of a top down culture which encourages it, be the focus of faculty and resident development to promote and assess it, and be embedded with opportunities for student to reflect on it. Each of these comments can apply to health advocacy and the literature review would suggest that most of these components are missing at the present time.

I close with this quote which Wear and Kuczewski (2004)attribute to McGibbon (2000): “Professional [read health advocacy] development efforts, then, should be designed to help students see themselves as situated individuals who have a specific social and economic location that influences every interaction they have with patients” (p.8).
Chapter 3
Methodology

3.1 Conceptual Framework

We have seen in earlier sections how social responsibility of medical schools has been mandated by The WHO (1995), Health Canada (2001), and The Association of Faculties of Medicine of Canada (2001, 2009). One can surmise that a medical school which has accepted this mandate and is located in an area with a significant marginalized population, including Aboriginal peoples, would take the fact of this marginalization and ensuing health inequities into consideration when planning curricula and programs. Similarly, we have seen that Health Advocacy is a Competency which is part of the objectives of all post-graduate training programs in Canada, is included in the undergraduate medical education objectives of many Faculties of Medicine in Canada and is considered by The Medical Council of Canada to be an attribute of a competent physician. Therefore, it would seem reasonable to find evidence of teaching regarding health advocacy in undergraduate medical education programs. Therefore, my thesis question is: How is the teaching of health inequities and the Health Advocate Competency incorporated into the undergraduate medical education curriculum of two self-described socially responsible medical schools in Canada? This is an important practical question which needs to be addressed as it establishes baseline data which does not exist about teaching of these important topics. It also establishes a program of research linking the areas of health inequities, the Health Advocate Competency and social responsibility from which other questions will evolve. The conversations on health advocacy and social responsibility are important conversations taking place across Canada. However, to date, these are largely separate conversations whereas I believe that they should be joined in the same conversation. The answers to my research question may also provide a basis to contemplate curricular changes which will support these teachings and enhance health equity. Further research in this field is justified as curricula interact with powerful agendas in society and can shift understanding, interpretation and action.
As I approach my thesis question, I have been consistently drawn to approach this study in keeping with my disciplinary roots. My grounding as a health care executive orients me to look at issues from multiple perspectives as over 35 years of experience in finding pragmatic solutions to complex problems has shown me the benefits of a multi-faceted review of causes and potential solutions to problems. Additionally, I do not want to limit myself to a single theoretical framework as using a specific theory privileges a way of looking while obscuring other facets of a problem. I believe that the problem that I am exploring can benefit from multiple theoretical perspectives to help not only illuminate the issue but also contribute to the solutions. Therefore although I am primarily joining the theoretical conversation on intersectionality, a theoretical approach advocated by Bannerji, Crenshaw, Collins, Dill, Zambrana and Robertson to name a few, I will also integrate other theoretical approaches such as biomedical ideology and socialization as well as business theories. In chapter one, I situated myself and explained the journey which led me to be drawn to intersectionality as my primary theoretical lens.

3.1.1 Intersectional Lenses

The term intersectionality has been attributed to Crenshaw (1991) who first coined it when writing about violence against Black women. She spoke of the fact that in real people’s lives patterns of racism and sexism intersected readily whereas they seldom did in feminist and antiracist discourse and practices. She noted that efforts by both groups occurred as if they were on mutually exclusive terrains. She felt that looking at one dimension only, such as gender or race, did not capture the full extent of the issues that a study of the intersections of the two could highlight. Additionally, she noted that by silencing discussions of violence in the Black community to avoid stereotyping or racism, the terror experienced by abused Black women was unlikely to be addressed as a serious issue and they would continue to be isolated. Similarly, silencing the voices of Asian women because “saving the honor of the family is a priority” (p.1257), would have a similar impact.

This is an important statement as it acknowledges that many marginalized individuals are impacted by multiple systems which interact and intersect thus reinforcing each other. The cumulative impact of these systems (for example racism, sexism, and classism) on a disenfranchised individual or group is stronger because of their interaction. Additionally, if treated separately, the historical hegemonic processes which created these systems are
reinforced on an ongoing basis. Thus the importance of understanding the origins of these systems, and tackling them as a group and not in an isolated manner.

Crenshaw further recognized that the concept of intersection could be expanded to include intersections of class, sexual orientation, age and colour. In fact, she suggested the “need to account for multiple grounds of identity when considering how the social world is constructed” (p. 1245). Crenshaw continued to say that where systems of gender, race, and class domination converge, interventions strategies based only on gender will be of limited help as the race and class of these different women will result in different obstacles to resolution. For example, she vividly describes the case of an abused Latina woman who fled, with her son, from her husband who had promised to kill them both. Shelters would not take her with her son so they were forced to live on the street for two days. A hotline counselor tried to help her and found a shelter that could accommodate her and her son. However, the shelter refused to take them because the Latina woman could barely speak English and they gave a variety of reasons for this refusal such as inability to participate in the counseling sessions. They refused the suggestion that her son could translate for her. They basically ignored her desperate situation because of the shelter’s commitment to rigid exclusionary policies. After multiple calls by the hot line counselor, the shelter finally agreed to take her. However, after the plan was finally in place, the Latina woman never called back. The hot line counselor wondered whether she was killed or had just given up, understanding that she could not count on help from the established English speaking feminist resources. Because the Latina woman did not match the profile of the shelter’s clients, the shelter failed to accomplish the raison d’être for shelters, to save a woman from danger. Crenshaw (1991) notes that this monolingualist policy was an ongoing problem in New York where this incident and many other similar incidents occurred, thus further marginalizing minority women in need.

Later in the article, Crenshaw (1991) suggests that: “intersectional subordination need not be intentionally produced; in fact, it is frequently the consequence of the imposition of one burden that interacts with preexisting vulnerabilities to create another dimension of disempowerment” (p. 1249). Again, it is important to stop and reflect on this statement. Individuals who are barely coping with their lived circumstances can be pushed over the brink with a minor illness, or the need for a therapeutic intervention which would not impact on a less vulnerable person. The additional burden is beyond their financial or emotional ability because they are coping with so many other stressors.
Thornton Dill and Zambrana (2009) define intersectionality as follows:

…an innovative and emerging field of study that provides a critical analytic lens to interrogate racial, ethnic, class, ability, age, sexuality and gender disparities and to contest existing ways of looking at these structures of inequality, transforming knowledges as well as the social institutions in which they have found themselves (p.vii).

Thornton Dill and Zambrana further elaborate that intersectional analysis sees inequality as derived from race, ethnicity, class, gender, and their intersections place some groups, based only on group membership, in privileged positions with unearned benefits with respect to other groups. An intersectional analysis should provide a critical lens to question health inequities and to advance an equity agenda.

Thornton Dill in Thornton Dill and Zambrana (2009) also suggests that intersectionality is “…pioneering work….done in the face of indifference and hostility” (p.229) and that those promoting intersectional scholarship must be “…change agents, willing to take risks…” (p.231). She proposes that understanding power is at the heart of intersectional thinking and that students must be taught: “to identify and understand concepts of power and privilege as they are implicated in systems of racial, gender and class oppression” (p.241).

She continues that intersectionality “…is a commitment to exploring questions of identity, inequality and social justice” (p. 245). She states that students who engage in intersectional scholarship gain important critical thinking skills. Thornton Dill further notes that scholars are trying to develop innovative and creative methods to teach the nuances, concepts and complexities of intersectionality and that: “Service learning and community connections are one of the ways that they sought to illuminate the connections between theory and practice” (p.241). These points by Thornton Dill will be further addressed in the discussion and conclusion of this thesis.

An example from the field of education of an equity agenda developed through an intersectional lens is discussed by Gatta (2009). In order to address the barriers that single, working poor mothers face in obtaining training and education, The New Jersey Department of Labor and Workforce Development piloted an innovative workers training program specially designed to address the needs of these women. The women received computers, printers, internet access and courses for a year via online learning in their homes. By understanding the problems that these women faced because of the intersection of gender, class and marital status and removing the obstacle to participation (transportation costs, child
care responsibilities leading to child care costs, traditional program hours, inflexibility due to working hours, no support system, etc.), a highly successful program meeting their needs was developed resulting in a high retention rate in the program. In today’s world, education is an important determinant of success and competence. This example clearly demonstrates how gender and class impacts access to education. Programs that facilitate access to education for disenfranchised individuals such as these women are likely to also positively impact the intergenerational trend to access education thus mitigating historical processes.

In Black Feminist Thought, Collins (2000), who also advocates an intersectional approach, discusses how groups who occupy different positions based on these intersectionalities demonstrate varying expressions of power which frame group participation in a wide range of activities and involvement accordingly shaping dominance and resistance. She gives the example of White women in The US who are disadvantaged because of gender but privileged because of race and citizenship, whereas African-American women will usually see the intersection of race, class and gender as the axis of oppression. She goes on to say that empowerment, for those suffering under multiple intersecting systems of oppression, lies not only in criticizing the hegemonic ideologies but also in building new knowledge. Years later, Collins (2009) refines this idea by noting that intersectionality focuses the analysis on the social structural processes by which inequality is organized and the mechanism that could be used to change these structures. In fact, the goal of intersectional analysis is to improve the lives of all marginalized persons, not just selected marginalized groups.

Rooney (2008) notes that intersectional analysis: “…integrates gender and social class along with other dimensions of discrimination and inequality into anti-discrimination practice” (p. 457). She also speaks of “learning to listen to silences” to ensure that no marginalized voices are missed or knowledge concealed when working with marginalized groups.

As this research study originates in the medical education world, an intersectional lens can be used to examine biomedical knowledge production as a racialized and gendered historical process and to give a voice to those who may have been silenced as a result of years of subordination.
3.1.2 Biomedical Ideology

The questionnaire results which follow in chapter four illustrate the overwhelming impact of scientific medicine and biomedical ideology on all aspects of medical education, the socialization of medical students, and the power of the hidden curriculum. It is therefore important to understand the origins of this scientific discourse. Sociologist Waitzkin (1989) states that: “…the acquired class position of physicians is one of relative privilege. Their predominantly comfortable lifestyle does not encourage professionals to criticize the social structural roots of their client’s distress, especially the sources of suffering in class structure” (p. 227). In other words, there is an ingrained reluctance to acknowledge physician power and to engage in a discussion which would broach the topic of sharing power with the disenfranchised. Waitzkin refers to the number of key contextual elements in the medical encounter including social class, gender, age and race which he argues profoundly influence the medical encounter in relation to what is said and what is deemphasized. He further notes that the language of medical science can and does convert social problems into technical ones that can then be fixed with a technical solution such as medication. By addressing these social problems in this manner “…medicine ideologically reinforces the status quo” (p. 236).

Manson (1994) suggests that in the same way that each culture has its character-ideal, professions have the same. He goes on to suggest “…that the character-ideal of the medical profession is, in large part, defined by the Protestant ethic” (p.154). He quotes William Osler, an influential physician, teacher, educator in the early 20th century, who strongly believed that the Protestant ethic and the Puritan temper were essential to the practice of medicine. Manson interprets this to mean that “…the moral education of a physician must come from mastery of the traditional ideals of Western culture” (p.155). At the time of Osler’s comments, these traditional ideals of Western culture were gendered and influenced by race, class, religion, and the scientific revolution taking place in medicine.

Turner (1990) notes that in the mid and late 19th century, the medical profession had low status, low income and did not have monopoly over delivery of medical services as most medical services were delivered at home. Furthermore, the hospital system as we know it did not exist. Brown (1979) says the mal-distribution of regular physicians, the high fees they charged and their focus on unpleasant and unsuccessful methods such as the use of the lancet and purgatives made physicians very unpopular. Furthermore, Nachman and Marzuk (2011)
write that the medical education curriculum of that time was vague, ill-defined, and contained little science.

Brown (1979) suggests medicine came of age at the same time as industrialization and capitalism came to dominate the economy. He notes that philanthropic foundations, such as those started by Rockefeller and Carnegie, both Social Darwinists, were the major external influences on medicine starting in 1900. The advances in scientific medicine, such as the germ theory and the focus on technical effectiveness were winning the support of the new capitalists as they believed that scientific medicine would improve the health of the work force and thereby increase productivity and profits.

Medical research was using new tools which promised more effective techniques for prevention and treatment of disease and the medical campaign for acceptance of scientific medicine was aimed at the capitalist group. Foundations, established by the newly wealthy entrepreneurial class, provided capital to fund the resources needed for scientific medicine which included well-equipped laboratories, clinical teaching facilities and teaching personnel in both the laboratory and clinical setting. Political power was held by the new capitalist class and their support was needed for the medical profession to gain and maintain professional status which would bring high income, and prosperity. The support of the capitalist groups would come if the ideology and practice of medicine was linked to the social interests of this politically dominant group who needless to say were homogenous in terms of gender (male), race (white), social class (upper-class and wealthy), religion (Protestant) language (English) and citizenship (American). A stable and healthy population was important for the growth of capitalism and industry as a healthy worker was ‘human capital’ which increased profits and decreased costs. The definition of health was linked to the capacity to work, and work was the core of the secular Protestant ethic. If physicians could keep the workforce healthy, their contributions to this developing economy would be rewarded. To this day, physicians decide when a patient can return to work, investigate whether a patient’s problems will interfere with work and write letters to employers and other agencies about work limitations for their patients.

Brown (1979) also suggests that medicine, by finding a technical reason for disease masked the causes of illness related to working and living conditions as well as poverty. Therefore, the biomedical model obscured the impact of the intersections of social class, poverty, housing, and potentially race and gender on health.
The 1910 landmark *Flexner Report*, commissioned by The Carnegie Foundation with the goal of improving the quality of medical education in North America profoundly influenced and dramatically shifted the development of medical education, an influence still strongly felt to this day. This report resulted in the move of medical training from a trade school model to a university based scientific model. Prior to this date, medical schools in The United States and Canada fell into three categories. These were: the apprenticeship system with a local practitioner, second, proprietary schools were students attended colleges with owner-physicians as their teachers, and finally, the university system with a combination of didactic and clinical training at a university-affiliated school (Halperin et al., 2010). Before Flexner, there were no standards or scientific foundation in medical education (Irby, Cooke, & O’Brien, 2010; Nachman & Marzuk, 2011). In speaking of the *Flexner Report*, Nachman and Marzuk note that this report has been cited as directly leading to the “national dissemination of the megalithic academic health centres” (p. 56). A similar statement is also discussed in *A Global Independent Commission Report* (2010). The *Flexner Report* revolutionized medical education with recommendations that focused on the biomedical scientific basis of medical education which were linked to the perspectives of the dominant capitalist groups. Hospitals also benefited from this report as they became clearly associated with scientific medical practice. Boelen (2002) notes: “…this emphasis on the biological and hospital-centered model of the Flexner report has contributed to shaping many medical educational programmes in a reductionist fashion” (p 592).

Rockefeller and Carnegie were interested in social order and a homogenous physician workforce attuned to the character, values and ethics of these leading capitalists would be ideal in advancing their worldviews. The influence on the *Flexner Report* of The American Medical Association (AMA), sustained by the Rockefeller and Carnegie philanthropic Foundations who funded early scientific medicine, cannot be discounted. The AMA’s advocacy for the dominance of scientific medicine through more rigid requirements such as the completion of a four year high school diploma, followed by a four year medical course and licensure was evident in the *Flexner Report*. In fact, as evidence of The AMA pressure, Brown (1979) notes that a member of The AMA accompanied Flexner on most of his fact finding medical school visits. According to Barzansky (2010), the individual accompanying Flexner was the secretary of *The AMA*, Dr. Colwell. Additionally, many of the state licensing boards, whose members were from the dominant class (male, White, English-speaking, socially prominent, likely Protestant and US citizens) were also supportive of raising the
standards of medical education. Brown (1979) states that *The General Education Board of the Rockefeller Foundation* was a powerful force articulating the interests of the corporate class while promoting and giving direction to the development of American health care and scientific technological medicine. In this environment, it is not surprising that Flexner’s recommendations included more rigid standards for admissions, extensive university-based training in scientific medicine and integration of basic and clinical sciences into the curriculum. Further Flexner recommended the establishment of full time faculties and laboratories as well as clinical teaching facilities. Without the support of the Carnegie and Rockefeller Foundations as well as *The AMA*, it is unlikely that Flexner’s report would have the impact it has had for the last 100 years. The *Flexner Report* also heralded the beginning of the ongoing relationship between capitalism and medicine, a relationship that continues today with many programs and buildings named after wealthy philanthropists, as well as funding of scientific biomedical research by corporations.

Flexner was lauded for his achievement and “…remarkable attempts to improve the quality of medical education” (Boelen, 2002, p. 592). He is considered by many as an icon in medical education because of the significant improvements which accrued as a result of his focus on excellence. It is important to note that Flexner also endorsed the societal obligations of physicians to prevent disease and promote health since: “…the physician’s function is fast becoming social and preventative, rather than individual and curative” (Flexner, 1910, p. 26). However, the discourse of societal obligation failed to embed in the medical culture which unreservedly adopted the scientific discourse as its mainstay. 100 years later, Nachman and Marzuk (2011) note that this obligation to society still represents a challenge to medical schools.

Flexner’s report, despite the advances it created in medical education, resulted in an increase in inequitable situations for the poor, Black people and women. As previously discussed, the report proposed entry to medical school after the completion of high school followed by an extensive university-based training in scientific medicine. The result of these recommendations was that only middle and upper class candidates could afford to undertake this education a situation which we have seen earlier, persists to this day (Waitzkin, 1989; Dhalli et al., 2002; Freeman et al., 2007). Additionally, in his report, Flexner recommended the reduction of a number of the 155 medical schools which existed in 1910 to 31 (Boelen, 2002). Bonner (1995) refers to Flexner’s “savage description of the inadequacies” of the medical schools he recommended for closure. These closures impacted 5 of the 7 segregated
schools for Black people leaving only two. According to Bonner (1995), Flexner was equally critical of both mainstream and Black schools which did not meet his exacting standards. Miller and Weiss (2001) suggest that, in fact, Flexner exhibited greater leniency with the Black medical schools than he did with the White medical schools. They also point out that subsequent to his report, as an employee of The Rockefeller General Education Board, he helped direct philanthropic gifts to secure the future of many of the remaining medical schools including the two remaining Black medical schools.

Halperin et al. (2010) characterize Flexner’s view on Black physicians as “benevolent paternalism” and along with Miller and Weiss (2001), note that Flexner suggested that Black physicians be trained to serve the lesser role of “hygiene” maintaining health and controlling infection and contagion. However Miller and Weiss go on to say that Flexner’s recommendation in this regard parallel statements made by the leadership of the two Black schools in the years prior to his report. This approach by the Black medical school leadership could also be viewed as an attempt to assimilate the dominant view in order to survive the closures of the medical schools. Miller and Weiss further argue that the steeper premedical education requirements established by The American Medical Association were more directly influential in curbing the production of Black doctors’ than the Flexner report. In addition to medical schools for Black people, many of the schools closed as a result of Flexner’s report included three women’s medical colleges and medical schools which admitted women as medical students. Halperin et al. (2010) references an article by Chapman (1974) that states that after the Flexner Report was published, the number of female medical students at coeducational medical schools declined in six years to 464 from a high of 752. Using an intersectional lens, the significant contributors to the demise of medical schools for Black people and women would be understood to include at the very least, social class, gender, poverty, racism and the social forces of that time as evidenced by the few hospitals which would provide internship to Black people and women.

Thus, the professionalization of medicine and the focus on scientific medicine impacted the poor, ethnic minorities and women all of whom suffered not only by being excluded from entering the medical profession but also by losing medical care that was indigenous to their communities (Brown, 1979). Midwifery and traditional healers were also negatively impacted by the new scientific approach. Furthermore, the rapid growth of medical knowledge in the nineteenth century resulted in the splintering of medicine into specialties and sub-specialties. Women suffered from additional health inequities in the form
of unnecessary surgeries and over-medicalization from gynecologists, one of the new specialty categories created as part of the reductionist approach to medicine (Brown, 1979). In 1931, less than one doctor in 5 was a specialist (Bloom, 1988), a situation quite different from today when the ratio of specialist to primary care physicians in The United States is closer to 1 in 2.

Flexner lived in a time where discrimination was endemic. Bhopal (1998) points out that: “the history of racism in science and medicine shows that people and institutions behave according to the ethos of their times…” (p. 1970). Since Flexner, there have been many examples where scientific medicine was involved in discriminatory, racist and even inhumane activities. Beagan (1999) discusses the implication of medicine in:

…historical oppression of all those subordinated social groups defined as Other. From medical decrees that intellectual stimulation would cause a woman’s uterus to atrophy, to biological theories of racial inferiority, to the construction of homosexuality as a category of psychiatric illness, to eugenics theories and ‘treatments’ for ‘feeble mindedness’, physical disabilities and ‘social undesirability’ (read poverty)- medicine has been willing to recognize cultural and social differences among its patients (p. 30).

The eugenics movement of the early 1920’s was a prime example with medical leaders such as Dr. Charles Kirk Clarke, former Dean of The Faculty of Medicine in Toronto and Dr. Clarence Hicks, co-founder of The Canadian National Committee for Mental Hygiene at the forefront of the movement in Canada. Two decades later, the Nazi experiments in the concentration camps were another example of scientific medicine spearheading acts of unbelievable atrocity under the guise of scientific experiments. Bhopal (1998) discusses the Tuskegee syphilis study which deceived Black subjects into participating in research examining the progression of syphilis, without treatment, even after a cure was available. He also alludes to the atrocities undertaken by Nazi doctors in the name of scientific progress and the unethical treatment of Black South Africans in custody during the apartheid. He further speaks of racial inequalities in treating a number of diseases. In a subsequent article, Bhopal (2001) explains that when scientific research implies that genetic factors are the cause of racial differences in health, this suggests that racial minorities are biologically weak. Sheets et al. (2011) provide a recent example of this perspective in their study describing pathology textbooks with unsupported labeling of race as a risk factor for certain diseases. Bhopal further expands that science has in the past helped to justify slavery, social inequality, eugenics and even immigration policies. In Canada, we have previously
discussed the role that Dr. C.K. Clark, former dean of The Faculty of Medicine at The University of Toronto, played in the development of the exclusionary Canadian immigration policies of the early 20th century. The Institute of Medicine’s *Unequal Treatment* report (2003) is replete with study after study outlining how patients from certain ethnic or racial groups have received inadequate investigations and treatment.

On the 100th anniversary of *The Flexner Report*, a plethora of articles and reports discussing new directions subsequent to the immense, groundbreaking reforms which succeeded *The Flexner Report* have been published (Cooke, Irby, Sullivan, & Ludmerer, 2006; The Carnegies Foundation’s *A Call for Reform of Medical Schools and Residencies*, 2010; A Global Independent Commission, 2010; Nachman & Marzuk, 2011; Wen et al., 2011; Hemmer et al., 2011). Additionally, the entire issue of two prominent medical education journals, *Academic Medicine* (February 2010) and *Medical Education* (January 2011), have been devoted to articles which reference Flexner and his work.

Frenk et al. (2010) in a Global Independent Commission note: “the work of the Commission is intended to mark the centennial of the 1910 *Flexner Report*, which has powerfully shaped medical education” (p. 9). The report states that reforms sparked by the Flexner report have “…contributed to the doubling of life span during the 20th century” (p.1). Flexner’s reforms were adopted not only in North America but also in Europe and even in China through the establishment of The Peking Union Medical College in 1917 by The Rockefeller Foundation.

In 2010, The Carnegie Foundation published a new report entitled *Educating Physicians: A Call for Reform for Medical Schools and Residency* (Irby et al., 2010). Nachman and Marzuk (2011) note that this recent Carnegie Foundation report “Flexner Redux or Flexner 2” recommends “…shifts to the current medical education paradigm that are ‘corrective’ to Flexner 1” (p. 57). Publishing interestingly in The *Perspectives of Biology Journal*, they note that a radical reform is now required as *The Flexner Report* in combination with The National Institute of Health (NIH) and others: “…contributed significantly to the ‘unintended evolution’ of a physician work force that is imbalanced in favor of highly paid specialists and a profoundly unaffordable health care system that is scientifically advanced but relies heavily on expensive technology” (p. 56). However, Nachman and Marzuk (2011) are still laudatory about *Flexner 1* stating: “…the remarkable scientific and medical achievements generated in part by *Flexner 1* are among the great
accomplishments of the modern civilized world” (p. 59). These significant scientific achievements keep the culture of medicine focused on a biomedical ideology.

Since I am speaking about the culture of medicine, a definition of the word culture is probably useful at this time. Jenkins (1996) defines culture as follows:

…a context of more or less known symbols and meanings that persons dynamically create and recreate for themselves in the process of social interaction. Culture is thus the orientation of a people’s way of feeling, thinking, and being in the world-their unself-conscious medium of experience, interpretation and action. As a context, culture is that through which all human experience and action-including emotions-must be interpreted (p.74).

Beagan (2000) studied students and faculty at one medical school to see if the change, since the 1990’s, in homogeneity of the student body has had an impact on the culture of medicine. She found pressure on students towards homogeneity during medical school and part of that push to conformity appeared linked to the development of clinical diagnostic thinking. She notes that there is an expectation that students will learn to think in standardized ways following the same thought process to reach the same diagnosis: “Firmly rooted in scientific knowing, medicine is based on the ideal of impartial reasoning: dispassionate, abstract, and objective, separated from feelings, desires, commitments, experiences” (p. 1262). And: “…medicine incorporates an ideal of the socially neutral physician working with universal medical knowledge following universally accepted medical thought processes to come up with the same diagnosis that any other medical colleague would reach” (p. 1262). She argues that medical education produces “socially-neutral physicians” and that: “…medicine has always allowed for the existence of differences in the objects of its gaze, but much less so in its subjects, the medical gazers themselves” (p. 1261). This is similar to Taylor’s (2003) idea that medicine sees itself as a “culture of no culture.”

As the result of her research, Beagan (2000) submits, there is a need: “…to teach students that medical knowledge is socially constructed, rooted in time and space and particular social relations. Impartiality, the view from nowhere is a myth” (p. 1263).

A few years later, Beagan (2003) studied the effects of exposure to a new course in the first and second year of medical school which addressed social and cultural issues in medicine. The goals of the course were to teach students sensitivity to gender differences, cultural diversity, and social diversity and how these factors affect well-being as well as physician-patient interactions. The results of her study indicated that at the completion of the
course, students still failed to recognize the effect of race, class, gender, culture and sexual orientation and the theme from the students in the interviews was that diversity is not an issue. In fact, Beagan states that: “…the standard of medical practice is to treat everyone neutrally, objectively, as if they were cultureless, classless, raceless, genderless” (p.612). Additionally, she notes that when students see clinicians model care that does not address cultural and social diversity they begin to see socially responsible medicine as “ …all very nice to talk about in theory, but ultimately it makes no difference” (p. 614). Her study clearly shows the importance of Faculty role models.

Waitzkin (1989) discusses the traditional medical encounter as described in most textbooks and as used by medical students and practicing physicians as follows:

- Chief complaint (CC)
- Present illness (PI)
- Past history (PH)
- Family history (FH)
- Social history (SH)
- Systems review (SR)
- Physical examination (PE)
- Other investigations (OI)
- Diagnosis (Dx)
- Plan (P)

Anything that “does not contribute to the cognitive process of reaching a diagnosis is either ignored or interrupted” (p.228). He noted that:

Practitioners and doctors in training view the facility of diagnostic categorization as one of the most important professional skills in medicine…….Contextual concerns that do not lend themselves to the technical lexicon of diagnostic possibilities tend to gravitate towards the margins of medical talk (p. 230).

Bloom (1988), a medical sociologist, notes that since the Flexner report there has been a resistance to change in medical education because at its core, the concentration of academic medicine is: “on a scientific mission that has crowded out its social responsibility to train physicians for the society’s most basic needs in the delivery of health care” (p. 295).

He further recognizes that the structure of modern medical education was established at the time of the Flexner Report for “…the purposes of incorporating the revolution in biomedical sciences” (p. 295) and after the success of this endeavour, has added “…high-technology specialization as the main goal for clinical medicine” (p.295). Most importantly, Bloom argues that although preparing physicians to serve society is repeatedly declared as the objective of medical education:

…this manifest ideology of humanistic medicine is little more than a screen for the research mission which is the major concern of the institution’s social structure. Education is secondary and essentially unchanging, even though brave ideology statements guide curriculum reforms that do little but mask the underlying reality (p. 295).
Bloom speaks to the many attempts since Flexner to change medical curricula to “...repair the de-humanizing effects of scientific specialization” (p. 296) while retaining the best of science and reducing the polarization of the what of medicine (the reductionist scientific approach) and the how (the humanistic approach). He calls these attempts “reform without change” (Bloom 1989) and discusses the 1988 World Federation of Medical Education conference which produced a special report to try and answer the questions of why change in medical schools is so difficult and why innovations are so taxing that innovators prefer to set up new schools. A case in point is The Northern Ontario School of Medicine which welcomed its first medical student class in September 2005 and whose core mandate is social accountability. As previously discussed, this medical school’s approach to meeting its social accountability mandate to its community is evidenced by its organizational structure and the inclusion of its various communities in all aspects of the school’s life. This approach is what Bloom calls the ability to “…synchronize organizational structures more closely with educational values” (p. 299), in this case the educational value of social accountability. As the first graduates of NOSM enter medical practice, research is required to see if this new school has been able to produce more socially responsible physicians and if these physicians will have an impact on health equity.

Bloom’s thesis is that desired outcomes are not achieved because the research mission is the major concern of medical schools and the social structure and resource requirements supported by the corporate interests is focused on that vision. Bloom returns to the theme of biomedical reductionism in his 1989 and 1990 publications. In his 1990 article he notes that “…biomedical research receives the financial support and attention of the medical community” (p.2) and he explains why this occurs quoting Leon Eisenberg, Professor of Social Medicine at Harvard School “…because being able to describe the pathophysiology of disease is so central to the culture of biomedicine...” (p.2).

Kuper and D’Eon (2010) note that it is now widely accepted that there are multiple domains outside of the objective biomedical bio-scientific knowledge framework which are deemed to be important for a competent practitioner in the 21st century. They further note that there are major gaps between competency frameworks such as CanMEDS, based on societal expectations of doctors, and the actual content of medical curricula. They suggest that to address this lacuna requires the engagement of disciplines outside the traditional scientific biomedical sciences curricula.
Wen et al. (2011) comment on both *The Flexner Report* (1910) and *A Global Independent Commission Report* and call for more emphasis on service and social mission in health professional training to create the kind of physician that Flexner would have wanted. They suggest that a critical section of *The Flexner Report* which is often overlooked is Flexner’s emphasis on the social contract of physicians and their commitment to society.

According to the *Beyond Flexner Report* (Mullan & Lee, 2012) The W.K. Kellogg Foundation is supporting a study of the unintended consequences of *The Flexner Report* in regard to health equity in The United States. The *Beyond Flexner Report* will explore educational models that go beyond Flexner in addressing the social mission of medical education.

The foundation of scientific medicine is reductionist, looking at a section rather than the whole and focusing on bacteriology and cell pathology (Kay, 1993; Brown, 1979). Although this approach has been extremely successful in identifying new technology and treatments and in eradicating disease, it is deficient in meeting the present health care challenges and addressing health inequities. As Coulehan and Williams (2006) note: “…in medical education scientific knowledge serves as a Rosetta stone for understanding other forms of human discourse….The emotional and symbolic aspects of human experience are distanced and diminished” (p. 599). The scientific culture of medicine values objectivity, positivism and hard facts and appears to socialize medical students to this limited vision ignoring other dimensions of the human experience. The unintended consequences of this socialization may be the loss of altruism, an attribute that supports health advocacy and therefore social responsibility.

It is also interesting to briefly compare the philosophical approach of scientific medicine and intersectionality. As we have seen, at its core, scientific medicine is rational, reductionist and objective. Its focus is on specialization and its gaze reduces the person to body parts and essential findings. However, intersectionality proposes that the gaze be holistic, encompassing the total person including all social aspects of their lived circumstances. Intersectionality is expansive and inquiring and seeks to uncover and understand historical oppression and its impact on different groups.

### 3.1.3 The Hidden Curriculum and Socialization to Medicine

Coulehan (2005) speaks of the conflict that many (Bloom, 1989; Hafferty & Franks 1994; Hafferty, 1998) have explored concerning: “…what we think we are teaching medical
students and young physicians (the explicit/formal curriculum) and a second set of beliefs and values that they learn from other sources (the informal or hidden curriculum” (p.893). Further in the same article Coulehan defines it more concisely stating “…what they see us do (the hidden curriculum) and what they hear us say (the formal curriculum)” (p.895). He goes on to say that this informal/hidden curriculum consists of: “…tacit learning of objectivity, detachment, self-interest and distrust of emotions, patients, insurance companies and the state” (p. 894).

Lempp and Seale (2004) describe the hidden curriculum as: “…the set of influences that function at the level of organizational structure and culture, for example, implicit rules to survive the institution such as customs, rituals and taken for granted aspects” (p.770).

There are many more articles in the medical literature referring to the hidden curriculum as a major influence on student learning (Hundert, 1996; Ratanawongsa, Teherani & Hauer, 2005; Ozolins, Hall & Peterson, 2008; Allen, Wainwright, Mount, & Hutchinson, 2008; Hafferty, 1998; Karnielle-Miller, Vu, Holtman, Clyman & Inui, 2010), to name a few.

According to The Association of Faculties of Medicine of Canada (AFMC), “The hidden curriculum encompasses what students learn outside the formal curriculum. It is pervasive and complex and can be deeply instilled in institutional culture” (AMFC, 2009, p.23).

Hafferty and Franks (1994) note that the socialization into medicine is a fundamental enculturation into the profession of medicine which impacts the established values of the students. They further suggest that many of the “messages” that are transmitted by the hidden curriculum may directly conflict with the formal curriculum and may, in fact, unintentionally convey images that perpetuate gender, racial, ethnic, and cultural or disability stereotypes.

Hafferty and Franks (1994) further note that:

…all educational strategies (however targeted, task specific or “factually” based) involve the presence and transmission of cultural values and therefore the prospect of change. Similarly, educators routinely acknowledge that the overall process of education is a form of socialization and that all socialization involves a moral dimension… (p.863).

They go on to state: “…traditionally, such a paradigm has found little receptivity among medical school faculty particularly those who view the knowledge base and application of science as value neutral, “objective” and therefore transcultural” (p.863).
Hafferty (1998) defines the learning environment in medical education as consisting of three spheres 1- the stated, formally offered curriculum, 2- the informal curriculum: the unscripted, ad hoc interpersonal learning that takes place between faculty and students and 3- the hidden curriculum which is a set of influences that function at the level of organizational structure and culture. The end result of the interaction of these three curricula is that there is a difference between what students are formally taught and what they learn. In fact, several authors suggest that medical students often learn the ideology and professional values of medicine by observing their role models (Hafferty & Franks, 1994; White, Kumagai, Ross & Fantone, 2009; Karnielli-Miller et al., 2010). Irby et al. (2010) suggests that Flexner was concerned about students having role models and the development of professional identity. Flexner believed that students should spend time with scientifically grounded university faculty role models to become socialized into their new profession. Today, socialization through role models is a reality of medicine although the result of that socialization can be problematic.

Manson (1994) states that several studies of medical education in the 1950s-1960s found a decline in altruism and a rise in cynicism as students go through medical school. On page 160 he states that:

…the consensus of these studies is that role-models, not curriculum, are the main determinants of student values, thus confirming what Osler already knew, that the do’s and don’ts of doctorhood are taught by example, by the “silent influence of character on character” (Osler, 1996, p.234).

To illustrate this point, a comment from a student in a study by Ratanawongsa et al. (2005) indicates the profound influence of teachers and role models on the developing attitudes of medical students: “The most important thing was the leadership at the top, was our attending and how he dealt with these issues. I think that if he had been very clinical and detached, it would have signaled to me ...that’s my role model, that’s how I’m supposed to act” (p. 644).

In his 1998 article, Hafferty suggests that we go further to understand the hidden curriculum and “…explore the underlying structure and the organization of our institutions themselves” (p.404). He suggests a review of policy development, evaluation, resource allocation, institutional “slang” or nomenclature to see what values and messages are being transmitted in each of these domains. For example, a review of evaluations used would suggest what is valued enough to be assessed or a review of resource allocation would
indicate the priorities of the school. He suggests that “…medical training is, at root, a process of moral enculturation, and that medical schools function as moral communities” (p.406). Until this is accepted, reforms will be “both elusive and enigmatic” (p.406).

Sinclair (1997), Lief and Fox (1963), as well as Becker et al. (1961) discuss the training for detachment that medical students must acquire in order to become physicians. Students observe and absorb the manner in which residents and staff physicians display this characteristic of objective detachment. These authors suggest that the idealized image of the profession, which students aspire to, is that of detachment and scientific objectivity, and the language they learn helps them to maintain consensus and the scientific focus of the profession, in short, to adopt the culture of medicine.

Wear (1997) suggests that as a result of the socialization into the culture of medicine: “…students may experience their medical education as one built around inconsistencies between what is touted as desirable and the unacknowledged or unquestioned enactments of privilege and exclusion in medical institutions and in the delivery of care” (p. 1058). She suggests that there should be an examination of: “the fit between the institutional values of medicine (reflected in its organizational structure and system of rewards) and its stated educational values; between how we act (with students, non-physicians colleagues, and patients) and what we say is important” (p. 1057). She further states that current medical education says it values: “…compassion, reflectiveness, social responsiveness, autonomy and diversity but all the while is rewarding and sustaining practices based on competition, hierarchies of authority, fixed spheres of practices, bottom-line thinking, and economic privilege” (p. 1058).

Beagan (2000) conducted a study of students and faculty at one Canadian Faculty of Medicine and found that students learn to conform as they do not wish to stand out in a hierarchical setting where “shamed-based” teaching is still common. They learn by observing their teachers in the clinical setting that some of their personal caring and humane responses to human suffering are unacceptable in medical professionals.

D’Eon (2010) suggests that unidentified and arcane elements of the formal curriculum are often the forces behind the hidden curriculum and that role modeling by practicing physicians and physician educators plays an important direct or indirect role in the transmission of the hidden curriculum. He further suggests that the hidden curriculum is more powerful than the formal curriculum in teaching attitudes and approaches to the practice of medicine and that it may also play a role in the loss of student idealism and
emotional sensitivity. White et al. (2009) provide an example of this when they reported on a survey of the first cohort of students to complete a Family Centered Experience at one US medical school which focused on providing patient centered care. Student comments revealed that they were exposed in their third year to role models who did not necessarily espouse the values that were being taught in first and second year of medical school. Students expressed feelings of powerlessness when exposed to this dichotomy and the fact that they were expected to act in the same manner as their role models. From the data, the researchers were able to develop three categories of responses to this experience as manifested by these students: maintenance, compromise, or transformation of values after this experience.

Irby et al. (2010) address the hidden curriculum in the key findings and recommendations of the 2010 report of The Carnegie Foundation. They acknowledge that physician professional identity formation, which includes values and actions, must be a key focus of medical education and in fact make identity formation one of the four overarching themes of The Carnegie 2010 Report. Under this theme, they recommend the following: “Address the underlying messages expressed in the hidden curriculum and strive to align the espoused and enacted values of the clinical environment” (p. 226). Canada has also acknowledged the hidden curriculum and the following recommendation is in The Future of Medical Education in Canada 2009 AFMC Report. Recommendation five reads as follows:

The hidden curriculum is a set of influences that function at the level of organizational structure and culture affecting the nature of learning, professional interactions, and clinical practice. Faculties of Medicine must therefore ensure that the hidden curriculum is regularly identified and addressed by students, educators, and faculty throughout all stages of learning (p. 23).

I have listed three conceptual frameworks in my methodology: 1- intersectional lenses, 2- biomedical ideology and 3- the hidden curriculum/socialization to medicine. The application of the intersectional lens will be further developed in Chapter 4 and 5. However, I felt compelled to address the other two frameworks of biomedical ideology and the hidden curriculum/socialization to medicine because their impact has been so endemic in medicine. Knowing about these frameworks and their established influence in medicine influenced my choice of methodology in the following manner. By identifying self-described socially responsible Faculties of Medicine located in an area with many marginalized populations, and targeting the undergraduate course directors, the individuals most familiar with the medical curriculum to complete my questionnaire, I thought I would be able to identify
whether there was a weakening of the predominance of the biomedical ideology discourse in their medical curriculum and a shift to discourses of health advocacy, health inequities and social responsibility. This in turn would suggest a potential commensurate change in the socialization of medical students into the biomedical ideology and the hidden curriculum which supports this ideology. The interviews which were initially planned with a smaller sampling of these same course directors would have allowed a more in-depth assessment of the questionnaire results and a better understanding of the dynamics at play. However, as I will explain later in this chapter, I had to change my original interview participants from a smaller sub-group of Course Directors to equity leaders in health care organizations and the community. The new interview subjects helped to further develop my intersectional approach.

3.2 Study Sites

Brosnan (2010) states that the vast majority of studies of basic medical school education are conducted with a single medical school. The reason for this reductionist approach may be related to the challenges in doing multi-centered Faculty of Medicine qualitative research. I originally hoped to work with four of the seventeen medical schools in Canada. However one of these medical schools displayed reluctance to participate unless the research question was re-structured to benefit the school. Therefore it is not part of the study. However, the challenges encountered in this study with the three remaining medical schools were significant. These challenges included months of delays obtaining sequential ethics approval and months to organize visits to distribute questionnaires.

The requisite criterion was that the medical schools selected be located in an area with a large Aboriginal population since the literature suggests that this population embodies health inequities (Adelson, 2005). This allowed a critical review of the demonstration of social accountability towards this marginalized community by these Faculties of Medicine in their teaching and community programs. After New Zealand, Canada has the second highest proportion of Aboriginal peoples in the world (Institute of Wellbeing, 2009). The June 2009 Report of the Senate Standing Committee on Social Affairs, Science and Technology commented that:

There are striking disparities between Aboriginal and non-Aboriginal Canadians in most health determinants and the gaps are widening. In particular, the socioeconomic conditions in which Aboriginal peoples live are often cited as being similar to those in developing countries. This
situation is not only deplorable, it is simply unacceptable (p. 39, Standing Senate Committee, 2009).

_The Institute of Wellbeing Report_ (2009) notes that internationally, _The UN Human Rights Working Group_ have expressed concerns both in 2003 and 2008 about the health, social and economic wellbeing of Aboriginal peoples and health disparities between Aboriginal and non-Aboriginal people. _The UN Human Rights Council_ periodic review recommends that Canada strengthen representation of Black and Aboriginal groups to include them in the government decision process (Institute of Wellbeing, 2009). This is an interesting and notable recommendation as writers such as Sir Michael Marmot (2004) have written extensively on health inequities, social gradient and social standing and how these affect health. They note that: “To have control over their life and opportunities for meaningful social engagement are necessary for health” (p. 249). McMurtry and Curling (2009) report that Aboriginal peoples experience a sense of exclusion as well as health and income inequities that are exacerbated by discrimination described as “virulent and entrenched.”

I consulted the 2006 Canada census to ascertain where Aboriginal peoples in Canada are primarily located and used this information as a guide to help identify four Faculties/Schools of Medicine in Canada which would meet the previously described inclusion criteria for this study. I approached all four Faculties/Schools and received initial support from three Faculties of Medicine. As previously mentioned, the fourth Faculty of Medicine would only participate if I changed my research question to one that was of interest to that Faculty.

The three medical schools selected have a large Aboriginal population in common. Review of the questionnaire results would provide information as to whether or not these schools had incorporated programs to discuss and/or enhance the health care of this population. All three Faculties of Medicine agreed to participate in this research proposal and ethics approval was obtained from all three Universities.

The participating Faculties of Medicine were assigned a unique identifier known only to the PI. No individual or institutions were to be named in the study results with information limited to the fact that the institutions are located in areas where there is evidence of significant health disparities (embodied by the local Aboriginal population). The anonymity issues seemed important to the Faculties of Medicine during the discussions about the project and therefore was agreed upon to encourage participation.
Eventually the behaviour of one of the associate deans at one of the three medical schools made ongoing participation with that particular Faculty of Medicine impossible. The behavior included sporadic responses to my one and half years of regular emails and phone calls, prolonged periods of unresponsiveness followed by promises of cooperation followed by more periods of unresponsiveness. A concrete example of the challenges with this assistant dean was a meeting I had with this individual. At the meeting I was asked to provide a copy of my questionnaire so that I could proceed with surveying the participants at this Faculty of Medicine within the next month. The comments about the questionnaire from this individual were extremely positive and include “perfect for the school’s purposes”. I promised to have survey results back to the school within a month of completing the survey. After taking a copy of my questionnaire, there were no more responses from this associate dean to my multiple calls. With the support of my thesis committee, this medical school was eliminated as a participant and questionnaire data was limited to the other two medical schools.

3.3 Study Design

I believe that my research is best characterized as a qualitative description study according to Sandelowski’s (2000) explanation that such studies entail “…the presentation of the facts of the case in everyday language” (p.336) and seek “descriptive validity” (336). I consider myself an “applied health researcher” as described by Thorne (2011) as I designed my research question with the purpose of beginning the conversation on an important previously unasked practical question. As I mentioned in section 1.3, situating myself, I have a pragmatic end goal for this research: I want to contribute to the process of addressing health inequities through the identification of meaningful changes in medical education which will produce medical graduates who are change agents for a more equitable world. However, the first step was to identify the status quo.

I selected my methodology in light of this purpose and the selection was challenging as the medical schools in my sample did not have curriculum mapping. Curriculum mapping is a process that documents course objectives and content, instructional practices, as well as assessments tools, exposing the relationship amongst courses and the contributions of each to the overall goals of the curriculum. It is a map outlining whether or not curriculum goals have been met. Without curriculum mapping, the description of the school’s curriculum is a high level comment on what the schools would like to teach but the specific daily content as
well as the elements emphasized are difficult to capture and their weight in the curriculum even more elusive. Measurement of any element in the curriculum becomes an approximation provided by the tool in question.

My study employed a mixed methods approach. Stewart, Makwarimba, Barnfather, Letourneau, and Neufeld (2007) suggest that mixed methods research enhances the relevance and provides a more balanced contextual perspective for research on issues related to health disparities. Schifferdecker and Reed (2009) point out that mixed methods analysis is beneficial when studying new questions or complex interactions.

The mixed methods used in this research include an initial structured questionnaire as an institutional scan, administered to undergraduate medical education Course Directors to collect initial base-line data. Without curriculum mapping, Course Directors are the most knowledgeable individuals about what is being taught in their course as part of the overall curriculum. There is however a caveat to this statement, Course Directors are not present at all interactions between the students and the faculty involved in the delivery of their course. They can provide an estimate of what the course Committee considers important but not the certitude that the delivery was as intended.

After the data from the questionnaires was analyzed, I had originally intended to interview a subset of these Course Directors to further probe and hone the descriptive validity of my research. However, the responses had such a biomedical focus that I despaired that interviews with this group would yield nothing further. Since I hoped to develop some recommendations to enhance health equity, health advocacy and social responsibility teaching in medical education, I had to change my initial participant profiles and look for participants who worked in equity frameworks. I therefore chose to undertake a series of open-ended semi-structured interviews with equity leaders. The purpose of the interviews was to bring the perspectives of these equity leaders as well as examples of frontline health equity work into the data collection. Of equal importance was that at this point, I was committed to my intersectionality framework and was convinced that these individuals could be content experts on this topic whether or not they were familiar with this terminology.

So to summarize my methodology, as a first step, I distributed a structured questionnaire to Course Directors at 2 Faculties of Medicine in Canada. Subsequently, the results of the questionnaire were manually entered into Survey Monkey and this commercial product generated results in the form of descriptive statistics. The comments in the questionnaire and the results of the questionnaire lead me to think of this data in light of
biomedical ideology, the hidden curriculum and socialization of medical students. Once these questionnaire results were analyzed and reviewed, I then did a series of semi-structured interviews with equity leaders. I analyzed the content of these interviews through multiple readings identifying clusters and similar categories of meanings which were eventually organized into themes. Both the results of the questionnaire and the semi-structured interviews were ultimately seen through the framework of intersectionality.

3.3.1 The Questionnaire

A survey design with a questionnaire as the instrument was used and the data generated will provide each medical school involved with data about if and how health inequities and the Health Advocate Competency are taught in their respective self-described socially responsible schools. The results may also help to generalize from this sample to the other Canadian medical schools about challenges in teaching about health inequities and the Health Advocate Competency. The questionnaire was developed based on a review of the literature and designed to provide very specific details about content, instructional methods, barriers and evaluation tools which could be used when instructing about health inequities and the Health Advocate Competency. The questionnaire has a brief introduction followed by two sections: one on health inequities and one on the Health Advocate Competency. The questionnaire was structured so that it was easy to complete (within 10 minutes) in recognition of the many time constraints faced by clinician educators. The scale used was one designed to diminish the bias related to a socially desirable response. The questionnaire was piloted, prior to use, with a range of individuals and educators who are not involved in this study but have an interest in these topics and are located at the participating medical schools. The reviewers include physicians, residents, medical students, educators, qualitative and quantitative researchers and market research experts. The pre-testing resulted in minor modifications to the questionnaire. The questionnaire is attached as Appendix 1 and the consent form for the questionnaire is Appendix 2.

The questionnaires were distributed at the two participating medical schools longitudinally over 2 academic years. The questionnaire distribution at Medical School A was done as soon as ethics approval was given. Medical School B’s ethics approval process did not start until their administration was told that Medical School A had given ethics approval. Therefore, the collection of data occurred in two different academic years. However, at each medical school, the distribution and follow-up process was approximately
three months. A unique identifier was assigned to each school as well as each individual survey respondent to assure confidentiality.

As an aside, Medical School C, which was dropped from the study at the time that questionnaire distribution was to start, also gave ethics approval as soon as Medical School A gave their ethics approval.

### 3.3.2 Semi-Structured Interviews

Initially, semi-structured interviews were going to be conducted with a few of the undergraduate medicine Course Directors from the participating medical schools to further delve into the results of the tabulated questionnaire. However, because the results from the data analysis clearly indicated that health inequities, health advocacy and social responsibility were not at the forefront of undergraduate medical education teaching, another approach was needed. After discussions with my thesis supervisor, it was agreed that the interviews would be done with equity leaders in health care. These equity leaders can discuss the lived experience of their work at the forefront of the equity movement and discuss approaches that have been successful as well as barriers encountered. It seems reasonable to move from the theory of health inequities and health advocacy to understand praxis as it exists in the community. To identify equity leaders, a prominent local equity leader was approached and through her, an initial list of interview candidates was developed. Both physicians and non-physicians were added to the list in order to see if these two groups brought a different perspective. Snowball technique was used to identify additional leaders and interviews were done until saturation was reached. The actual interview questions emerged from discussions with my thesis supervisor, reflection on the questionnaire data, as well as reflection on the intersectional equity literature informing this thesis. In the simplest of terms, the purpose of the interviews was to explore and identify elements and challenges of intersectional equity in practice and to see if these practical approaches can inform changes needed in the structure of medical education resulting in prioritization of health advocacy and social responsibility to address health inequities. As Kvale (1996) notes, “…the interview is a specific form of human interaction in which knowledge evolves through dialogue” (p. 125). The content of the interviews include factual information, lived experiences, personal perspectives and opinions. The interview participants were associated with two medical schools.
Participants signed an informed consent for these taped interviews and were assigned a unique identifier to ensure confidentiality through the entire process, from taping, transcription, analyzing and reporting. Participants were also informed that although the interview content will form part of my thesis, it is possible that parts of the aggregate data will be used in journal articles or in work to move forward the equity agenda in medical schools. Consent forms for the interviews are attached as Appendix 3. The interviews lasted a range of 45 to 70 minutes.

Immediately after each interview, I set aside time to review the context, experience, tenor and content of the interview and made pertinent notes to assist in the later analysis of the transcript.

The interview questions were as follows:

- Could you describe in as much detail as possible how you use an intersectional equity approach in your work? (Tell me about a typical day and how you use this approach).
- Describe some of the challenges you meet on an ongoing basis moving an intersectional equity agenda forward.
- Do you think incorporating an intersectional approach into medical practice to address social responsibility and health advocacy is feasible? Give me some concrete examples of how this can be done.
- Do you have an opinion on whether the reward system for physicians (funding, promotion and recognition for academic physicians) impacts their ability or desire to incorporate social responsibility and health advocacy into their practices?

### 3.4 Sample Size

For the questionnaires, the sample included all undergraduate medicine Course Directors at the two participating medical schools, except those involved as Course Directors for Elective or Selective rotations for a total of 81 invited participants. The exclusions are based on the fact that electives and sometimes selectives do not have defined core content. In cases were Course Directors were responsible for longitudinal courses across more than one year, their responses were counted as one unless they responded with different information for different years. Course Directors were selected to respond as they are the most
knowledgeable individuals to speak about the content, instructional methods, evaluations and settings used in their courses.

For the semi-structured interviews, eleven health equity leaders were interviewed.

### 3.5 Study Period

The original intent was that the data gathering would take place over one academic year. However the process of obtaining ethics approval from three medical schools took most of that year. This process was the result of a sequential approach to ethics approval requested by The Faculties of Medicine. Only after the home-based Faculty provided ethics approval did the other two Faculties begin the ethics approval process at their respective institutions. Once these approvals were in place, the process of obtaining consent to be placed on the agenda of regularly scheduled undergraduate medical education meetings proved to also be challenging. Therefore, the data gathering for the questionnaire took place over two academic years and the questionnaire asked about dates of course changes to support comparability of data. The third medical school appeared to lose interest in the project and after consultation with my thesis supervisor, this medical school was deleted from the sampling.

Once the questionnaires were completed and analyzed, interviews with equity leaders were conducted over a period of a few months. Analysis of the interview data was completed within 6 months of undertaking this phase of the research.

### 3.6 Data Collection

The data collection process for the questionnaire and the interviews was as follows.

#### 3.6.1 Questionnaires

Although the questionnaire was designed using the commercial company Survey Monkey, the questionnaire was not distributed electronically. The reason for this was that anecdotally, I was told by many colleagues that there would be a higher response rate if the questionnaire was distributed personally. For medical school A, I attended two scheduled Course Directors meetings where I explained my research interest, answered questions and distributed invitational letters and consent forms. The consent forms were collected at the end of the meetings by the administrative support staff for the committee and forwarded to my attention. Those not attending either meeting received their consent forms by mail. Within a week of these meetings, I distributed the questionnaires to the Course Directors who had
agreed to participate. Self-addressed envelopes were given to return the completed questionnaires. After three follow-ups with no response, it was concluded that non-responders were not interested in participating in the study.

The steps for Medical School B were as follows. I attended two scheduled meetings of Course Directors to explain my research and distribute questionnaire packages which included invitational letters, consent forms and the questionnaire. The slight change in the process of distributing the questionnaire packages was the result of reviewing the inefficiencies experienced in the distribution of the questionnaires to Medical School A. The new process was intended to delete one step in this distribution process. Additionally, the Chair of one of the committees where I presented my research gave individuals choosing to respond to the questionnaire, time in the meeting to do so. 100% of those in attendance at that meeting completed the questionnaire. Unfortunately in Medical School B, because of particularly inclement weather, only a small number of potential participants were at the two meetings which I attended. Therefore, the remaining questionnaire packages were mailed out. After three follow-up contacts it was assumed that the non-responders were not interested in participating in the study.

Table 2: Summary of Medical School Participation Rates

<table>
<thead>
<tr>
<th>Medical Schools</th>
<th>N=</th>
<th>%</th>
<th>Non-respondent #</th>
<th>Non-respondent %</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>22</td>
<td>92%</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>B</td>
<td>38</td>
<td>67%</td>
<td>19</td>
<td>33%</td>
</tr>
<tr>
<td>Combined</td>
<td>60</td>
<td>74%</td>
<td>21</td>
<td>26%</td>
</tr>
</tbody>
</table>

Because of the significantly high response rate in Medical School A, and the adequate response rate in Medical School B, response bias likely does not exist as the non-respondent percentage is insufficient to substantially change the overall results. In terms of age, participants were not requested to give their age but we know that most Course Directors are medical graduates who usually have been involved for some time in educational leadership activities in the medical school and would therefore be a minimum of 35+ years old. The normal pattern is that Course Directors usually have a maximum 10 year term and therefore it would be reasonable to assume that at the higher end, Course Directors would be age 60 or
less. The gender distribution of those who responded was as follows: Medical School A, females 9 and males 13 and for Medical School B, 15 females, 20 males and three individuals who did not identify themselves on the questionnaire so gender is unknown.

Information about the non-respondents is difficult to obtain as I only had a listing of the names of the Course Director provided as a reference. From this list, it appears that both male and females were non-respondents. Other information is not available to further comment on the non-respondents.

3.6.2 Semi-Structured Interviews

Semi-structured interviews were conducted with eleven equity leaders using the questions previously detailed. Ten interviews were face-to-face and one, of necessity because of distance, was by telephone. The face-to-face interviews were conducted in the participants’ office or convenient meeting room and on two occasions, in a coffee shop in proximity to the work place of the participants being interviewed.

Initial contact with the potential interview participants was through formal introductory emails which included the consent form outlining the details of the research and indicating that Ethics approval had been obtained. The name of the individual who had suggested the potential participant was also included in the introductory letter.

The eleven participants were a heterogeneous group who were all involved with marginalized populations. Five were women and six were men and of these, two of the females and three of the males were White. Two participants spontaneously self-identified as being of Aboriginal ancestry.

The six physician participants were working in settings as direct providers of services to marginalized populations such as Aboriginal Peoples, refugees and immigrants, substance abusers, the poor, the elderly and the homeless. These physicians were also involved in research as well as teaching undergraduate medical education students and residents. The remaining five participants were in leadership positions at different levels of their organizations which included advocacy organizations, hospitals and community organizations dedicated to achieving equity in health care. These individuals dealt with policy but were also involved in research as well as at the program/provider level. All participants were very supportive of this research and quite open and helpful in their answers.

Five additional individuals did not respond to three email invitations to participate and were therefore deemed uninterested in the study.
The information garnered from the semi-structured interviews was taped, transcribed and analyzed. Kvale (1996) notes that in an interview: “…language is both the tool of interviewing and, in the form of tapes and transcripts, also the object of textual interpretation” (p.43). He therefore urges caution on how the transcription is done to ensure fidelity with the original interview. To maximize consistency of the transcriptions with the original interviews, the professional transcriptionist was asked to transcribe verbatim including pauses, repetitions, etc. To further support consistency, immediately after each interview, I set aside time to review the context, experience, tenor and content of the interview and made pertinent notes to assist in the later analysis of the transcript. The transcripts were analyzed thematically, reviewed and refined over multiple iterations until a number of overarching themes were identified. No software was used to code the data which was all done manually on hard copy.
Chapter 4
Data Analysis and Results

4.1 Questionnaires (Environmental Scan)

4.1.1 Data Analysis: Questionnaires

A combined total of 60 completed questionnaires from Course Directors at Medical Schools A and B out of a possible 81 questionnaires were returned for a response rate of 74%. The results of the questionnaire were entered manually into Survey Monkey and this commercial product generated the results in the form of descriptive statistics. All numbers were rounded up. The full questionnaire results for Medical School A and B are attached as Appendix 4.

Brossman (2010) writes that a review of the significance of the social and educational differences between medical schools is a topic worthy of study. Therefore, as selected key data from the questionnaires are analyzed, salient differences between the two schools, as demonstrated by the responses of the Course Directors, will be discussed.

The 15 bar graphs which follow over the next pages were generated by survey monkey and were excerpted from the full questionnaire. In addition, under each bar graph, I have analyzed the comments made by Course Directors. Their comments led me to apply a framework consisting of biomedical ideology, socialization and the hidden curriculum to help explain their remarks. The questions which are not analyzed in this section are available in Appendix 4.

As these questions are analyzed, it is important to remember that for Medical School A, n=22 and for Medical School B, n=38. Additionally, the Course Directors who responded to the questionnaire are providing an estimate of what the faculty in their course is teaching. Furthermore, the courses about which they provide information range in delivery time from one week to two year courses within the curriculum. Therefore the analysis and results must be interpreted with these facts in mind. It is also important to note that not all respondents completed each question in the questionnaire.
The questionnaire was administered over 2 academic years for the reasons previously described. Because of this timeline, question one in the questionnaire asked about when the course was last reviewed and revised. The purpose of this question was to see if the schools had made major revisions in their curriculum which might impact these results. The answers to this question revealed that changes in course content in both schools had been made over a number of years, ranging from the previous year to over 15 years ago. Since there was no pattern in either school, it was assumed that this variable did not impact the outcome.

4.1.2 Results: Questionnaires

There were twenty-one questions in the questionnaire. Although I reviewed all responses, only the most pertinent questions and their responses are included in section 4.1.2. Please refer to Appendix 4 for additional questions and responses whose analysis is not included in this section specifically for answers related to question 5, 7, 10, 12, 18. There was space for participant comments after each question which forms part of the data.

Table 3: Question 2—Estimate of Course Specific Frequency of Formal Instruction About Health Inequities

<table>
<thead>
<tr>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>35%</td>
</tr>
<tr>
<td>Occasionally</td>
<td>26% 26%</td>
</tr>
<tr>
<td>Some of the time</td>
<td>17% 18%</td>
</tr>
<tr>
<td>Most of the time</td>
<td>0</td>
</tr>
<tr>
<td>Always</td>
<td>22% 5%</td>
</tr>
</tbody>
</table>

If the “most of the time” and “always” categories are collapsed, the Course Directors from both medical schools estimate that in their course, their teachers provide formal instructions about health inequities just over 22% of the time. However, one participant from Medical School A qualified this “always” answer by noting that this “component was small and related to the interview approach” \(^2\) Another noted that “equity scenarios would be launched the following year”.

\(^2\) Throughout this questionnaire analysis, italics are used when quoting comments from the study participants.
At Medical School B, one participant noted “health inequities are a major focus of our course one afternoon/week x 2 years”. It appears from this and other responses in this questionnaire (Q13, Q20) that some of the Course Directors in Medical School B have consigned this topic to one course.

Collapsing the “never” and “occasionally” categories shows that approximately 60% of the time, Course Directors estimate that there is rarely if ever formal instruction about health inequities in their course.

Since most medical students come from a privileged class, (Waitzkin, 1989; Dhalla et al., 2002; Freeman et al., 2007) how are they to learn about health inequities without exposure to and discussions on this subject?

Table 4: Question 3—Estimate of Course Specific Frequency of Discussions About Health Inequities When Marginalized Patients Present

<table>
<thead>
<tr>
<th>Health inequities/disparities are included if we see or discuss a marginalized/under-served patient</th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>18%</td>
<td>15%</td>
</tr>
<tr>
<td>Occasionally</td>
<td>26%</td>
<td>33%</td>
</tr>
<tr>
<td>Some of the time</td>
<td>22%</td>
<td>15%</td>
</tr>
<tr>
<td>Most of the time</td>
<td>22%</td>
<td>18%</td>
</tr>
<tr>
<td>Always</td>
<td>18%</td>
<td>30%</td>
</tr>
</tbody>
</table>

When a marginalized patient presents for treatment, this is an opportunity for increased discussion on health inequities. If the results from “always” and “most of the time” are collapsed into one category, under these circumstances, Course Directors in Medical School A estimate that these issues are addressed in their course 52% of the time, whereas in Medical School B, Course Directors estimate that this is addressed 43% of the time. However, even in these instances, Course Directors in Medical School B estimate that this topic is not discussed 18% of the time in their course.

In Medical School A, one participant who responded “most of the time” qualified that comment as follows giving an indication of the importance of this topic in the curriculum: “There is a formal session at the beginning of the year with demonstrations and discussions
on interviewing marginalized patients. However, since most of the course is tutor dependent, some tutors may and others may not address this issue and this is not monitored. Social history is an important part of the course and so if these issues are relevant...however this is not monitored.”

Other indicators of the priority given to the topic of health inequities is the fact that two participants from Medical School A felt the need to further qualify their answer as follows. When responding to the question about whether in their course health inequities are discussed when a marginalized patient presents, a participant qualified the occasionally category selected by emphasizing “very occasionally.” Still another participant qualified the response that this topic was always discussed by noting “if relevant to the discussion.”

### Table 5: Question 4—Estimate of Health Inequities Course Content

<table>
<thead>
<tr>
<th>Determinants of health</th>
<th>Socioeconomic factors/poverty</th>
<th>Aboriginal peoples</th>
<th>Access issues</th>
<th>Racism</th>
<th>Stereotyping</th>
<th>Other *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical School A</td>
<td>83%</td>
<td>89%</td>
<td>68%</td>
<td>65%</td>
<td>77%</td>
<td>44%</td>
</tr>
<tr>
<td>Medical School B</td>
<td>68%</td>
<td>81%</td>
<td>50%</td>
<td>33%</td>
<td>26%</td>
<td>42%</td>
</tr>
</tbody>
</table>

One participant from Medical School A added “sexuality” to the section on “Other”. Many comments were added by participants in Medical School B under “Other”. These were “Stigma: immigrant health, mental health, alcoholism and psychiatry.” “Addiction, sexual medicine, rural medical ethics.” “We talk about the differences in prevalence of diseases (i.e. diabetes) but not inequities in access to medical care.” “Clinical skills course, some of this comes up in conversation but it is not part of the formal curriculum.” “Addiction.”
The requisite criterion for participation in this research was that the medical schools selected be located in an area with a large Aboriginal population since the literature suggests that this population embodies health inequities (Adelson, 2005). This allowed a critical review of the demonstration of social accountability towards this marginalized community by these Faculties of Medicine in their teaching and community programs.

For both schools, Course Directors estimated that in their course, teaching about socioeconomic factors/poverty was the main content when teaching about health inequities (Medical School A, 89%; Medical School B, 81%). For Medical School A, Course Directors estimated that in their course, the next important content area are the determinants of health (83%), followed by access issues (50%) with Aboriginal peoples being further down the line at a mere 22%.

For Medical School B, Course Directors estimated that in their course, the second most commonly addressed topic is teaching about access issues (77%) followed by the determinants of health (68%) with Aboriginal peoples in fourth place (65%).

Since both medical schools have a large Aboriginal population, this data suggests that in their courses, Course Directors in Medical School B may demonstrate more social accountability towards this marginalized population and may be more likely to incorporate programs to discuss and/or enhance the health care of this marginalized population.
Course Directors at Medical School A suggest that in their course, immigrants, the homeless and the elderly are discussed most frequently when instructing on health inequities. The next most discussed group during health inequity instruction, according to the estimates of these Course Directors, are the poor (57% of the time). This seems to reflect the responses to question number 4 in which Course Directors at this medical school projected that socioeconomic factors/poverty were the primary course content when instructing on health inequities. Estimates place discussion on Aboriginal peoples and women at 52% of the time. It is interesting that a group which has been described as embodying health inequities and has considerable presence in the city in which this medical school is located is not given more prominence in course curricula. One would expect Course Directors in a socially responsible medical school to take these two features into consideration when planning course outlines. Medical School A participants also added the following under “Other:” “Psychiatric illness,” “substance abusers,” “adolescents,” “those with stigma from mental illness.”

Conversely, in Medical School B, Course Directors estimate that in their course, Aboriginal peoples and the elderly are discussed most frequently (74%) followed by the poor (65%) and immigrants (61%) the homeless (55%) and women (52%) when instructing on
health inequities. It would be interesting to further explore the actualization of this difference in course content, instruction type, assessment, etc.

Medical School B participants also added the following under the “Other” category. “rural/secluded regions.” “Geographically isolated populations (rural/northern communities).” “The mentally ill.” “a two hour lecture covers these types of issues. I can’t say exactly how deeply any particular is addressed”.

It is interesting to note that Course Directors in both schools guesstimate the same groups in their top 6 groups when instructing about health inequities. For example, immigrants are discussed frequently in courses at both schools (62% and 61%) probably a reflection that both cities have a high immigrant population. Unfortunately, when the responses to question nine are analyzed, it indicates that Course Directors in both schools estimate that the discussions about course content on health inequities (Q4) and the discussions about marginalized groups (Q6) are not necessarily translated into the next step, a discussion on social responsibility vis-à-vis these groups.

Course Directors at both schools appear not to be particularly concerned with the level of instruction in their course about “undocumented individuals lacking immigration status.” They estimate that in their course (Medical School A), these individuals are discussed 10% of the time and 3% of the time as estimated by Course Directors in Medical School B.

**Table 7: Question 8—Estimate of Frequency of Student Assignment to Settings with Marginalized/Underserved**

<table>
<thead>
<tr>
<th>Are students assigned to specific settings to learn about, and be exposed to, marginalized/under-served populations?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Never</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>48%</td>
</tr>
</tbody>
</table>

□ Medical School A □ Medical School B
It is interesting to note that both schools are situated in proximity to areas where many marginalized individuals live. If the “most of the time” and “always” categories are collapsed into one category, Course Directors at Medical School A estimate that in their course, students are assigned 30% of the time to experiences where they will be exposed to marginalized/under-served communities. In Medical School B, Course Directors calculate that in their courses, students are sent approximately 9% of the time into these communities.

One participant in Medical School A qualifies their “always” response by noting “Elderly and psychiatric patients can be marginalized. There are specific blocks in the history taking and physical exams in these settings.” Another in this same school notes “A clinical teaching unit always has a significant proportion of its patient population in this grouping. We see the end consequences of this marginalization. We do not specifically assign students to this--it is our reality.”

The Global Consensus for Social Accountability of Medical Schools (2010) suggest that students should be offered early and longitudinal exposure to community based learning experiences to understand and act on the determinants of health. If most medical students come from a privileged class (Waitzkin, 1989; Dhalla et al., 2002; Freeman et al., 2007) how are they to learn about those whose lives are less privileged if health inequities are not core to course curricula (see responses to Q2 and Q3) and students are not assigned to specific settings where they can interact with marginalized individuals and communities.

**Table 8: Question 9—Estimate of Course Specific Frequency of Instruction About the Social Responsibility of Physicians**

<table>
<thead>
<tr>
<th>Frequency of Instruction</th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>0%</td>
<td>24%</td>
</tr>
<tr>
<td>Occasionally</td>
<td>19%</td>
<td>29%</td>
</tr>
<tr>
<td>Some of the time</td>
<td>19%</td>
<td>32%</td>
</tr>
<tr>
<td>Most of the time</td>
<td>13%</td>
<td>18%</td>
</tr>
<tr>
<td>Always</td>
<td>0%</td>
<td>8%</td>
</tr>
</tbody>
</table>
Collapsing the “always” and “most of the time” categories, Course Directors in Medical School A estimate that in their course, the social responsibility of physicians is addressed 24% of the time, whereas Course Directors in Medical School B approximate that in their course, this is done 21% of the time. However, this must be seen in light of the fact that Course Directors in both medical schools estimate that in their courses, instructions on health inequities may occur 22% of the time (Q2). If the answers to question 9 are specific to the wording of the question, then Course Directors are estimating that when instructing about health inequities, their teachers discuss social responsibility less than ¼ of the time, and this should be understood in light of the estimate that health inequities instruction is also done less than a ¼ of the time in their courses.

This is an important finding since these two medical schools have assumed social responsibility as part of their mandate.

**Table 9: Question 1—Estimate of the Frequency of Course Specific Evaluation of Knowledge of Students About Health Inequities**

<table>
<thead>
<tr>
<th>Is the knowledge of students about the causes of health inequities</th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>50%</td>
<td>44%</td>
</tr>
<tr>
<td>Occasionally</td>
<td>44%</td>
<td>30%</td>
</tr>
<tr>
<td>Some of the time</td>
<td>24%</td>
<td>11%</td>
</tr>
<tr>
<td>Most of the time</td>
<td>11%</td>
<td>9%</td>
</tr>
<tr>
<td>Always</td>
<td>0%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Collapsing the “always” and “most of the time” categories, Course Directors in Medical School A estimate that their teachers evaluate the knowledge of medical students regarding health inequities 17% of the time, whereas Course Directors in Medical School B guesstimate that frequency to be 16%.

A participant in Medical School B notes “There is a lot of formative assessment through written reflections and feedback by tutors. These are difficult topics to evaluate in a cumulative way—they figure out what is the right answer.” Other participants in this same medical school offer comments such as “where relevant,” “as part of tutorial participation.”
Since previous questions (Q2 and Q3) indicate that Course Directors estimated that in their course, aspects of health inequities were discussed, an important finding is that students are rarely assessed in terms of their knowledge about health inequities according to Course Supervisors in both medical schools. As Maudsley (1999) notes “…it is widely acknowledged that on what, and to a good extent how, students are assessed determines what students and faculty perceive to be of real importance in the course of studies” (p.144). Similarly, Cooke et al. (2006) write that assessment drives learning.

This finding is a clear example of the hidden curriculum…the estimated frequencies from Course Directors about evaluation of student knowledge of these topics appears to suggest that this information is not deemed important enough to be evaluated; therefore the message conveyed is that the knowledge itself is not important.
Table 10: Question 13—Estimate of Course Specific Inclusion of Health Inequity Content

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical School A</td>
<td>30%</td>
<td>13%</td>
<td>24%</td>
<td>30%</td>
<td>0%</td>
</tr>
<tr>
<td>Medical School B</td>
<td>35%</td>
<td>0%</td>
<td>3%</td>
<td>27%</td>
<td>17%</td>
</tr>
</tbody>
</table>

The “already included” response from the Course Directors of both schools conflicts with their previous response to question 2 where only 22% (School A) and 23% (School B) of Course Directors anticipated that this topic was discussed regularly in their courses.

In Medical School A, some who responded “unlikely”, “maybe” offered the following explanations:

- “time constraints this is a one week course”
- “due to the nature of their course, this material would be difficult to include. However we will be introducing an international health program and will include students in this (however not as part of a formal course).” It is interesting to note the immediate qualifier that this subject will not be part of the formal course. Additionally, I know that substantial preparations are needed to introduce this topic. Therefore, it is unlikely that the 30% of respondents who answered “maybe” they would include this topic and the 4% who answered “probably” are going to include this topic in their courses in the future.

From School A, participants who either already included or were absolutely going to introduce this noted

- “plan to increase the exposure to Aboriginal health and other topics.”
- “plan to introduce a seminar on global health which will include international health and underserved/marginalized populations in Canada and immigrants/refugee health.”
One seminar lasting anywhere from 1 to 3 hours to address all these topics is unlikely to be effective. Additionally, this approach sends a message as to the importance of these topics and is another example of a hidden curriculum message.

Two themes emerged in comments from Medical School B participants with respect to their approximation of frequencies related to question 13. Firstly, the little time allocated to their course should be focused on teaching the biomedical curriculum and secondly, health inequities are addressed in another course and therefore this information does not need to be repeated. The comments from Medical School B follows:

- "But very peripherally. It is not on the ‘radar’ for much increased inclusion though perhaps it should be."
- “not relevant to course objectives: not adequate time in my course to address this; students get the material elsewhere in the curriculum. There is not enough time in the curriculum to repeat this material.”
- “we concentrate on .....conditions as we only have a week in year. If we had more time, then yes.”
- “Already strongly critical because too much content.”
- “Have few contact hours to cover large knowledge base. Other courses designed and mandated to address this type of topic.”
- “At the moment, teaching in the MD undergraduate program is not fully integrated so my block focuses purely on the ‘biophysical’ rather than on the ‘bio-psychological’ aspects of medicine. Social Advocacy is taught in other blocks.”
- “Content does not lend itself well to this issue. Would require major effort in re-addressing PBL cases.”
- “Basic science course.”
- “Not pertinent to my course. Little time to cover a lot of important stuff already.”
- “The topic is discussed clinically. There are so many ‘medical expert’ competencies that students must learn to be competent physicians. New themes should not take away from core medical knowledge. If something is added, it must be at the expense of something being taken away....”
- “in the...curriculum, a lot of these issues are located in the course...in the first two years.”
Table 11: Question 14—Estimate of Course Specific Frequency of Formal Instruction About Health Advocacy

<table>
<thead>
<tr>
<th>In my course, there is formal instruction on Health Advocacy?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>Never</td>
</tr>
<tr>
<td>Occasionally</td>
</tr>
<tr>
<td>Some of the time</td>
</tr>
<tr>
<td>Most of the time</td>
</tr>
<tr>
<td>Always</td>
</tr>
</tbody>
</table>

It is interesting that 50% of the Course Directors at Medical School A estimate that within their course, formal instruction about health advocacy is “never” provided and that 14% only do so “occasionally” even though the CanMEDS Competencies/Four Principles of Family Medicine is part of the framework of the undergraduate curriculum at this medical school. At the time of the data collection, Medical School B did not have the CanMEDS framework for their undergraduate curriculum and this may explain why Course Directors estimated that health advocacy is rarely addressed in their courses. However, The Medical Council of Canada (MCC) at the time of my study considered competence in health advocacy a requisite skill for all medical students in Canada. One would expect that this fact should have some impact on what is taught on this topic at both medical schools.

Participants in Medical School A made the following comments:

- “there will be in the future with smoking cessation and narcotic management potential prevention of chronic abuse.”
- “students at the point of care take direct responsibility to mobilize appropriate resources to address patient needs.” How do students learn from role models/teachers about mobilizing appropriate resources for the marginalized if this is not part of the teaching?

In Medical School B, participants commented:
• “the ratings don’t work very well for a course like mine. It’s a broad course we “always” include it—i.e. every year, but not in every session. Ex. there are sessions to very specifically teach how to interpret an X-ray. That is why I’m choosing “some of the time.”

• “Health advocacy is a thread that runs throughout the course in parallel with discussions of marginalized populations.”

Table 12: Question 15: Estimate of Course Specific Frequency of Health Advocacy Instruction When a Marginalized/Underserved Patient Presents

![Bar Chart]

Although not a formal part of my course, Health Advocacy instruction is included if a marginalized/under-served patient is discussed or presents for treatment

Health advocacy is one of the goals of the curriculum at Medical School A so it is interesting to note that even when a marginalized patient presents for treatment, Course Directors estimate that this competency is discussed less than 50% of the time. Additionally, a participant from Medical School A elaborates that this topic is addressed some of the time with the comment “guess so, depends on the tutor.” These responses are an indication of the real priority given to this topic.

A participant from Medical School B notes “we have a session called physicians as advocates and the specific discussion will depend on the facilitators and students. It could be any of these.”

These estimates from the Course Directors (discussions of health advocacy estimated as occurring only 21% of the time) and comments listed above infer that rather than an important topic, discussions on health advocacy in their courses at Medical School B are left to chance.
Table 13: Estimate of Course Specific Groups Discussed During Health Advocacy

Instructions

Question 16: In my course, the following are discussed when instructing about health advocacy. Check all that apply.

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking cessation</td>
<td>84 %</td>
<td>63 %</td>
</tr>
<tr>
<td>Diet</td>
<td>74 %</td>
<td>72 %</td>
</tr>
<tr>
<td>Exercise</td>
<td>68 %</td>
<td>72 %</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>74 %</td>
<td>59 %</td>
</tr>
<tr>
<td>Drug use</td>
<td>58 %</td>
<td>59 %</td>
</tr>
<tr>
<td>Health promotion activities</td>
<td>57 %</td>
<td>50 %</td>
</tr>
<tr>
<td>Navigating the health care system</td>
<td>58 %</td>
<td>31 %</td>
</tr>
<tr>
<td>Advocating for safe drinking water</td>
<td>21 %</td>
<td>6 %</td>
</tr>
<tr>
<td>Advocating for stricter tobacco control</td>
<td>21 %</td>
<td>9 %</td>
</tr>
<tr>
<td>Advocating for specific screening programs</td>
<td>37 %</td>
<td>25 %</td>
</tr>
<tr>
<td>Advocating for occupational safety</td>
<td>37 %</td>
<td>9 %</td>
</tr>
<tr>
<td>Advocating for environmental safety/decreased pollution</td>
<td>16 %</td>
<td>16 %</td>
</tr>
<tr>
<td>Advocating for improved education</td>
<td>5 %</td>
<td>9 %</td>
</tr>
<tr>
<td>Advocating for the elderly</td>
<td>37 %</td>
<td>41 %</td>
</tr>
<tr>
<td>Advocating for immigrants and refugees</td>
<td>53 %</td>
<td>16 %</td>
</tr>
<tr>
<td>Advocating for members of sexual minority groups</td>
<td>26 %</td>
<td>16 %</td>
</tr>
<tr>
<td>Advocating for an Aboriginal population health strategy</td>
<td>21 %</td>
<td>25 %</td>
</tr>
<tr>
<td>Initiatives to deal with child poverty</td>
<td>26 %</td>
<td>13 %</td>
</tr>
<tr>
<td>Advocating for Women’s issues</td>
<td>26 %</td>
<td>19 %</td>
</tr>
<tr>
<td>Advocating for affordable housing</td>
<td>21 %</td>
<td>13 %</td>
</tr>
<tr>
<td>Advocating for adequate social assistance</td>
<td>37 %</td>
<td>6 %</td>
</tr>
<tr>
<td>Participating in policy development</td>
<td>26 %</td>
<td>9 %</td>
</tr>
<tr>
<td>Other</td>
<td>5 %</td>
<td>3 %</td>
</tr>
</tbody>
</table>

Health advocacy can be practiced at the individual, community and population level. At the individual level, a large part of health advocacy is health promotion and disease prevention. This is mostly understood by physicians as this is part of their training. It is
therefore not surprising to see that in both schools, the top five most frequently practiced health advocacy actions, as estimated by Course Directors, are related to health promotion which is usually directed at the individual level. These include smoking cessation, diet, alcohol use, exercise and drug use. All other responses include issues that can be categorized as community/population initiatives which are clearly more difficult to promote.

Participants at Medical School A added under the category “other” “Seat belt use”, “helmets for biking/skiing”

An interesting observation is that in Medical School A, according to Course Directors, “navigating the health care system” is discussed as frequently (58%) as health promotion activities related to “drug use”. Course Directors also estimate that advocating for immigrants and refugees is also prominently discussed (53%) when instructing about health advocacy. These two areas of advocacy are clearly the beginning of advocacy that could be directed not only at the individual level but also at the community/population level. Unfortunately, health advocacy is not prominent in terms of “advocating for an Aboriginal population health strategy” which occurs only 21% of the time in their courses according to the Course Directors in this school located in a city with a significant Aboriginal population.

Outside of the health promotion activities previously listed, Course Directors at Medical School B suggest that in their courses, there is little regarding health advocacy. After the six health promotion activities previously listed, the next health advocacy instruction of significant number relates to “advocating for the elderly” (41%). Participants in this medical school added the following to the “Other” category: ”Not enough-this is to my mind one of the most important Achilles heels of the health care system” and “Advocating for stronger public health measures to control alcohol abuse and its effects on health.”

It is interesting to note that despite the fact that Aboriginal peoples are very prominently featured in teaching about health inequities (Q4 65%) or teaching about marginalized groups (Q6 74%), when instructing about health advocacy, “advocating for an Aboriginal population strategy” is taken up only 25% of the time according to Course Directors at this school located in a city with a significant Aboriginal population.

As the literature has previously suggested, (Frank, 2003; Oandasan & Barker, 2003; Oandasan, 2005; Walsh et al., 2006; Banack, 2008; Earnest et al., 2010), health advocacy is challenging to teach and evaluate particularly at the community/population level and this data reflects this fact.
Table 14: Question 17—Estimate of Course Specific Frequency of Health Advocate Knowledge Evaluation

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>68%</td>
<td>60%</td>
</tr>
<tr>
<td>Occasionally</td>
<td>5%</td>
<td>9%</td>
</tr>
<tr>
<td>Some of the time</td>
<td>27%</td>
<td>14%</td>
</tr>
<tr>
<td>Most of the time</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Always</td>
<td>14%</td>
<td>5%</td>
</tr>
</tbody>
</table>

According to estimates by Course Directors at Medical School A, 60% of the time, the knowledge and skills of students in health advocacy is not evaluated in their course. As one participant explains from Medical School A, “Rarely. Not never but not occasionally either.” Medical School B participants offer these two comments: “Mostly as a formative process through journal reflection and feedback,” and “as part of tutorial participation.”

As previously noted what is deemed important is usually evaluated. The low estimates from Course Directors regarding assessment of health advocacy skills and knowledge expose another hidden curriculum message about the importance of health advocacy.

Table 15: Question 19--Barriers to Health Advocacy Instructions

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unclear definition of Health Advocacy</td>
<td>18%</td>
<td>14%</td>
</tr>
<tr>
<td>Unclear learning objectives</td>
<td>23%</td>
<td>37%</td>
</tr>
<tr>
<td>Inadequate resources</td>
<td>32%</td>
<td>23%</td>
</tr>
<tr>
<td>Insufficient interest</td>
<td>5%</td>
<td>17%</td>
</tr>
<tr>
<td>Other</td>
<td>59%</td>
<td>54%</td>
</tr>
</tbody>
</table>
The majority of participants, 59% from Medical School A and 54% from Medical School B responded in the “other” category to discuss the most common barriers to instruction about health advocacy. Overwhelmingly, as noted below, participants from both schools elaborated in their comments that they perceive they already had insufficient time to teach the biomedical curriculum and that these additional demands infringed on the purpose of medical school. The comments with respect to faculty comfort with these topics are also of interest and are definitely a barrier to teaching health advocacy. Participants from Medical School B seem to be more verbal about their push back regarding teaching about health advocacy.

Participants from Medical School A elaborated on the “Other” and “Inadequate resources” categories by noting the following: The list of comments has been organized to reflect themes from the Course Directors comments.

- **Time constraints** (mentioned eight times).
- **Lack of specific faculty skills/staff uncomfortable with discussions on this topic** (mentioned twice)
- “‘Seems tangential to the course.’”
- ‘The objectives of the course are to teach information gathering not action plan.’”
- “Often, students do not have the opportunity to participate in this realm.”

This is an interesting comment given that this school has many marginalized communities close to its campus

- And the one tentatively supportive comment of “physicians may not realize the amount of influence they can exert.”

Medical School B participants commented as follows regarding the “Inadequate resources” and “Other” categories:

- **Time constraints and the needs of the basic science curriculum/medical expert competency** (mentioned ten times)
- **The difficulties associated with understanding, teaching and evaluating this topic.** (mentioned three times)
- **Not part/relevant to course objectives/not my responsibility** (mentioned four times)
- **Insufficient student interest.** (mentioned twice)
- **Never thought about it** (mentioned twice)
- “Siloization of curricular content.”
• “Lack of hands on experience for students.”
• “Patient advocacy and health advocacy are not the same. Physicians need the former, less of the latter.”
• “Have not considered it a primary topic for the course.”

The last two comments might be considered tentatively supportive.

• “Focus of course is history and physical exam skills. Advocacy relevant in this context.”
• “Experiential learning is the best way to do it coupled with reflection and feedback.”

There is also an acknowledgment from participants at both schools of the difficulties of understanding, teaching and evaluating health advocacy. The comments related to student interest in the topic of health advocacy are noteworthy. Is this perceived lack of interest from students related to the low profile of health advocacy in the curriculum or an a-priori lack of student interest? Since many advocacy/social responsibility programs are student led (Eckenfels, 1997; Woollard, 2006; Dugani & McGuire, 2011) this perceived lack of student interest may not be correct. To state that there is a lack of hands-on experience for students to practice health advocacy is a surprising statement as this school (as well as Medical School A), since it is surrounded by marginalized communities including Aboriginal peoples.

**Table 16: Question 20—Estimate of Future Course Specific Inclusion of Health Advocacy**

If you are not currently including the topic of Health Advocacy in your course, do you plan to include this topic in the future?

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Already included</td>
<td>33%</td>
<td>29%</td>
</tr>
<tr>
<td>Absolutely not</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Why not?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlikely. Why?</td>
<td>0</td>
<td>27%</td>
</tr>
<tr>
<td>Probably</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>Absolutely</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>3%</td>
</tr>
</tbody>
</table>

In general, Course Directors in Medical School A give halfhearted answers with respect to “probably” including health advocacy in their course in the future. The intensity of the refusal of Medical School B Course Directors to include this topic in the future is quite pronounced.

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The responses from Medical School A Course Directors are very tentative and suggest a lack of commitment to the topic. The first comment is an explicit message about the importance of these topics in relationship to the biomedical curriculum.

- “low priority given time constraints and other pressing curriculum priorities.”
- “Likely will include in our global health seminars but not formally. However, it is discussed around subjects like smoking and alcohol cessation.”
- “will likely increase this component.”
- “{there is} additional health equity material in the new curriculum.”

The push back from Medical School B Course Directors is very strong as noted below. The comments have been thematized where relevant.

- **Time and the need to focus on the basic science curriculum (mentioned four times)**
- **Lack of relevance to course (mentioned two times)**
- **Taught but done superficially (mentioned twice)**
- “Siloization of curricular content.”
- “No direction/requirements in curriculum.”
- “to the degree that is desired.”

And the one weak supportive comment relating to the “already included” category
- “but could be more explicit.”

**Question 21: Participants were given the opportunity to comment on any aspects of the questionnaire. The following comments were made:**

**Medical School A**

- “This is a very thought provoking activity for me-it makes me think we should be doing more in both areas addressed. Many thanks for the chance to answer the questions.”
- “Interesting. These areas we don’t generally devote a lot of teaching or assessment around.”

The comments from these two participants from Medical School A seem to suggest openness to these concepts.

**Medical School B**

The first four participants in Medical School B offer positive comments on the teaching of health inequities and health advocacy but the other comments are less positive.
- “This is highlighting some deficiencies. Carry on and good luck.”
• “This is an important topic and at the moment it is lack of integration in the overall course structure that is preventing teaching of content such as this in my course.”
• “PBL discussions provide a useful platform to include these discussions while still emphasizing basic science objectives.”
• “I have not thought about advocacy and inequities as distinct entities to be taught. If I thought about the importance of these issues, these could be better emphasized.”
• “To put these issues in the context of clinical competence would be helpful. If a physician is not clinically competent, the rest is much less important.”
• “These topics are important for medical students. However, they are utterly and completely irrelevant to the objectives of my year 02 course in much the same way that basic medical science objectives would be out of place in a clerkship course on marginalized patients and navigating the health care system. PLEASE do not ask medical schools to ‘emphasize’ social responsibility any more than they already do. All new ‘emphases’ always seem to take time away from teaching basic medical science.”
• “The course is the teaching of the clinical examination.”
• “There is a danger for added topics/concepts to erode the core learning that is so critical for students to acquire in their four years of medical school. What good is it to have students who are great Communicators, Collaborators, Managers, Health Advocates and Professionals if there are serious deficiencies in their knowledge and skills. Unfortunately, this is happening more often. The full CanMEDS scope is best left for postgraduate training. Undergraduate training should focus on Medical Expert Competencies”.

The push back from the last four Course Directors from Medical School B is quite strong and the focus on the CanMEDS Medical Expert Competency and the biomedical curriculum is very pronounced. Irrespective of what the leadership of this medical school espouses on these topics, it appears that health advocacy and social responsibility are not at the forefront of important topics for many Course Directors at this medical school. Instead, the Medical Expert Competency is the Competency which is privileged.

Boler and Zembylas (2003) quote Britzman (1991) that: “…in the organization of the subject matter what is not included in the school curriculum can be as telling as that which is included” (p. 120). The results from the questionnaire suggest that instruction about health inequities, the Health Advocate Competency and social responsibility are not significant
components of many of the courses in these medical schools despite their commitment, on paper, to social responsibility. This lack of inclusion in the curriculum is suggestive of a lack of real commitment to these important topics.

Course Directors estimate that instruction about health inequities takes place “always” 22% of the time in their course (Medical School A) and 5% of the time in courses at Medical School B. This number rises slightly to 30% (Medical School A) and 15% (Medical School B) when a marginalized patient presents or is discussed. Few courses, 17% in Medical School A and 3% in Medical School B were “absolutely” going to introduce the topic of health inequities into their course in the future and of these, one clarified that this would be in the form of one seminar on international health/refugees/immigrants/underserved/marginalized populations in Canada.

Health advocacy instruction was also poorly integrated into courses with only 23% of Course Directors at Medical School A and 5% at Medical School B calculating that this topic was “always” part of their course. The numbers for “always” rose to 40% at Medical School A but rose only slightly to 9% at Medical School B if a marginalized/underserved patient was discussed or presented for treatment. Since Medical School A has health advocacy as a curricular objective, this low number is surprising. At Medical School A, 10% of Course Directors agreed that they would “absolutely” include this topic in their course in the future. If this is a mandate of Medical School A, why is this topic not integrated across the curriculum?

There appears to be less interest from the courses in Medical School B on the topic of health advocacy. A possible explanation for this apparent indifference is the fact that at the time the questionnaire was completed, the CanMEDS framework, including the Health Advocate Competency, had not been adopted as part of the undergraduate medical education program objectives of Medical School B even though this framework was part of The Medical Council of Canada (MCC) objectives and therefore, at the very least, nominally prioritized for learning.

It is also important to note that neither student knowledge nor student attitudes regarding health inequities and the Health Advocate Competency were deemed important enough by Course Directors at either medical school to introduce evaluation practices in their courses, an explicit indicator of their value.

These two medical schools have accepted the mandate of social responsibility and are located in areas in close proximity to marginalized communities. Social responsibility by
definition encourages meeting the needs of the community served by the medical school. Given these facts, one would expect consideration for the surrounding marginalized communities when planning course curricula and programs. However the responses of Course Directors to question 6 indicates that in their courses at Medical School A, discussions about Aboriginal peoples is estimated to occur 52% of the time when discussing health inequities. Course Directors in Medical School B seem to have somewhat prioritized this topic as discussions about Aboriginal peoples and the elderly occurs 74% of the time when discussing health inequities. On the other hand, this apparent prioritization must be understood in light of the fact that Course Directors in Medical School B estimate that discussions on health inequities occur 5% of the time.

The responses to question sixteen regarding health advocacy clearly suggests that advocating for an Aboriginal population health strategy is not a priority for Course Directors at these school (21% for Medical School A and 25% for Medical School B).

The responses to question 9 indicate that Course Directors estimated that the social responsibility of physicians was “always” addressed 24% of the time (Medical School A) and 8% of the time (Medical School B), despite statements on Social Responsibility of medical schools by The WHO (1995), Health Canada (2001) and The Association of Faculties of Medicine of Canada (2001, 2009) as well as a commitment to social responsibility by the leadership of both medical schools under discussion. These responses, in addition to the responses related to evaluation of knowledge and attitudes of students with respect to health inequities and health advocacy, are examples of the hidden curriculum which was discussed in Chapter 3.

The last question dealt with barriers to instruction about health advocacy and the answers were very revealing. Time and the need to focus on the biomedical curriculum was the overwhelming reason for not teaching about health advocacy. There was a particularly strong push back from Medical School B regarding further eroding the time devoted to the biomedical curriculum with the introduction of these topics. It is difficult to surmise why from the data available.

As previously discussed, the responses to the questionnaires indicated that despite a commitment on the part of these medical schools to social responsibility, and in one school to health advocacy, the primary goal of their course, as perceived by the Course Directors at both schools, is a focus on the biomedical model. This was very apparent in a number of responses. For example, to fulfill a social responsibility or social accountability mandate
necessitates being aware of the health inequities in the community. Yet Course Directors from both medical schools in their response to question 2 indicated that in their course, teaching about health inequities occurred less than 40% of the time. Their responses to question 3 indicated that even when a marginalized patient presented for treatment, they estimated that discussions about health inequities only rose incrementally (from 39% to 52% in Medical School A; from 33% to 43% in Medical School B). However, it is the response to questions 13, 19, 20 and 21 that reveals the overwhelming importance of the biomedical curriculum in relation to any other curricular input. The responses from Medical School B are very forceful and unequivocal regarding the importance of health advocacy. In fact, the lack of pertinence of this and other non-biomedical topics in the curriculum are clearly enunciated.

It appears from the Course Directors’ responses to the questionnaire data that biomedical knowledge is privileged to the exclusion of other knowledges which are considered less important in a hierarchy of knowledge implicitly understood by all Course Directors.

Evidence of the hidden curriculum can be found in most of the responses to the questionnaire. The most profound example of the hidden curriculum is the responses to question 9. In their responses, Course Directors suggest that in their courses, in only 24% of the time (Medical School A) and 21% of the time, (Medical School B) is there teaching about the social responsibility of physicians. However, both schools have made a commitment to this value. Nevertheless, by its lack of prominence in the curriculum, a clear message is sent…this topic is not important.

A clear indication of the importance of teaching about health inequities is found in the answers to questions 10 and 11. The attitude and knowledge of students about health inequities is considered by Course Directors in both schools to be too insignificant to evaluate. Research has shown that students understand that important topics will be assessed and those topics not assessed are not considered significant by either faculty or students (Maudsley, 1999; Cooke et al., 2006). The hidden curriculum with respect to health inequities teaching is clear to students because of the lack of assessment. The same conclusions can be made about the teaching of health advocacy as the attitudes, knowledge and skills about this competency are rarely evaluated (14% in courses at Medical School A and 5% in courses at Medical School B) according to the responses to questions 17 and 18.
Question 13 also shows the real importance of health inequities teaching for the Course Directors at both schools. There is inadequate time to teach, or this topic is not relevant to course objectives [read the biomedical curriculum] or the topic is “silod” in another course. The few Course Directors that may introduce this topic will do so in the form of an additional seminar. One Course Director who suggests that there will be additional health inequities content introduced in their course hastens to add that this will not be part of the formal course. The messages are again very clear...teaching about health inequities is not an important element of the curriculum.

The hidden curriculum also reveals the importance of teaching about health advocacy. Questions 14 and 15, indicate that this topic is of some importance to Course Directors in Medical School A where they estimate it is taught 23% of the time and this figure increase to 40% of the time if a marginalized patient presents for treatment. However, the hidden curriculum at Medical School B is clear...this topic is not important on a regular basis (taught 5% of the time as guesstimated by Course Directors) and even when a marginalized patient presents, this topic is taught only 9% of the time.

Questions 19, 20 and 21 clarify beyond the shadow of a doubt the importance of health advocacy and the message that is sent to students about what is important in the courses over which these Course Directors hold responsibility. These Course Directors make it clear...it is the biomedical curriculum irrespective of what is stated by the medical school and The Medical Council of Canada objectives as the attributes needed to be deemed competent as a physician. Health advocacy is very marginal to this description as relates to the biomedical curriculum.

I am not suggesting that teaching about health inequities, social responsibility of physicians and health advocacy overtake the curriculum. I am not diminishing the importance of being a medical expert. However, I believe that acquiring knowledge and skills in the other CanMEDS Competencies and being aware of health inequities and the social responsibility of physicians actually enhances the physician’s role as a Medical Expert. Without looking at the whole patient and including social information in the diagnostic workup and treatment plan, important aspects of a person’s life which impact on health are lost. These factors can and do impact health care outcomes. For example, not being aware and adjusting a treatment plan for pneumonia for a single mother on welfare with pre-school children may prevent this patient from accessing the necessary treatment. Health advocacy is part of a therapeutic intervention for this patient.
To relegate health advocacy, health inequities and social responsibility teaching to one or two courses in the curriculum creates silos and diminishes the importance of these concepts. Weaving these teachings throughout the curriculum and taking every opportunity to reinforce these concepts does not take time away from the Medical Expert Competency. It adds another dimension to this Competency.

4.2 Semi-structured Interviews (Praxis)

4.2.1 Data Analysis: Interviews

After I finished the environmental scan in the form of the questionnaire completed by Course Directors at the two medical schools in my study, I was left with a problem. The analyzed results from the questionnaires highlighted the focus of these participants on the bio-medical model making it difficult for these individuals to see beyond this ideology to a different form of education which would encourage health advocacy, social responsibility and therefore help to address health inequities. In discussions with my thesis advisor, we concluded that interviews with equity leaders in health care were needed to present the lived experiences and challenges of successful equity endeavors, understand intersectionality “in action”, and help develop approaches to health advocacy and social responsibility teaching. I also wanted to see how the term intersectionality resonated with this group of health care professionals.

The purpose of the interviews with the 11 equity leaders in the community was to find out what they do and to see what could be learned from their practice. Four major questions dealing with four separate issues were asked during the semi-structured interviews. However, after each of these four questions was asked, many follow-up questions were posed. The responses to each major question were analyzed separately since they all dealt with a distinct issue under the overarching topic of intersectionality.

These semi-structured interviews were analyzed as follows. Multiple readings of the interviews were undertaken for the purposes of extracting significant and relevant information. As a first step, the responses to each of the four questions by all 11 participants were read separately and themes extracted. The responses from the five health equity leaders were kept separate from those of the 6 physicians. The reason for this was to be able to later compare across the two groups to identify any cross-cutting themes and significant differences which might impact the results. These individual participant themes were then
compared within their group and subsequently grouped into clusters again within their
groups. Multiple other reviews resulted in statements being moved to similar categories of
meanings (with this analysis always being kept in two different groups) then summarized
into broad themes which are presented below. The first analysis consisted of the responses
from the equity health professional leaders which will be followed by an analysis of the
responses from the physician group. A comparison of these two analyses follows.

4.2.2 Results: Interviews

A- Equity Leaders in Health Care Organizations

This group consisted of 5 individuals with leadership positions in advocacy in health
care organizations. Four were women at the middle management level of which two were
White and two were women of colour. The male participant was White and in a senior
leadership position at the policy development level. Many participants asked for and were
given the questions prior to the interviews.

Three participants worked in a hospital, one in a Faculty of Medicine and one in a
health equity research/policy development organization. Their work was primarily focused
on promoting diversity and identifying barriers to health equity. All participants were
involved in policy development, research as well as service provision in these areas. One
participant was focused only on health equity and diversity policy development as well as
political advocacy.

Despite the fact that the majority of participant names were recommended by one of
the participants familiar with the intersectional theoretical framework, only one other
participant was familiar with terms such as intersectionality or intersectional analysis.
However, when the terms were explained, all agreed that they worked in environments where
intersectionality influenced health care outcomes. For purposes of the interview and for this
thesis, I continued to use the term intersectionality in all the interviews. Participants
responded to it in a positive manner easily switching from their previously used terminology
of the Determinants of Health (DOH) to intersectionality. Only one individual reacted
negatively to the term calling it too academic and noting that it would cause challenges in
translating into service action and stating a preference for the well-established Determinants
of Health (DOH) terminology. I countered that since it was an academic work, I would use
the term intersectionality and he could use the DOH terminology. We agreed that we were
speaking of the same concepts but using different nomenclature.
**Question 1**

Could you describe in as much detail as possible how you use an intersectional equity approach in your work? (Tell me about a typical day and how you use this approach)?

The job description mandate of these participants focused on policy development and identifying barriers to health equity. Although four did provide direct service, this was linked to identifying and resolving issues of diversity or barriers to health equity in their organizations. All five participants dealt with intersectional issues, of which the most prevalent were the intersections of race and gender. However, intersectionalities of immigration status, ethnicity, income, age, disabilities, aboriginal status, low social class, sexual orientation, rural and remote communities, and social isolation were also mentioned by the participants in this group.

The responses to question 1 were analyzed and categorized over a number of iterations until the following themes emerged from the responses to question 1: equitable access, education and working with communities.

1- **Equitable Access**

Equitable access focused predominantly on health care access, but also dealt with access to work which corresponded with qualifications. All participants spoke of the challenges faced by individuals whose identity is multidimensional and whose access is constrained by the intersectionality of their identity categories. Participant 4 described this as follows:

> Working with women who experience marginalization because of gender...within that category women are different women because of race, ethnicity, income, age, language, sexual orientation who are experiencing different healthcare outcomes because of these different identities.

Access to equitable health care was difficult for a variety of reasons which were often made more complex by the multiple different identities which intersected to increase the barriers to equitable access. These include immigrant status which brought language barriers and issues related to navigating complex health care systems compounded by lack of provider awareness regarding their own prejudices and biases. For example, providers might be insensitive to their Westernized view of pain, grief, bereavement assessment and management. Providers might also be unaware of how individualistic and collectivistic societies differ in terms of parenting practices and thus be judgmental about unfamiliar approaches. Almost all participants made comments regarding how Westernized views
coloured the approach of health care providers to the care of individuals from other cultures thus creating barriers to access.

Participant #5 notes that it is important to consider: “who you plan your programs for and where you locate them, not in Rosedale but in Parkdale…then translate, not just language but culturally also.” As participant #5 continues in speaking of poverty:

You cannot reduce the incidence of diabetes or the impact of diabetes unless you take all of the determinants of health, lines of inequality and the different circumstances people bring to the health care system. There is a high percent of folks {with diabetes} who report food insecurity and what is our Westernized view of health promotion? Eat broccoli. Well these people can’t.

This participant continues with another food-based example adding the intersection of culture to the health care outcomes of poor diabetic patients: “How are you going to decrease the eating of rice to a culture that has been raised on it?” Another participant adds the intersection of gender and marital status when discussing the single, poor mother’s challenges in seeking health care, following up on tests or getting nutritious food for her children and herself.

For those with disabilities, access to health care was impeded by physical access to health care facilities designed for those without disabilities. Examples included the inadequate size of change rooms, the number and accessibility of disabled washrooms. The intersection of race, gender and disabilities was considered problematic for both patients and staff. As participant #3 noted: “I have not seen individuals fitting that profile in management positions when these intersectionalities interlink.”

For women, the subtle differences in timely referrals to certain specialists but the quick referrals to mental health specialists were mentioned. Participants also discussed how South-East Asian women and low income women, often suffer higher rates of diabetes with poorer outcomes because of their inability to access resources such as a more nutritious diet. These women are likely to prioritize others such as their children when food is scarce. They spoke of the fact that low income individuals in general do not have the resources to attend appointments that cost $3.00/TTC ticket each way. Additionally, for women, these arrangements usually involve making child care provisions in addition to transportation costs. Urban Aboriginal women and even more specifically pregnant urban Aboriginal women experience the worst outcomes because they are without access to federally funded resources available on the reserves. Two participants mentioned the irony of statements made by some
of their peers that there were no longer gender issues in health care. These participants had witnessed many situations such as those described above which illustrate that gender can still influence health care access and therefore health care outcomes.

Two participants mentioned bias and prejudices encountered by queer and trans women and men which resulted in their presentation for cervical screening much later than the rest of the population. Unfortunately, when they do present later, their cancers are more advanced and they suffer higher than average mortality rates.

Some spoke of the access challenges of individuals living in rural and remote communities which are usually compounded by low income and low social class. As participant #4 noted: “the further you get out of the downtown core, the sparser the community services but the higher the need because of diversity, lower housing, income and poverty issues.”

A pressing challenge which led to further intersectionalities compounding marginalization and resulting in mental health issues was access to work commensurate with one’s abilities and qualifications. This problem was mentioned frequently. For immigrants, the problems of not finding work despite having good qualifications resulted in low income, lower social class than in their country of origin, difficulties adapting, social isolation, language barriers and the increased potential for gender violence.

Participants also spoke of the intersection of race and gender which favoured White males for promotion through the ranks even in diverse racialized departments. Participant #3 spoke of conducting training around fair employment practices and raising the issue of the unconscious bias that favours non-racialized men in so many positions, including leadership positions, and the joy of witnessing the Human Resource staff having “ah hah moments”, realizing their unbeknownst to them bias towards White people.

Participant # 5 suggested that to understand the systemic barriers at the population level, look at person-based care which translates to the lived circumstances of each patient. All participants framed their comments in light of a focus on health outcomes.

2- Education

It is important to note that everyone has intersecting identities and that these of themselves do not lead to poor health outcomes. What leads to poor health outcomes are identities which intersect with axis of oppression. To counter these types of intersectionalities leading to poorer health care outcomes, participants spent much time educating and raising awareness of these issues of power and privilege within and outside their organizations.
Education appeared to be the essential core of their work in addition to review and development of policies and programs to improve access, diversity and equity in their organizations. There was acknowledgement that diverse cultures in an organization can lead to conflict. They spoke of using these challenges and conflicts to “unpack and educate”, and of raising provider self-awareness to their own prejudices and biases. Harassment incidents around gender and sexual orientation were mentioned as an opportunity to educate and develop protocols to prevent further issues. Participant #1 suggested that she would like to establish a community of practice where people can actually communicate with each other, get ideas, and consultations to support their work.

Participant #3 spoke of using statistics extensively to bring home the point about diversity and equity. For example, this participant suggested highlighting the gender and race profile of low-status jobs in the organization, the LGBT suicide rate in the community, etc. Another tactic that this participant uses in teaching is to share information with staff about the “micro aggressions, the day-to-day, unconscious-to-the-perpetrator, invisible-to-the-perpetrator conversations” to explain the impact of language.

Participant #5 is heavily involved in educating outside groups and organizations about barriers to health equity, diversity issues and in meeting with government and other political bodies to address structural changes to overcome health inequities. This participant focuses largely on research and policy analysis around the: “complex understanding of social determinants of health, complex in the sense of the various determinants which intersect and interact with each other…” and “how you arrest that slide”. The education outreach of this participant is largely based on sharing the results of the research and policy analysis of the organization.

3- **Outreach to the Community**

Participants spent much time putting strategies in place to deal with access issues. All worked with the clinical leadership in their organizations to both educate and provide more responsive services. They also worked within their organizations to facilitate access and 3 worked extensively as well with their external communities. For example, one (1) did a broad community consultation resulting in fifteen (15) recommendations for management and the clinical leadership to address as part of the LHIN equity accountability agreement. Another participant worked with local agencies and community health agencies to deliver equitable services such as breast self-exam and pap smears for communities which are impacted differentially. This participant worked with, amongst others, LGBTQ communities and
agencies as well as Immigrant Women’s Health Centers which has a mobile bus to bring services to this marginalized group. One participant spoke of integrating equity outreach with a volunteer recruitment strategy. The intended outcome of this approach was that the community outreach reflected the patient population served which is extremely important in terms of putting patients at ease. Additionally, this deliberate strategy provided the volunteers with necessary references which could facilitate entering the workforce in Canada.

**Question 2**

*Describe some of the challenges you meet on an ongoing basis moving an intersectional agenda forward.*

1. **Embedding Intersectional Equity in an Organization**

There are considerable challenges of awareness and understanding in addition to the challenges of moving an intersectional equity agenda forward as intersectional problems can seem so large and interconnected that people do not know where to begin. The most frequently mentioned challenge was that of embedding intersectional equity in their organization. Participant #5 suggested “thinking big but starting small around a community or an issue or levers that can make a difference.” Participant #3 spoke of trying “to turn a big boat around” of “being an island”, while another spoke of how overwhelming the work was as solutions are never quick or simple, taking years to produce results. All participants spoke of the danger that equity work would reside with the facilitator or the department only “thus re-inscribing a particular kind of marginality.” Participant #3 declared that the present reality of their situation was still “one voice in the organization bringing up these issues” and that this reality “is no longer acceptable.” Mechanisms to centrally incorporate equity so that it was not an “extra” or a marginalized program were consistently being sought. The challenges of integrating equity across the organization were many but needed to be met to avoid the silo mentality. The importance of bringing an intersectional analysis to all equity issues and rigorously linking these to clinical and equity outcomes was considered a key determinant of success. As participant #4 noted: “…intersectional equity requires deliberate strategies around changing organizational culture and putting structural systems in place for equity indicators and targeted initiatives for particular populations and sustained work that becomes integrated into the business.”

Participant #1 wanted to find a way “to embed positive changes in daily practice” and participant #5 wanted to build equity into all services. Participant #5 further noted that:
…the danger facing equity is that there is an approach of let’s have diversity training and all will be solved...however, the solutions require a look at power, structural issues and an understanding of the determinants of health to really make headway.

The importance of integrating equity and intersectionality in all meetings across all departments and in all planning and delivery discussions was emphasized. Participant #1 was promoting: “…applying cultural lenses to key policies and changes as needed, remembering that the current health care system was established decades ago and much has changed since...we now need to meet the needs of a broader population.”

The work involved in bringing the various groups and levels of leadership in an organization into a partnership around intersectional equity issues was considered to be extraordinarily difficult but essential to success. Having champions at the medical and executive leadership level was considered crucial and mechanisms to achieve this were sought. It was however considered to be a major challenge to have the present “homogenous leadership” in health care organizations at the Board, senior executive and medical leadership level truly take this on as a core issue. Participant #3 spoke of working under an executive team which was all White calling them “expensive wall paper...all White” as their pictures appeared in an organizational newsletter. Embedding intersectional health equity in the clinical areas was repeatedly mentioned as a challenge. Participant #5 wanted to “talk and educate until equity is immersed in accountability agreements.” A “road map” a “big picture of equity” was vital in order to develop a more equitable system which addressed not just access issues but also quality and culturally appropriate care. One participant noted that moving an organization towards intersectional equity requires a cultural shift that addresses power differentials in an organization. Another participant noted that the work of building relationships with the executive, clinical and financial teams can be “very labouring.” Participant #4 cautioned that: “it is sometime presumed that with diverse representation comes a progressive stance around equity issues which is not always the case.” Therefore, it is important to push for intersectional equity analysis to inform the work needed to identify appropriate organizational equity strategies.

All participants spoke of the crucial importance of linking intersectional equity with positive health outcomes in order to move this intersectional equity agenda forward. As participant # 1 noted:

…speaking of anti-racist frameworks will not work with health care professionals…they are most interested in improving the health care
outcomes of the patients they are caring for, and so framing the work within that lens will have a higher likelihood of success.

2- **Denial**

Most participants noted that in Canada, we think there are no problems because we have a universal health care system and a Federal policy on multiculturalism. We don’t talk about discrimination and marginalization but about diversity and multiculturalism. As participant #4 noted “we don’t problematize or acknowledge...putting the gaze on the gaze”. An example given of this is the fact that the Federal Anti-Racist Secretariat was terminated because it was considered too confrontational for the Canadian palate. Participants noted that because The United States acknowledges that health disparities exist, they are developing targeted initiatives for physicians, targeted funding for promotion and prevention, endowed chairs around equity and developing the kinds of reports about these issues and initiatives that we do not have in Canada. There is also an Office of Minority Health in The US Department of Health and Human Services which establishes standards for culturally specific and linguistic care. Four of the five participants mentioned The Ontario Ministry of Health equity assessment form as a positive first step, a good tool for starting the conversation about making decisions based on equity considerations. However, to truly advance equity, the importance of using an intersectional lens when analyzing the results was made very clear.

Another instance of denial was mentioned by participant #5 who spoke to a group of researchers who explained that research in gender equality was no longer necessary as this issue had been resolved. Participant # 6 thought that part of the denial might in fact be a reluctance to identify incidents of discrimination especially in small communities where repercussions can follow such actions.

3 **Education**

Education was both a key component of the work of all the participants as well as a significant challenge. Participant #5 spoke of the challenges of “making complex issues understandable” and teaching about “how the determinants of health interconnect, interact and reinforce each other.” Making these intricate issues understandable was considered essential to making them actionable. But reaching out to all staff was difficult and although e-learning modules were a consideration “how to implement e-leaning for these sensitive issues” was a concern for participant #1. All spoke of the challenges of raising awareness,

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3 Refers to Foucault’s (1994) “medical gaze” which is medicine’s analytic observational approach to the patient’s body separated from the patient as a person.
understanding the historical roots of disadvantage and of educating about these sensitive topics. Getting to the physicians in the organizations who are not usually able to attend these staff learning sessions was a challenge. These participants understood that staff was paid their regular hourly salary to attend such sessions outside of their normal work day. However, there was no funding for physicians to attend these educational sessions which were normally held during working hours and to attend meant closing their offices or clinics thus exacerbating access issues for patients. Although electronic resources were considered a good tool allowing physicians to asynchronously access these learning resources, developing effective electronic learning resources around these sensitive topics was considered a big challenge.

4 Resourcing an Intersectional Equity Agenda

Understanding the resources needed to deal with issues and effect change and accessing these resources were key especially when equity programs were competing for funding with more tangible resource requirements such as MRI’s. One such resource mentioned by participant #6 was the wherewithal needed to deal with incidents of discrimination in a timely manner. One participant noted that there was a misalignment within organizations between the optic of change and the resources needed to bring about substantive change. Most participants spoke of the need to have access to interpreters to help address language barriers. Participant #5 noted that there is good data from The United States that if you provide good interpreter services, you reduce costs as patients understand their treatment regime and are less likely to bounce back in the system. As participant #3 notes: “the right interpreter supports good information leading to the correct diagnosis and good communication for follow-up leading to fewer re-admissions.”

Two participants spoke of the present political and economic climate which was focused on tax cutting and program cutting. To paraphrase their comments on this issue, they felt that the health care system was being corporatized and this approach could be in conflict with a more person-based approach such as intersectionality. One participant noted that to change the conversation from cuts and funding shortages required a complex intersectional analysis and these analysis tools do not presently exist. Participants suggested that aligning equity initiatives with system drivers such as the new equity requirements from the LHIN was key to success. In order to effectively access funding sources, most participants noted that it was important to understand that “what gets done is what is measured.” Providing evidence of improved health outcomes was considered a significant lever for implementing
changes even though the difficulty of doing this was acknowledged. As participant #4 noted: “measuring improvement in disparities and/or improvements in people’s experience in relation to discrimination is very much qualitative and not quantitative...within this health care environment, we need both.”

Equally important was to use accepted performance management measurements to evaluate the success of an intervention. One participant suggested developing indicators around chronic disease management compliance in marginalized groups. Others suggested accessibility to care indicators for an identified population at risk, or accessibility to interpreters (mentioned frequently), access of low income women to diabetes care and, finally, treatment and patient satisfaction.

The idea of disaggregating patient satisfaction information presently collected was a clear message. The suggestion was to further categorize the information collected by race, gender, sexual orientation, income, disability and residence/living conditions. This kind of categorization would allow for an intersectional approach to patient satisfaction to see how individuals in these various categories are experiencing access to care and patient satisfaction. This would then allow organizations to more accurately plan the programs needed by their users and to target resources to remove specific barriers to access. For example, one participant suggested studying whether the post-surgical re-admission rate differed from poor to rich neighborhoods and suggested this kind of review should be part of hospital performance management scorecards. Another participant has had the organization’s patient feedback questionnaire translated into different languages and although not at liberty to share the results, mentioned that the feedback from the non-English populations served was strikingly different than the previous patient questionnaire results from English speaking patients. Making equity understandable and embedded in the organization and subsequently aligning incentives for successfully meeting indicators was a key challenge to moving this agenda forward.

**Question 3**

*Do you think incorporating an intersectional approach in medical practice to address social responsibility and health advocacy is feasible? Give me some examples about how this can be done.*

**1- Weave Through the Curriculum**

All 5 participants stated that it was possible to incorporate an intersectional approach to teach about social responsibility and health advocacy and it was important to weave this
throughout the curriculum. Participant #3 suggested that physicians have an advantage to make changes as they have power, status, recognition and they have the duty to use that power to advance the rights of those who lack power. Participant #4 noted that: “if health professionals acknowledge that there are health inequities then they must acknowledge that it is part of their role to address these inequities.”

Participant #3 spoke of inequities presently reproducing themselves in the health care system and participant #1 elaborated on this point by noting that:

…the health care system was established many years ago with a very particular population in mind, and you know, that population changed immensely and we need to think about how we need to make changes to the system itself so that it can in fact meet the needs of the broader population… and not remain embedded in the same day-to-day work.

Participant #6 observed students losing their initial altruism as they progress through medical school, thus the importance of addressing these issues. “my concern is, as I listen to the students as they go through the years of medical school, even here at the school that, you know, promotes social accountability, is that they are changed by the medical school experience.” The concerns expressed were reflective of the research previously quoted which has repeatedly discussed the loss of altruism that medical students experience as they progress through medical school.

Participant #5 said that social responsibility will have limited impact and will not work unless intersectionality is taken into account and shown concretely. Ironically, this is the same participant who thought the term intersectionality was too academic to be accepted. Sometime during our interview, this participant started using the term unreservedly.

Scenarios were considered the most effective mechanism to teach about equity and should be integrated throughout the curriculum. These scenarios would promote discussions as to how power is linked to gender, class and race thus framing intersectionality and further, would allow exploration about how identity impacts on everything including people’s experience of using healthcare. This information is not new but as one participant noted “creating the time to explore this and get at the assumptions that are operating and leading to these health care outcomes might be a new approach.” One participant suggested that teaching about social responsibility and health advocacy would be more effective if embedded in evidence within Problem Based Learning (PBL) cases. For example, using available data linking homelessness to mortality, chronic disease rates and violence and then showing students how to advocate for better housing strategies. Another concrete example is
the impact of insufficient income (poor diet and the lack of funds to improve this) in producing poor health outcomes or impeding clinical interventions from improving health outcomes. As participant #4 notes “without these discussions then physicians will spend time providing care to patients who cannot comply.”

Participant #3 suggests including case scenarios addressing how racialized emerging leaders feel about always being taught by White men. This participant elaborated that at a recent 2 day leadership educational session provided by a “world class” faculty, the entire faculty was comprised of middle aged White men. Their leadership examples were Jack Welsh, former President and CEO of General Electric who fired thousands of people and destroyed innovation in General Electric (a former major patent producer in The US), and Henry V known as a warrior who killed fiercely in battle but also killed many of his French prisoners. This participant summarized the thoughts of many in the program:

Man, its 2011, I’ve been in two days of training about leadership, I have been taught only by three White men, and been given two models of leadership, two more White men….this is so inculcated into our European way of thinking, the macho, the aggressive, the male.

Another participant suggests including health equity statistics as data about access to service, mortality and morbidity statistics are very powerful. This participant notes that using statistics would allow students to see how prevalent and insidious the interaction of gender, marital status and poverty can be on access to personal health care of a single mother. This participant who teaches medical students notes that they are willing to talk about disparities. However, an important consideration is the lack of teachers with the appropriate skill-set to deal with equity and diversity and issues raised during these discussions. Participant #6 suggested discussions about the hidden curriculum and how this impacts discussions on these issues.

1- **Experiential Learning in the Community**

Participant #5 noted that all health professions must be included in this teaching and all must be exposed to communities and populations where marginalization exists. Most of the participants agreed that providing direct service to marginalized populations was an excellent teaching approach. One participant also suggested incorporating some of these marginalized individuals into the teaching program so that they could speak to their experiences in health care such as being disabled and not being spoken to directly by health care providers or being HIV+ and having food delivered, but left at the door.
2- **Professional Associations**

Two participants suggested teaching about how to partner with professional associations and both used the example of the recent Ontario Medical Association (OMA) position whereby this association took on the government to try and eliminate the 3 month waiting period for immigrants to access health care. Although 2 out of 5 participants mentioning this may not seem robust enough to consider this a theme, according to these participants, it was an extremely important political advocacy endeavour which they thought was a first for this organization and worthy of being highlighted.

**Question 4**

_Do you have an opinion on whether the reward system for physicians (funding, promotion and recognition for academic physicians) impacts their ability or desire to incorporate social responsibility and health advocacy into their practices?_

These participants were circumspect in their answers to this question. However, two themes emerged from the discussions.

1- **New Funding Models**

Community health centre models, family health teams and a different funding model were all suggested. All agreed that the fee-for-service model made health advocacy more difficult. Salaries or mixed remuneration models were suggested as examples of new reward systems which should be considered. There was acknowledgment that many medical students complete their medical training with considerable debt and the funding model must marry personal goals to system goals.

2- **Endowed Equity Chairs**

The US was referenced again as an illustration of the value of equity chairs and foundations which support equity work. Two participants mentioned the importance of establishing such chairs which could concentrate on intersectional equity work. Resourcing scientists and giving them recognition for their work commensurate with that given to scientists working in the biomedical domain was considered important.

**B- Physicians**

This group consisted of six individuals who were direct care providers. Five were males and one was female, and of these, two were of Indian origin, two self-identified as of Aboriginal ancestry and the remaining two were White. Three worked in teaching hospitals, two in community centres and one in a remote community. All had a teaching affiliation with one of two Faculties of Medicine and taught at the undergraduate and post graduate level.
Four were involved in research about marginalized patients. None were familiar with the terms intersectionality or intersectional lenses but all agreed that this term aptly described their patients and their approach to work. They were all familiar with the Determinants of Health terminology. Their patients were immigrants, refugees, people of colour, Aboriginal peoples, the elderly, substance abusers, former prisoners, Hepatitis C positive individuals, the poor, and the homeless. These physicians were a heterogeneous group in terms of their own identities but almost all focused their practice on working with marginalized populations.

**Question 1**

Could you describe in as much detail as possible how you use an intersectional equity approach in your work? (Tell me about a typical day and how you use this approach?)

1- **Providing Direct Equitable Care to Marginalized Population: One Size Does Not Fit All**

All participants provided health care to marginalized patients and gave rich descriptions of their patient populations and the impact of multiple identities on their patients’ health and health care. All were concerned about health outcomes for their patients. These participants cared deeply about their patients and were committed to helping them. For example, participant #10 visits prison patients and does work with remote communities. Participants #8 and #9 do home visits and participant #8 also does street visits and has “hunted patients” in the park to do follow-up but notes that this is obviously not efficient. As participant #9 said, “I have a number of patients who keep me up at night.”

One noted that immigration data shows that many immigrants are multilingual, better educated than previously but are struggling for longer periods than they were 10 or 15 years ago. The struggles they face include finding housing, language barriers, immigration status, social exclusion and difficulty accessing work because their skills or qualifications are not recognized. As participant #2 noted: “there is an initial euphoria when arriving in Canada…they will learn English, get a job and get used to snow…after 6 months they realize, English is difficult to learn, jobs are scarce and snow is not fun.” This participant continues:

I can think of a number of people where we have identified PTSD (post-traumatic stress disorder) or depression and we send them for hours and hours of counseling, prescribe medication and then they disappear. They show up a year later and they look fantastic, they have a smile on their faces, and what was the therapeutic intervention? They got a job and that changed everything.
If they are refugees, many are also dealing with previously unrecognized trauma. This often leads to mental health issues which present as somatic complaints, for example chronic headaches. Immigrants and refugees are also dealing with chronic diseases, must be screened for infectious diseases no longer present in Canada, undergo primary care screening and be immunized.

Participant #8 noted that as his practice is limited to only marginalized groups with chronic conditions, infections and acute episodic care, he cannot limit himself to only the medical aspect of care. He has many poor, immigrant Black women patients who have faced horrible sexual violence. If in addition they have HIV they are totally stigmatized in Canada. To help his patients, he needs to be creative and knowledgeable about the social supports in the system as well as all community agencies. Participant #9 agreed and noted that in addition, you need to build an informal network of people who can pitch in as needed to help with your patients. Participant #9 spoke of working with the elderly struggling with dementia, mental health issues, physical co-morbidities, social frailty, and poverty. If in addition they have lost their partner, or are from a different culture, each of these compounds the original problem. Part of the assessment must acknowledge, review and address these different intersecting layers of their identities.

Participant #10 spoke of working with opiate-dependent patients, HIV/AIDS patients and Aboriginal peoples. This participant noted “that people become marginalized because of their drug use and marginalized people become more so if they become drug users.” Further, marginalized groups who speak a different language have difficulty accessing health services and health professionals do not understand their cultural preferences. But according to this participant, Aboriginal peoples are the most disadvantaged because of the interplay between housing (overcrowded houses heated by wood-burning stoves which results in respiratory issues), environment (40% of Aboriginal communities have boil water orders) culture, distance (most communities are remote with no road access, only fly-in access), economic disadvantage and low education. The education system for Aboriginal peoples is underfunded and therefore has poor resources including schools, teachers and equipment. Additionally, the system only goes to grade 6 or 8. To finish high school, students of 14 or 15 must leave their communities and go live with strangers or one relative must leave their job to live with the student. If parents want their child to go to university, they cannot leave them in an Aboriginal school as these have inadequate programs to prepare for university. They
must send their child to public school and pay an annual tuition of $1,400.00–1,500.00/year. All of these factors impact health and health care outcomes.

Participant #11 works with patients on welfare, patients with substance abuse problems, and HIV/AIDS patients and commented that: “you would need to be blind not to see how these multiple interlocking factors lead to poor health.” He/she gave as a specific example a patient, who is a sex worker, a woman of colour and who is homeless. Further: “it is impossible to ignore that class, gender, personal histories, immigration status all play on health and these impacts do not disaggregate”. This point is driven home to participant #11 when occasionally, as a favour to a colleague a privileged patient is seen and “the difference in health status is astounding.” When discussing intersectionality, this participant further noted: “if a patient is racialized, or has a substance abuse, or the intersections of these various identities...people are not a homogenous group of homeless people...we must understand the heterogeneities and bring these into research question.”

The participants used a Determinants of Health approach to understand how poverty, education, housing, and language influence health and health care outcomes. A few commented that the Determinants of Health are now publicly recognized and accepted everywhere. As participant #2 noted: “we must recognize that people who are doing well socially tend to have better outcomes...we must include these issues in our lenses.”

2 Advocacy

In addition to their primary role as direct health care providers, these participants were all committed to advocacy as an essential element of their medical practice. Some were doing case-based advocacy with The Ministry of Social Services for housing and disability support or advocating for extra coverage for immigration issues. Two were often involved in actions to stave off deportations. Participant #2, in addition to full-time work in a Community Health Centre, has set up a small clinic in a refugee centre and was working with the shelter staff to deal with housing issues and support community integration of refugees. Another participant spends much time advocating for system changes such as treatment guidelines for substance abusers or researching new treatments or public health approaches to improve the lives of marginalized patients. This participant was part of a group which successfully advocated that patients disabled by drug abuse should receive disability support. One participant was involved in the movement to increase access to the special diet allowance, as well as advocating for housing for the homeless. This participant was also involved in advocacy work for drug abusers and prisoners and with reframing social policy noting that:
“as health providers we have a moral duty to show that certain systems and policies lead to ill health.”

Working with group movements such as, Health in all Policies and Health Providers Against Poverty, advocacy efforts are concentrated on advocating against welfare reductions, shelter closures, ending school nutrition programs, as well as ending subsidized spaces in daycare centers. These groups also urge that social policy be seen through health equity lenses using health impact assessments to understand the effect of policies on different communities. The impact of potential reductions in the safety nets of the marginalized are immediately shared with governments. Participants also advocated for an improved and un-fragmented system of care for transgendered patients.

Participant #2 explained the link between health care and advocacy: “we must deconstruct what is happening in patients’ lives and understand their struggles, it is then easy to move to want to advocate on their behalf.” Advocacy was also focused on teaching medical students and residents about the importance of incorporating advocacy as an important element of patient care. Thus, incorporating advocacy work into the curriculum was seen as essential. As participant #11 noted “medical education is apprentice style so that this generation can influence the next generation.” This participant also acknowledged the impact of role models on medical practice and advocacy work.

Participant #7 bemoaned the fact that of the seven CanMEDS Competencies, what was valued in the medical culture was the Medical Expert Competency. The “hierarchy of knowledge” ingrained in the medical culture diminished other CanMEDS roles to a lesser level. Explicitly bringing an Aboriginal world view and an approach to patient care incorporating the impact of the various intersections on health care outcomes was an essential element of this participants’ advocacy.

One participant focused on teaching medical students about different marginalized patients, then showed these differences overlapping to explain how this compounds health issues and that the sum of these issues results in poorer health outcomes. Two participants used Venn diagrams to reinforce their teachings about marginalized patients and the need for advocacy.

**Interprofessional Approach**

All participants discussed the need for an interprofessional team, or a multidisciplinary team approach when dealing with marginalized patients and to support advocacy work. Participant #10 stated: “dealing with marginalized patients requires a team of
Participants. Physicians don’t have the skills or the time to deal with the many issues of these patients.”

Participant #11 concurred but noted that although treating marginalized patients requires a team approach: “medicine is not well trained to work in teams…medicine trains for individual decision makers, managers of resources.” This participant further elaborated that advocacy also required teamwork because group advocacy brings greater creativity, support and allows the work to be spread over a number of people as advocacy takes “lots of time and energy.” Participant #2 spoke of working with other health professionals to make changes in The Immigration and Refugee Act to support the health of newcomers. Participant #9 noted that:

…we must link advocacy to inter-professional teams because when you start peeling the layers, there is both medical complexity and social complexity….you need the expertise of these people and cannot adequately take the time as a physician to do all that is required.

Participant #8 works with a multidisciplinary team and considers the other professionals more important than him to provide patients with “wrap-around care”.

**Question 2**

*Describe some of the challenges you meet on an ongoing basis moving an intersectional agenda forward.*

1- **Time, Energy and Frustrations**

Four of the participants spoke of the time and energy needed to deal with the social issues surrounding their patients as their number one challenge, while the other 2 participants also acknowledged this as a challenge. Participant #7 found there are inadequate resources to deal with marginalized groups and so physicians discharge patients or patients discharge themselves against medical advice only to bounce back because of issues associated with their social conditions that aggravate the medical issue. Participant #11 wants to create a system that supports the homeless so that these patients are not sent back to the street, and another system to encourage substance abusers to change their behaviours when they are in hospital, but it “all sucks time.” Participant #10 spoke of the years needed to get approval for a new drug of choice and notes that the process is not always rationale. One participant described how basic the care can be…a new immigrant comes with cracked lips and a dry throat and when a humidifier is recommended does not know what it is, where to purchase a humidifier or how to pay for one. Participant #9 noted: “the problem is that there is so much
burden and the system is so disconnected and there is so much work for physicians and you need so much time to meet the needs, and see that the system is not working well, it is easy to just give up.” And further “if physicians become disenfranchised because they cannot make necessary changes they feel helpless.” Just building trust with these marginalized patients was a time-consuming challenge. As one participant noted: “it takes so much time…building trust with me as a White man takes time. So in a first visit, I don’t want to overwhelm with multiple tests, meds and referrals to specialists. I need to build a partnership, clarify how the clinic works, how the system works.” Another participant, #10 concurred saying that: “one must first create a clinical space where patients feel safe with me, where I understand the barriers they face.” Participant #11 noted: “you get a sense of futility…since Harris cut welfare in 1997, we are fighting to get a decent welfare wage…even with The Poverty Reduction Act…nothing has changed. You get the sense that you are banging your head against the wall.”

2- Access

These participants were already providing access to health care that they acknowledged is not a “universal” health care system. According to these participants, the most frequent access issue for the poor, including the working poor, is access to over the counter or prescription drugs. Participant #8 spoke of the patients who come back ashamed after 3 days with worsening symptoms because they have not been able to fill the prescription given to them or their child since they do not have prescription coverage or money to buy the prescription. Participant #10 also has many poor patients who are employed but have no prescription coverage and getting drug benefit coverage for new medication is challenging. Some Aboriginal patients in addition to the costs have the additional problem that pharmacy fly-in access is one/month. For these distant patients, the problem is not only the cost and provision of drugs but how to adjust the dosage remotely.

Although most medication costs are covered for those over age 65, the pre-elderly (60 and over) who lose their jobs also lose their prescription benefits at a time when many people in this age group have multiple prescriptions. For those dealing with addiction, there are challenges accessing methadone treatment and doctors must spend much time supporting these patients, helping them apply for benefits and disability support.

Participant #8 also spoke of Black immigrant HIV/AIDS patients who will not go to agencies that serve women with HIV/AIDS for fear of being recognized and the ensuing overwhelming stigma in their community.
There are structural issues about how patients transition to different levels of care in the system, especially for complex patients. As one participant explained, long term care access is not provided for immigrants and refugees until they have been in Canada for 10 years and non-OHIP patients can languish in hospitals because they do not have the resources to personally pay for less expensive levels of care. There are access issues for patients created by health providers which are rarely discussed, such as older LGBT patients who are not treated with respect in health care facilities according to participant #9. This lack of respect creates a structural access to health care. Participant #8 further elaborated on this noting that hepatitis patients do not want to go to hospitals for treatment because they have had negative experiences in these environments and they also cannot wait 3 hours in a crowded room. For this group of patients, this participant and interprofessional team have built a peer support system based on a meal linked to an educational session. This provides “social cohesion, health literacy, and knowledge to empower these patients to make decisions about their health they never felt they had the power to do.” This program has resulted in “phenomenal transformational success” such as the individual with Hepatitis C, a drinking problem and a horrific childhood history who has stopped drinking, has new housing, his hepatitis is cleared and he is now the primary support for another patient from a men’s shelter who is undergoing cancer treatment. Participant #9 stated that there is a need for a better system of resources which is less fragmented and allows flexibility of access for marginalized patients. Participant #10 reaffirmed the difficulty marginalized groups have to access care when they have language difficulties and health professionals do not recognize their cultural preferences.

3 Availability of Cultural Interpreters

The use of cultural interpreters was considered essential and without them, challenges to providing equitable care increased. As participant #2 noted, 47% of Torontonians are foreign born and the problems created for immigrants because of language barriers are significant. These are interpreters who are especially trained to do more than word to word translations. As participant #8 explained:

They know how to intervene when the patient has not responded appropriately, how to clarify where there are cultural differences. For example, the word depression does not exist in certain cultures or explaining to the physician that in Somalia, putting the root of plant x is normal practice for y complaint.
Participant #10 said the same more succinctly: “culture influences how one speaks of symptoms” and further notes that as people develop dementia, they tend to lose a second acquired language so language becomes a big barrier to health care and quality health care outcomes.

**Question 3**

*Do you think incorporating an intersectional approach in medical practice to address social responsibility and health advocacy is feasible? Give me some examples about how this can be done.*

All six participants felt it was not only feasible but also desirable to incorporate an intersectional approach to medical practice although they mostly use the Determinants of Health terminology. In fact, most participants felt because the determinants of health have been included in most medical curricula in the past decade, medical students are starting to think more about the social issues. Participant #2 stated: “It’s very hard to provide primary care without looking at the intersections of the social determinants of health and health care outcomes.” Participant #11 gave the example of teaching about intersectionality when working with children living in poverty and suggested they are not a homogenous group. So one starts looking at other nuances or intersections such as immigration status, social support, neighborhood, etc. and: “intersectionality can help you look at the big picture and then start to think about targeted solutions in specific areas.”

However, two participants were concerned that for this approach to be successful a major shift in the culture of medicine is required. Participant #8 noted: “most people go to medical school to help people but this altruism gets beaten out of them during medical school…school is grueling”. Participant #10 agreed saying: “medical school makes students less idealistic and more cynical.” Participant #7 noted that: “medicine needs to deal with the hierarchy of knowledge which places the Medical Expert Competency at the top of the grid.”

The approaches to teaching about intersectionality, health advocacy and social responsibility that were most frequently discussed were as follows:

1- **Weave Through the Curriculum.**

All participants spoke of the importance of weaving these concepts through the curriculum in case studies, patient care and in experiential learning. Information on how poverty, literacy and social issues impact health should be at the forefront. As participant #2 stated: “you can’t just give a prescription and not ask about insurance. You also need to ensure that the patient has the language or intellectual capacity to understand the treatment
plan.” Using the drug prescription example, two other participants concurred noting that this provides an opportunity to do more than teach about drug interaction. This opening allows a physician to delve into payment capacity, understanding of the treatments, etc.

Participant #7 and participant #11 suggested that this teaching should be woven through the four year undergraduate medicine program and throughout all postgraduate programs. As participant #11 noted there is a huge fragmentation, an enormous difference between how different specialties are trained around these issues: “In primary care you are forced to confront these issues and it’s very much part of training. However in other specialties they are trained to deal with single encounters and not the longitudinal aspect.” But this participant also suggested that the lack of teaching about advocacy in certain specialties could also be related to student selection issues or the climate existing within these specialties. Two other participants noted that post-graduate training in their specific specialty combined with their work has made them “problem solvers” (participant #9) or has trained them to do a full psycho-social assessment which includes all aspects of their patients’ lives. They therefore conclude that these skills can be taught.

Participant #10 believed that to do intersectional work requires a comprehensive analysis and so the tools to do a systematic assessment and develop a treatment plan to incorporate the result of the assessment must be taught. This participant also applauded the change in the teaching of how to conduct a medical interview. The traditional approach tried to narrow down to the diagnosis but efforts are now being made to include social factors into the medical interview teaching sessions.

2- **Teach Advocacy**

The participants suggested that teaching about Advocacy was an important curricular component and that health issues must be linked to advocacy work. This involved teaching about public policy and the impact on patient’s health. Participant #2 noted: “as guardians of the health care system, we need to identify issues and public policy that have an impact on the health of our patients.” Further this participant noted:

> When you deconstruct what is really going on in people’s lives and understand that their social reality is what they are really struggling with, it is hard not to identify that, embrace it and try to help people deal with those issues. I can see in many ways it’s challenging for us as physicians, not part of our training, but unless we incorporate that into our approach, it makes family medicine a very frustrating exercise.

Participant #9 stated:
...as physicians you are the natural leader in health care and if you see issues that need to be addressed you need to take the lead. This is a responsibility that you hold as a physician and take seriously as a physician to move forward. We need to create a system that supports activism.

Participant #10 noted that: “efforts are now being made to include social factors in the interview, diagnosis and treatment plan. This includes trying to make students become advocates for public policy and system changes.” Participant #11 agreed that medical students are being taught to incorporate the social determinants of health. The challenge is making these students want to take the responsibility to help because: “we are trained to be aware of it but we’re not trained to look for solutions.” Participant #8 suggested that students should be taught how to advocate at the individual and population level because:

...they must play a role in addressing systemic issues and injustices because of the privileged way doctors have of seeing things and the ability to bring about changes. For example if the welfare rates are too low to buy food, physicians must advocate for better welfare rates.

However, teaching advocacy can be challenging. For example: “teaching advocacy must include information about how to reach and influence policy-makers in our society....how to create a succinct brief with all the information that will get your brief through the door.” Participant #11 was concerned that in addition to the challenges about teaching health advocacy, there was an erroneous assumption that teaching advocacy actually changes behavior. This participant was not convinced that medical schools knew how to teach advocacy at the individual and population level with the assurance that this teaching would create/result in change.

Participant #10 suggested that there also needed to be a shift in the selection process of trainees as at the moment the physician population is: “the Davos effect…diversity within a population whose net worth is quite high.” Participant #9 was concerned that: “we have to also create a system that actually is receptive and allows that kind of advocacy work to continue.”

Most said that medical students today are clamoring for this information. One suggested that the issue is the slow pace of medical school administrators in taking up this challenge. Another participant had a different view point about student interest in intersectional equity. This participant gave a lecture on power, marginalization and equity and received the worst evaluation after this teaching session. This is a highly sought after
teacher who concluded that since there had been no change in the teaching style, the material must have been of no interest to students and thus the low scores for the teaching session.

3- Experiential Learning in the Community

Participant #8 noted that:

…the experience in the hospital does not support altruism and the fact that most doctors will practice in a community setting begs for another setting for teaching where doctors are off the pedestal. This is in the community including homeless shelters, women’s shelters, community health centers, soup kitchens.

Most participants agreed that experiential learning was important. As participant #10 noted: “medical students become more cynical as they go through medical school and then they are further trained in hospitals where medical culture is indoctrinated.” Another participant suggested that: “medical students should know before they enter medical school that during their training, they will work with inner-city communities and that they will spend time up North for extensive periods.” Participant #11 felt that hospitals could take on the problems of their communities and teach about intersectional equity in that context.

Create Partnerships

A majority of these participants noted the importance of working with interprofessional teams as well as professional associations such as The Ontario Medical Associations (OMA) to meet their responsibilities. As participants #8 noted: “working with The OMA on immigrant waiting time issues was brilliant.”

Question 4

Do you have an opinion on whether the reward system for physicians (funding, promotion and recognition for academic physicians) impacts their ability or desire to incorporate social responsibility and health advocacy into their practices?

All participants had opinions on this issue which could be summarized into two themes. Interestingly, most participants were hopeful that change was on the way. Participant #7 spoke of some of the accreditation changes supporting this kind of work as well as the fact that role models such as this group of participants were now involved in teaching medical students. Participant #10 noted that:

…I am optimistic for the future because medical students are more concerned with societal factors than they were 20 years ago…perhaps because of social media. Additionally, the medical system is trying to move to be socially accountable, and you can’t
publicly say that is your goal unless you align your efforts to do something about it.

This participant also believed in the power of data to support change and matching funding to meeting stated goals.

1- **New Funding Models**

All said that providing socially responsible care for marginalized patients required tremendous time which was not compensated by the traditional fee-for-service model as: “the extra work presently comes out of your own time.” As participant #9 noted: “time spent advocating takes time from other activities such as teaching, research and personal time.” Those working in community centers noted that their advocacy work was supported both in terms of their alternate funding models and the presence of an interprofessional health care team to support marginalized patients.

There was consensus that another funding model should be developed such as the alternate funding plan for academic paediatricians or a salaried model tied to specific health care outcomes. The funding of health care teams was mentioned but the opportunity for “cherry picking” low-maintenance/healthy patients was a danger.

One participant was an outlier in terms of looking at different funding models saying:

…physicians are within the 1% in our society in terms of income, that combined with the fact that you are seeing people who earn far less than you, are living on far less than you, you’d think it would induce a sort of self-critique that would say, I should be involved in advocacy. But people align themselves with their class interest so you will not see physicians calling for increased taxation to higher-income individuals.

2 **Create Research Streams for Equity Research**

All participants spoke of creating equity research streams that parallel the system of recognition and promotion that exists for biomedical research. As participant #7 said: “research involving observation and ethnography usually takes more time and usually results in fewer publications and therefore a slower academic promotion stream.” Further: “external funding comes to quantitative researchers from companies who are not usually interested in funding qualitative research dealing with marginalized populations or non-scientific topics.” Or as participant #10 stated:

…the present academic system rewards those with many grants and publications not those who do public addresses or public education. There should be opportunities to align academic rewards for those who advocate for policy change and who spend time educating the public.
Participant #9 is in a leadership role which has provided a large grant enabling work related to these issues. He realized how unusual this was and how privileged he was to have received this grant.

### 4.2.3 Cross-cutting Themes

It is interesting to do a high level review and compare the themes that were discussed in both groups to synthesize the commonalities between groups. As previously noted, four overarching questions were posed to each participant followed by a number of follow-up questions which developed as a result of the conversations with each participant. The major themes delineated from both groups for each overarching question are summarized in the four tables which follow. Cross cutting themes are summarized in the brief narrative which follows each table.

#### Table 17: Work Focus….Typical Day

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Equity Leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of equitable care</td>
<td>Creating equitable access</td>
</tr>
<tr>
<td>Advocacy</td>
<td>Education</td>
</tr>
<tr>
<td>Interprofessional approach</td>
<td>Outreach to the community</td>
</tr>
</tbody>
</table>

Both groups sought to enhance access to equitable health care. Physicians by directly providing equitable health care whereas equity leaders worked with their organizations to develop and implement policies and procedures which would augment equitable access for all. Physicians spent a considerable portion of their day advocating for patients ranging from advocacy at the individual level to political advocacy for groups of patients. Education was a substantive focus of equity leaders and this education can be understood to be a type of advocacy. Their goal was to raise awareness about issues of equity, biases and prejudices which operated within their organizations and to identify and remove barriers to access. In doing so, they were advocating for marginalized staff and/or patients in their organizations to enhance future access and improve quality of care. Physicians commented that interprofessional work was foundational to success in both improving access and doing advocacy work. From the perspective of equity leaders, outreach into the community was also an essential element of improving access and conducting advocacy work. Therefore,
there was synchronicity in both groups whose work day, although markedly different, was ultimately focused on the two themes of improving access and advocacy.

**Table 18: Challenges**

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Equity Leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time, energy and frustration</td>
<td>Embedding an intersectional agenda</td>
</tr>
<tr>
<td>Access issues</td>
<td>Denial</td>
</tr>
<tr>
<td>Need for resources like cultural interpreters</td>
<td>Finding resources: Cultural interpreters</td>
</tr>
</tbody>
</table>

Both groups expressed their frustrations about the seemingly insurmountable challenges in their work day. Physicians spoke of a disconnected system and the huge health care burden in society which they faced each day. Equity leaders spoke of the challenges of moving an intersectional equity agenda forward as being so large as to almost paralyze action. These initial challenges were compounded for physicians by the lack of support for marginalized patients, which translated into many hours of additional work for each of these marginalized patients to facilitate access to drugs and programs. Equity leaders spoke of the frustrations of having to deal with denial about health inequities from colleagues who, for example, spoke of gender issues as being resolved. Trying to educate staff and colleagues about intersectionality, historical oppressions, and the needs of marginalized individuals was very challenging. Both groups needed resources, which were scarce, to support their work and primary amongst these was access to cultural interpreters. The major cross cutting theme arising from this question was that both groups worked within a health care system which was developed at a time when Canada was largely a White country. The root cause of both their major challenges was the fact that this health care system has not adjusted to the new reality of the Canadian population.
Table 19: Incorporating Teaching about Health Inequities, Health Advocacy and Social Responsibility into the Medical Curriculum

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Equity Leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weave through the curriculum</td>
<td>Weave through the curriculum</td>
</tr>
<tr>
<td>Experiential learning</td>
<td>Experiential learning</td>
</tr>
<tr>
<td>Create partnerships</td>
<td>Create partnerships</td>
</tr>
<tr>
<td>Teach Advocacy</td>
<td></td>
</tr>
</tbody>
</table>

Both groups unanimously agreed that these concepts could be incorporated in the curriculum and further, they agreed that it was important to weave this material throughout the curriculum. Experiential learning was considered by both to be essential. Both voiced the opinion that partnerships with professional organizations could be useful. Physicians reiterated the importance of teaching advocacy to medical students.

Table 20: Impact of Reward System for Physicians on Health Advocacy and Social Responsibility Work

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Equity Leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td>New funding models</td>
<td>New funding models</td>
</tr>
<tr>
<td>Create equity research streams</td>
<td>Create endowed chairs</td>
</tr>
</tbody>
</table>

With the exception of one dissenting voice, both groups agreed that a new funding system to replace the fee-for-service model would support health advocacy and social responsibility work. All participants also voiced the opinion that money earmarked for equity research and endowed equity chairs is essential in order to move these agendas forward. Since this kind of research takes more time and is more difficult to fund, it is important to have a system which parallels the biomedical research system for both access to funds and promotion through the academic ranks.
Chapter 5
Discussion and Conclusion

I chose this thesis topic because of my interest in health inequities and the role that medical schools can play in helping to address these inequities. I wanted to make a positive difference in the approach used to socialize students to health inequities in Canada, health advocacy and social responsibility. Because these inequities appeared so entrenched, I looked for a theory that would facilitate analysis across inequities and found that intersectionality was a framework that I could use to help in my analysis. Intersectionality does not privilege one marginalized group over another. Intersectionality understands that an individual’s identities cannot be divided into discrete components but functions as a whole and impacts a person differentially throughout their lives and depending on circumstances. It tries to identify the underlying historical structures as well as the power systems at play which privileges some groups and consequently marginalizes others. Intersectionality requires more than merely identifying these issues, it promotes actions to address the marginalizing processes.

Intersectionality originated in Black feminist literature but I wanted to take this framework and apply it to a new domain, that of medical education.

The significance of using this research lens was re-affirmed for me by many readings including Taylor’s (2003) submission that medicine sees itself as a “culture of no culture”, and Beagan (2003) who notes that: “…the standard of medical practice is to treat everyone neutrally, objectively, as if they were cultureless, classless, raceless, and genderless” (p. 612).

Intersectionality demands exactly the opposite. It requires that we look at the simultaneous impact of the multiple identities of individuals and groups. It suggests that the impact of these identities may change according to time, place, and circumstances. Neutrality and objectivity are not valued by intersectionality. Intersectionality also focuses on questions of power and suggests that those who hold power should reflect on the privilege they achieve because of this unearned power and become reflective about how to use their power in a more constructive manner to help address marginalization and inequities.
5.1 Summary of Results

As I delved into the literature, I was energized when I found evidence that all seventeen medical schools in Canada had agreed that they had a social responsibility to their communities and society in general which included dealing with health inequities. Exploring The RCPSC Health Advocate Competency was important as it appeared to be a potentially highly effective means to address social responsibility. In fact, through my research with colleagues at the Wilson Centre (Girard-Pearlman Banack et al., 2011), the link between health advocacy and social responsibility was made explicit. The link was previously discussed in an earlier chapter of this thesis.

Therefore, my thesis question was centered on finding what was being taught in self-described socially responsible medical schools in Canada regarding the Health Advocate Competency, health inequities and social responsibility.

However, before answering the question, I wanted to situate my research and to understand the origins of health inequities and for this reason, I explored Canadian historical legacies related to racism, Aboriginal people, multiculturalism and immigration. I also explored the role of medical schools in addressing health inequities through their social responsibility commitment and became aware of the challenges this commitment was posing.

Further, I analyzed the re-emergent discourse on health advocacy in Canada and The United States.

The literature review on health advocacy was a useful environmental scan which indicated the challenges that this competency posed for medical educators and practitioners who presently function from within a specific professional ideology. The results from the questionnaire were even more revealing. They indicated the wide gap between the idea of the Health Advocate Competency and social responsibility and the reality of these concepts in the fabric of medical education. The two medical schools involved in this research both profess to be socially responsible. However, the results from the questionnaire appear to demonstrate that neither health advocacy nor social responsibility were being adequately discussed or prioritized within these medical schools where biomedical scientific knowledge holds primacy. Course Directors, who are primarily responsible for curriculum delivery, were clear about their priorities related to health advocacy and social responsibility when these concepts were interfacing with the scientific biomedical curriculum.
Waitzkin (1989) defines ideology as “an interlocking set of ideas and doctrines that form the distinctive perspective of a social group” (p. 221). The questionnaire results seem to confirm the biomedical orientation and ideology of medicine and suggest that for this social group, introducing new domains outside of the objective biomedical, bio-scientific framework is challenging. Waitzkin (1989) comments that:

The exclusion of social context from critical attention is a fundamental feature of medical language, a feature closely connected to ideology and social control. Inattention to social issues, especially when these issues lie behind patients’ personal troubles, can never be just a matter of professional inadequacy, or the inadequacy of professional training. This lack is a basic part of what medicine is in our society (p. 232).

This is a very strong indictment of medicine and the biomedical ideology which reproduces itself from one generation of physicians to another. The hidden curriculum which socializes students into the medical profession contributes significantly to this reproduction. In the questionnaire data, the hidden curriculum manifested itself in a number of ways. The responses from the Course Directors were a strong indicator of what is actually valued in the medical curriculum (rational, scientific knowledge), clearly showing, from their perspective, the relative unimportance of the espoused values of the medical school regarding social responsibility, and the espoused values of The RCPSC, The CFPC and The Medical Council of Canada with respect to the Health Advocate Competency. The fact that knowledge about health inequities and the Health Advocate Competency is not evaluated was another clear indicator of the hierarchal position of these concepts in the medical school curriculum since what is valued, in this case the Medical Expert Competency, is always measured.

5.2 The Questionnaire Results

The questionnaire results provided concrete data regarding the possible root causes of the challenges associated with the Health Advocate Competency. Such challenges appeared to be linked to a hierarchy of knowledge which privileges scientific medical information and the biomedical curriculum, over other forms of knowledge.

There is no argument about the importance of the Medical Expert Competency to patient care and medical education. However, in today’s society, the Medical Expert Competency cannot stand alone. The other CanMEDS Competencies are not intended to reduce the information needed to become a Medical Expert but are meant to enhance good patient care. Additionally, unless students are socialized early and longitudinally into a
culture of advocacy and caring, the waning of idealism which was discussed in Chapter 2 will continue unabated.

Beagan (2000) notes that presently: “Students are learning that as long as they act impartially as doctors, treating everyone the same, equality will have been served” (p. 1263). This type of thinking where equality is the goal is closely linked to the objective biomedical discourse of medicine. However, equitable care differs from equality of care. Equitable care requires doctors to be patient-centered and treat each patient according to their specific needs and circumstances which may result in different approaches to the same diagnosis. Equitable care demands that physicians understand the necessary dissimilarities in health care approach necessitated as a result of a patient’s specific circumstances.

5.3 The Interviews

The interviews provided rich data about working in an intersectional equity framework which supports health advocacy and actualizes social responsibility. Both the equity leaders in health care organizations and the physicians who participated in these interviews were working within an intersectional equity framework although the majority used the determinants of health terminology.

All eleven participants implicitly showed through their work or explicitly stated that their goal was to improve health care outcomes for marginalized groups. All eleven participants were very aware through their own work experience of the cumulative impact of the multiple identities of marginalized individuals and knowingly or unknowingly, were looking at them through intersectional lenses. In this light, they were effective teachers about the impact of intersecting oppressions on health outcomes. Whether working in policy development or as direct care providers, they were aware of the challenges faced by individuals whose gender, race, social class, immigration status or other identities interlocked with systems of power and left them at a disadvantage. All participants worked at eliminating structural barriers to access efficient quality appropriate health care.

For those equity leaders in health care organizations, this work was focused on policy development, education and identifying structural barriers for access to health care. However, these participants were also involved in addressing interpersonal harassment incidents in their organizations and using these incidents to educate. Barriers to access were identified through a variety of means including complaints, workforce census, workplace environmental studies, and community consultations. Some barriers were structural such as
the washroom and change facilities for disabled individuals. Other barriers were less tangible but equally deterring such as the judgmental or negative attitudes of health care professionals towards certain groups or customs from other cultures, which resulted in unacceptable delays to access care. The health outcomes for certain marginalized groups were understood by all participants to be influenced by their intersecting identities.

Embedding an intersectional equity agenda as a core value in their organizations was made challenging because executive teams and medical leadership were predominantly White and might pay “lip service” to this program. The new Ontario Ministry of Health equity assessment form was considered to be a very good first step in this process of embedding equity in an organization and the focus on intersectionality was seen as a way to further advance equity. Participants understood that to promote a successful equity program requires absolute commitment from the executive team, a change in organizational culture, a review of all policies from an equity perspective, targeted initiatives with an intersectional approach, equity indicators and finally performance measurements. All of these strategies are also necessary to embed social responsibility in an organization.

For the six physician participants, the focus of their work was direct care provision. However, because their patients were from marginalized populations, their work was not limited to addressing health care. They were all involved in advocacy work, including activism and politics, to bring attention to the plight of these underserved individuals and provide them with access and resources supporting better health care outcomes. Their advocacy work ranged from the individual level where they addressed a variety of needs such as obtaining housing or disability support. At the population level, activities included working with their professional association, The OMA to address a significant barrier such as the three month waiting period for immigrants to access health care. Their work was extremely demanding and they voiced a strong preference that it be conducted within an interprofessional team. They had firsthand knowledge of the impact of employment, poverty, immigrations status and how the interlocking nature of these statuses could impact health care.

For physicians, as direct care providers working within a system that presently does not recognize the impact of intersectionality, their challenges were time-consuming and frustrating. There challenges were the results of attempting to access the appropriate treatment and social support based on the individual patient in light of their full social circumstances. Their work involved considerable advocacy to try to address the shortfalls of
the health and social care systems. It also took much longer than if they were to address only the direct health care needs and ignore some of the fundamental social issues which exacerbated the health care needs. However, for those participants working in community health care settings, this work environment was more supportive of their efforts in this light and allowed them to create programs that addressed their patients’ needs through innovative means. One such program created by participant #8 and the interprofessional team at the community centre was a peer-support program based on a meal and linked to an educational session. This program provides food, social cohesion, health literacy and the knowledge to empower this group of hepatitis C patients.

All eleven participants agreed that it was possible and desirable to incorporate an intersectional approach in medical practice to support health advocacy and address social responsibility. All participants, except for one physician, agreed that a new funding model to pay physicians should be sought as the present fee-for-service funding system was not ideal. The one dissenting voice was a physician who noted that since physicians were part of the power structure of society and were already well funded for their work, they were less likely to support funding changes.

All participants spoke of creating streams for equity research that would allow this kind of research to compete with the traditional biomedical research. This would include equity chairs, equity foundations or other mechanisms to support equity research. There are many questions that need to be explored with respect to advancing the research on health inequities, health advocacy and social responsibility. According to the participants, funding sources for this type of research, such as CIHR, are more difficult to access. This means that researchers working in the equity field are more likely to have a lower or a different productivity than those doing biomedical research. This in turn impacts other aspects of their lives such as promotion within their departments.

5.4 Actualizing Health Advocacy and Social Responsibility in Medical Schools

Reflecting on the literature review, the data from the questionnaire, the interview analysis and intersectionality highlighted the need to develop a plan to counterbalance the entrenched scientific ideology and develop a set of recommendations for the future. This action-oriented thinking is likely the result of the archetype under which I functioned for more than three decades. This research uncovered some significant historical barriers to the
integration of health advocacy and the actualization of social responsibility in the medical education curriculum. The most significant barriers appear to be related to biomedical ideology, selection and socialization of medical students, the apparent inability to teach about health advocacy and the apparent inability to concretely actualize social responsibility. The focus on scientific medicine appears to create challenges to the teaching of health advocacy and social responsibility as well as to the provision of health care from an intersectional perspective. However, it is important to remember that medical schools reflect the society in which they exist. Thus the Canadian mindset that universal health care, multiculturalism and diversity programs are adequate tools against health inequities may have inhibited the teaching about historical oppression and structural systems of power that privilege some and marginalize others. Denial has been allowed to exist and has not been addressed in the same manner as it has in The United States and Great Britain where high profile reports have outlined the problems of racism and their impact on health care. The recommendations and rationale which follow in the next section are an attempt at concrete actions to address many of these concerns and to support medical schools in their desire to teach health advocacy and be more socially responsible to their communities.

The discussion regarding future directions will be framed through an intersectional equity framework and The Health Equity Council’s living definition of equity provides such a framework:

Fair and equitable health outcomes across diverse communities will result from utilizing an inclusive health framework for publicly funded and other universally accessible health services. This requires policies, planning, education and training, funding and research that clearly recognize racism/racialization and all other forms of exclusions and oppression as fundamental social determinants impacting health and wellness. We further recognize the intersecting and compounding impact of various forms of marginalization, including, but not limited to, race, national or ethnic origin, class, spirituality or faith, sex, gender, sexual orientation, age, mental or physical disability (visible or invisible), immigration status, and identified arising from these, on individuals’ and communities’ state of health and wellbeing (Health Equity Council, 2005).

The recommendations which follow will be framed by this definition which encompasses intersectional lenses but will also be grounded in the literature, the results of the questionnaires and interviews and, of necessity when moving an agenda forward in any organization, some business theory. Issues whose jurisdictions are outside of the realm of
Faculties of Medicine will not be incorporated. This includes certain findings which impact health such as the challenges for immigrants in finding work, the lack of affordable housing, the lack of facilities in hospitals for disabled people and the need for new funding models for physicians. These are important findings that could form part of a political advocacy course in medical school but lie outside of the overall medical school curriculum. Therefore, the recommendations in this thesis will be focused on simple steps that medical schools can implement to advance the equity agenda, enhance health advocacy and social responsibility. This follows the advice of participant #5 who suggested “thinking big but starting small around a community or an issue or levers that can make a difference,” in this case at the medical student and medical school level.

Each recommendation which follows will be supported by a rationale which will underscore the justification for the proposed suggestion and will draw from the questionnaire and interview results, as well as intersectional and business theories.

5.4.1 Recommendations

To frame the first recommendation, it is useful to review the definition of a socially responsible and accountable medical school that all seventeen medical schools in Canada have accepted:

Social responsibility and accountability are core values underpinning the roles of Canadian physicians and Faculties of Medicine. This commitment means that, both individually and collectively, physicians and faculties must respond to the diverse needs of individuals and communities throughout Canada as well as meet international responsibilities to the global community (AFMC, 2009, p. 5).

**Recommendation 1: Social Responsibility**

In order to meet the mandate of the AFMC definition, medical schools in Canada should explicitly state their social responsibility mandate in their mission statements. This is an essential foundational step. The mandate should be developed with key stakeholder input which should include the community. To ensure ongoing progress towards this mission statement, and to profile the equity component of social responsibility, The WHO Social Accountability grid (Boelen & Heck, 1995) should be used and be an essential piece of all information disseminated about the school. The social accountability grid is a chart which incorporates the tripartite mission of medical schools and also principles of relevance, quality, cost-effectiveness and equity. It was first developed by Boelen and Heck (1995) as a
visual to illustrate interrelated progress in all aspects of the medical school’s tripartite (education, research and patient care) mission. Boelen and Woollard (2009) as well as Palsdottir et al. (2008) consider that measurement tools such as the social accountability grid are core to success in meeting social responsibility. The social accountability grid which follows shows clearly how progress and staging along all aspects of the social responsibility mandate can be clearly represented.

Table 21: Social Accountability Grid

<table>
<thead>
<tr>
<th>Values</th>
<th>Education</th>
<th>Research</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevance</td>
<td>Planning</td>
<td>Doing</td>
<td>Impacting</td>
</tr>
<tr>
<td>Quality</td>
<td>Planning</td>
<td>Doing</td>
<td>Impacting</td>
</tr>
<tr>
<td>Cost-effectiveness</td>
<td>Planning</td>
<td>Doing</td>
<td>Impacting</td>
</tr>
<tr>
<td>Equity</td>
<td>Planning</td>
<td>Doing</td>
<td>Impacting</td>
</tr>
</tbody>
</table>

Rationale for the Recommendation about Social Responsibility

A mission statement describes an organization’s raison d’être. If social responsibility and the resulting concern for health inequities in the community is not explicitly included in the mission statement of all 17 medical schools in Canada, then it cannot profess to be a core mandate. The results of the research questionnaire highlighted the fact that it is not core to the mandate of the two participating medical schools despite their expressed intent to be socially responsible institutions. AFMC makes it clear that responding to the needs of the community is the duty of all medical schools. Thus it follows that consultation by the medical schools with their communities is de rigueur in order to understand the diverse needs of their specific communities. Using an intersectional lens to analyze community needs will help medical schools understand the forms of health inequities in their communities resulting from the exclusion and marginalization of certain groups. With this knowledge, an approach that attempts to address all needs, not just those of a selected few, can be more easily developed.

This consultation is rarely done, as McCurdy et al. (1997) found when they conducted a survey of U.S. medical schools on behalf of The Association of American Medical Colleges, to see whether medical schools identified their stakeholders and responded to their
needs. As a result of this survey, the Deans who responded became sensitized to the issue of a social contract with their stakeholders (students, faculty, community and government) even though most had not consulted them when deciding on the mission and future of the medical school.

It was outside of the purview of this study to ask the two participating medical schools whether or not they consulted with their stakeholders, to decide upon their mission statement. However, the literature seems to suggest that NOSM is the only medical school in Canada which has truly done a community consultation and has incorporated social accountability into their raison d'etre.

Palsdottir et al. (2008) note that only scattered efforts worldwide have been undertaken to establish social responsibility into medical education programs as the traditional bio-medical hospital-centered models of education have continued to prevail. They identified eight schools throughout the world, one of which is NOSM, whose mission statements clearly state their purpose in training socially responsible physicians. These eight schools are presently cooperating to develop a common evaluation framework to measure performance and impact of their programs on marginalized communities, and to ascertain if they have been successful in training physicians who are socially responsible.

Explicitly highlighting the social responsibility mandate in the mission statement is also one mechanism to deal with the hidden curriculum. The hidden curriculum operates at many levels and Hafferty (1998) suggests that to understand the hidden curriculum we must “explore the underlying structures and the organization of our institutions themselves” (p.404) to see what is valued enough to be assessed and review resource allocation to understand what is important enough to be funded as the priorities of the school. If the mission statement does not unambiguously incorporate the social responsibility mandate, this is a lacuna which translates into resource allocation decisions and assessment strategies which give a powerful hidden curriculum message. As some interview participants expressed, embedding equity concepts and social responsibility as a core value in an organization requires more than lip service by the executive and leadership teams. In fact, it requires absolute commitment from the executive team, a change in organizational culture, policies and programs that reflect an equity perspective as well as indicators and performance management measurements. Only with all of this is in place can the hidden curriculum (or the parallel ‘informal organization’ in business parlance) be countered.
Wen et al. (2011) and others advocate for an explicit social mission in medical schools to foster maintenance of the idealism with which new medical students are imbued so that medical students are educated to be change agents. However, it is not enough to mention the social responsibility mandate in the mission statement. There must be evidence of its importance and the dynamic nature of the mandate by the use, ideally, of the social accountability grid or another similar performance measurement tool.

The business literature is replete with articles about measuring performance and performance measurement systems. Kaplan and Norton (1992) are credited with introducing the balanced scorecard concept to the business and hospital world. As they note, a balanced scorecard is both an effective strategic management system and a performance measurement that gives a concise and accurate picture of the achievement and progress of an institution towards meeting its mission. Although a true balanced scorecard would include financial data, the social accountability grid can be understood to be an amalgam of the balanced scorecard, albeit without explicit financial metrics. Developing such a measurement tool is essential if the tripartite mission of the medical school is to be melded with its social responsibility mandate. Without a measurement tool, accountability to the community is not possible.

Interview participants emphasized the need to adopt a number of key processes for success in achieving health equity. These should include making equity understandable across an organization as well as being accountable and aligning incentives for effectively meeting indicators. As Kaplan and Norton (1992) state “what you measure is what you get” (p.71) which echoed the words of many interview participants who noted that “what gets done is what is measured.”

**Recommendation 2: Incorporate Intersectionality into the Medical Nomenclature**

Incorporate intersectionality into the determinants of health, a nomenclature which is understood and accepted within the biomedical culture of medicine. Change the terminology to co-determinants of health to reflect the interlocking and intermeshing characteristics of the co-determinants listed.

**Rationale for the Recommendation to Incorporate Intersectionality into the Medical Nomenclature**

The literature review and the questionnaire responses as well as the interviews indicated how the determinant’s of health terminology was well accepted within the biomedical curriculum. Building on this acceptance is a way of infiltrating with the expanded
discourse of intersectionality which provides a more analytic lens and is steeped in concepts of social justice. Table 22 compares the determinants of health as described by two dominant organizations, *The WHO* (Wilkinson & Marmot, 2003) and *The Medical Council of Canada (MCC)* and shows the variations between the two organizations. I have added a third column called intersectionalities based on intersectional theory. A fourth column entitled co-determinants of health is the development of a new concept whose emergence is described in this rationale. The co-determinants of health support the definition of *The Health Equity Council* referred to on page 196.

**Table 22: Comparisons between Determinants of Health, Intersectionalities and Co-determinants of Health**

<table>
<thead>
<tr>
<th>WHO Social Determinants of Health</th>
<th>MCC Determinants of Health</th>
<th>Intersectionalities</th>
<th>Co-determinants of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work</td>
<td>Employment</td>
<td>Employment type</td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>Poverty</td>
<td>Poverty</td>
<td></td>
</tr>
<tr>
<td>Social gradient</td>
<td>Social status</td>
<td>Social class</td>
<td>Social class/gradient</td>
</tr>
<tr>
<td>Culture</td>
<td>Culture</td>
<td>Culture</td>
<td></td>
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<tr>
<td>Social support</td>
<td>Social support</td>
<td>Social support</td>
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<tr>
<td>Education</td>
<td>Education</td>
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</tr>
<tr>
<td>Housing</td>
<td>Housing</td>
<td></td>
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<tr>
<td>Diet/ exercise</td>
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<tr>
<td>Lifestyle issues</td>
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<tr>
<td>Gender</td>
<td>Gender</td>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Stress</td>
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<td></td>
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<tr>
<td>Early life</td>
<td>Genetics</td>
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<td></td>
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<tr>
<td>Unemployment</td>
<td>Unemployment</td>
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<tr>
<td>Social exclusion</td>
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<tr>
<td>Addiction</td>
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<tr>
<td>Food</td>
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<tr>
<td>Transport</td>
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<td></td>
</tr>
<tr>
<td>Race</td>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immigration status, language</td>
<td>Immigration status, language</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>Sexual orientation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In the foreword to *The WHO* social determinants of health document (Wilkinson & Marmot, 2003), the editors acknowledge the ‘clear scientific evidence’ on which these determinants of health are based. It is interesting to note that in this *WHO* determinants of health list, the structural issues mentioned as having impacts on health do not include race, gender, sexual orientation, immigration status, which we have seen through the literature review and the data from the participant interviews interlock and significantly impact on health. Although *The WHO* publication never mentions the concept of intersectionalities, it acknowledges that disadvantage, whether it is absolute or relative tends to concentrate among the same people. Critically analyzing *The WHO* determinants of health list, it is clear that many of these determinants are better conceived as outcomes of the root cause of the disadvantages experienced rather than the determinants themselves. For example, if you analyze *The WHO* list, I would submit that stress is not a determinant but often an outcome of disadvantaged conditions such as poverty and unemployment. Similarly, early life impacts if you are born to a poor family unable to provide all the necessities which promote good development. Conversely, being born to a more affluent family results not only in all the necessary ingredients for good development but also advantages in other spheres such as education. Social exclusion often stems from poverty, unemployment, racism, and discrimination. Social support is frequently linked to social and economic status and food availability is influenced by poverty which limits your food quantity and quality. Addiction, which *The WHO* names as a determinant of health, can also be understood as a health damaging behaviour in response to racism and discrimination as mentioned by Ahmed et al. (2007); Mayer et al. (2008); and O’Hanlan, Cabaj, Schatz, Lock, and Nemrow (1997). *The WHO* publication again skirts the idea of intersectionality when noting that “the chances of living in poverty are loaded heavily against some social groups” (p.16).

*The Medical Council of Canada’s (MCC)* determinants of health list, although slightly different is derived from *The WHO* listing and so conceivably has a similar ‘scientific’ origin. An important difference is the fact that *The WHO* listing does not include gender whereas *The MCC* list does. Both organizations ignore the evidence that personal identities of race, sexual orientation, immigration status and employment type also impact on health. Additionally, *The MCC* determinants of health list mentions lifestyle, genetics, diet and exercise as specific determinants which takes the focus away from multilayered socially constructed systems which negatively impact health and attributes it to individual responsibility. Bhopal (2001) notes: “when research implies genetic factors as the cause of
racial differences in health, racial minorities may be perceived as biologically weak” (p. 1504).

The omission of race and sexual identity as determinants of health in The WHO and MCC determinants of health lists, the omission of gender in The WHO list as well as the addition of individual lifestyle and genetics issues in The MCC list is problematic. Adding the individual lifestyle and genetics component might be acceptable if a complete list of intersectional identities which impact on health had been included. However, since gender (in The WHO list) and race and sexual orientation (in The WHO and MCC list) are excluded these additions have the quality of a blaming the victim approach. It is difficult to understand how these identities were not included from the onset in The WHO and MCC determinants of health lists unless it is understood to have been either an intentional or inadvertent exclusion which continues to privilege the dominant group. The determinants of health lists as they presently stand could be interpreted as appearing to address the problem while in fact only addressing the edges and not the core issues. Another way to understand these determinants of health lists is to see it as the reflection of the Flexnerian scientific approach which is incompatible with non-scientific information. In fact, the core finding of this thesis is that medicine continues to privilege scientific bio-medical knowledge and holds at bay important determinants of health in its ‘scientific’ listing.

There is strong evidence as to the negative impact of race on health care and healthcare outcomes as noted in the section on racism in this paper (2.2.2). Most prominent is The Institute of Medicine Unequal Treatment Report (2003) which gave extensive evidence of the negative impact of race on all aspects of treatment and care in The United States.

There is also evidence of the impact of gender on health and health outcomes which arose through participant comments. I did not originally include a literature review on this topic but the results of my discussions with the interview participants suggested that I needed to more fully explore this topic.

There are differences in the health needs of men and women as women’s biology is different resulting in their unique experiences of menstruation, pregnancy, and menopause and men’s of erection and ejaculation. Doyal (2000) speaks of the biological sex differences in the causes, incidences and prognosis of a number of health problems which reveal complex biological differences in patterns of risk and susceptibility. However, the author also speaks of socially constructed inequalities (for example in work and income) and the disadvantages faced by females in accessing health related resources. Doyal notes that:
Though they [women] have a longer average life expectancy than men, they do not necessarily lead healthier lives. And most importantly, a considerable amount of the illness they experience can be traced back in one way or another to the nature of their daily lives and should therefore be preventable through public policy (p.934).

This author also speaks to intersectionality, without using that terminology, when noting that: “…it is impossible to understand the impact on health without taking factors such as class, race and geopolitical status into account” (p.935).

Doyal concludes that gender equity requires policies for universal access to reproductive health care followed by removal of gender inequalities in access to resources as well as educational and employment opportunities. The author acknowledges that the implementation of these changes might also result in a number of unintended consequences which will need to be addressed.

Pilote et al. (2007) conducted a comprehensive review of a number of articles regarding sex-specific issues related to cardiovascular disease (CVD) noting that CVD is the leading cause of mortality in women. One of the articles questioned why the CVD incidence and mortality rates are decreasing for men but stable for women. At the end of this review, the authors conclude that although many aspects of CVD are similar in women and men, there is a growing body of data that supports sex and gender differences in prevalence, presenting symptoms, management and outcomes of CVD. However, they suggest that more work is needed to understand these differences and improve health care outcomes for all.

Davidson et al. (2012) also studied CVD in Australian women and found that women with acute coronary syndromes consistently had poorer outcomes than men independent of co-morbidity and clinical management. They note that differences in presentation, management and experience highlight the need for health professionals to develop disease prevention and treatment strategies for women. Further they explain that CVD is often overlooked as a health issue for women. They suggest that approaches to CVD should be tailored to the circumstances of diversely situated women.

Zaidi (1996) looked at gender and quality of care in underdeveloped countries to find an explanation for gender inequalities. He concluded that:

…to effectively change the position of women in the health matrix and increase access to services, the structures which cause the inequalities in the first place will have to be dealt with….there is also a need to incorporate men and their role in changing the
inequitable system which distributes resources inequitably (p. 728).

The goal of The Project for an Ontario Women’s Health Evidence-Based Report (POWER) study (Bierman, 2009), was to serve as an evidence-based tool to be used by policy makers and health professionals to reduce documented inequities among the women of Ontario. The study authors note that there are well-documented differences not only in the health of women and men but also in the kind of health care they receive. They further note these variations extend to women who are diversely situated because of age, income level, education, ethnicity and geography. Again, although the word intersectionality is not used, the idea of these additional influences which intersect and potentially compound access issues to resources and health care outcomes is suggested.

Study participants also spoke of the impact of gender on health care such as the subtle differences in timely referrals for women to certain specialists but the quick referrals to mental health specialists. The interview participants also spoke of the challenges for low-income women to access resources such as more nutritious food. They noted that these women usually prioritize their children’s nutrition needs when food is scarce and for this reason, they suffer high rates and poorer outcomes when faced with health issues such as diabetes. Interview participants also spoke of the difficulties these women have to attend medical appointments both in terms of the transportation costs and the challenges of making child care provisions. And finally, they spoke of pregnant urban Aboriginal women who have the worst outcomes as they are without access to federally funded resources once they leave the reservation for the city.

Sexual identity can also impact on health care access and therefore outcomes. In the interviews for this research, participants spoke of the discrimination that LGBT groups experience which creates structural barriers to access care, resulting in delays and thus increased morbidity at the time of presentation for care. Mayer et al. (2008) discuss the fact that homophobia affects access to health care for LGBT individuals which results in stress which affects mental health. In the same article, they reference existing research which shows that substance abuse, obesity and tobacco use are more prevalent in sexual and gender minorities. O’Hanlan et al. (1997) speak of the increased disease vulnerabilities that are present in LGBT groups. They suggest that the negative stereotypes, discrimination and violence etc., to which these groups are exposed results in low self-esteem, depressive distress, poor health habits, substance abuse, poor compliance with standard screening

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recommendations, reduced access and utilization of services and higher risk profiles for many cancers and heart disease with potentially higher morbidity and mortality. They further state that many studies have indicated that gay men and lesbians are at risk for violent assaults and injuries. They note that the peer-reviewed evidence confirms that being part of LGBT groups adds health risk factors because of homophobia on the part of society and the health professions.

An important step forward in Ontario for LGBT individuals is the recent update of *The Ontario Human Rights Code* which extends protection to transgendered people. All three parties voted in support of an amendment to the code to include the terms “gender identity” and “gender expression”.

My readings led me to understand that the intersections of race, gender, sexuality and class are the most prominent identities that impact all aspects of our lives. The impact on health of these intersections was demonstrated through an empirical investigation by Veenstra (2011) who studied *The Canadian Community Health Survey* to understand the degree to which the self-rated health of Canadians varied by these identities and to see if this was consistent with intersectional theory. He found that: “…from an intersectional perspective, each axis of inequality interacted significantly with at least one other…(p. 10).”

The results of my interviews with the six physician participants supported this notion that it was not only feasible but also desirable to incorporate an intersectional approach to medical practice although they mostly use the determinants of health terminology. In fact, most participants expressed the opinion that because the determinants of health have been included in the majority of medical curricula in the past decade, medical students are starting to think more about social issues that impact health care outcomes.

Intersectional lenses provide a more expansive scan, but the challenge is how to incorporate these lenses into the medical gaze. One study participant was very adamant that the word intersectionality was too academic and that the terminology of determinants of health should be used as it was widely accepted in the medical community. The acceptance of this terminology was re-enforced by all the physician participants. However, while the participants used the term determinants of health, their descriptions indicate that they are discussing and working within an intersectional framework and that they fully understand the interlocking characteristics of these identities that privilege some, but marginalize others. For example, one participant gave the example of teaching about intersectionality when working with children living in poverty and suggests they are not a homogenous group and must be
seen in light of other nuances or intersections such as immigration status, social support, neighborhood, etc.

However, two participants were concerned that for teachings about intersectionality, health inequities, health advocacy and social responsibility to be successful, major shifts in the culture of medicine would be required as altruism is lost during medical school as students become less idealistic and more cynical during their 4 years of medical education.

As we have seen throughout this research, the culture of medicine is strongly influenced by the biological sciences. This culture has accepted the terminology of determinants of health. It will likely not accept a term such as intersectionality. But creating a slightly amended term which includes an intersectional approach and clearly articulating the connection between the previously accepted determinants of health and a new terminology of co-determinants of health may have some success.

Collins, in the foreword for the Dill and Zambrana book (2009), as well as Manuel and Zambrana in the same book, note that intersectionality is still in its infancy and still underdeveloped. Collins further suggests that intersectionality should be used not only to build alternative explanations for existing phenomena but also to create new knowledge. The recommendation to incorporate intersectionality into the determinants of health and to rename this new entity the co-determinants of health is made in the spirit of enhancing the content of the presently structured determinants of health and focusing students on the strong interplay between multiple social identities. To accurately evaluate the social reality of individuals and groups, assessment tools for physicians must conceptualize different patient identities as co-determinants of health. If intersectionality is incorporated into the determinants of health and this latter term is changed to co-determinants of health, this change can help articulate the interlocking aspects of intersectionality identities and their impact on health and health care outcomes.

Co-determinants of health would be defined in the same way that the determinants of health are defined, that is, social characteristics that influence health outcomes. Focusing on health outcomes is important as most of the participants were clear that health outcomes were the focal point of all their interventions.

Co-determinants of health would include intersectional identities and emphasize how the interlocking characteristic of these identities further marginalizes (or privileges) individuals and groups. Using the established determinants of health nomenclature as the initial Trojan horse through which intersectionality is brought to the forefront in the co-
determinants of health is an attempt to add important dimensions presently missing in the patient assessment strategies of physicians. The co-determinants of health also provide a vehicle to discuss historical oppression and marginalizing systems that have, and continue to operate in our society. More information about the co-determinants of health and how they can be used to enhance the education of medical students will be discussed under recommendation 5a.

The proposal to introduce intersectionality and the co-determinants of health is understood to be a mechanism specific to medical education and medical schools to help actualize social responsibility and address health inequities.

Recommendation 3: Clarify the Definition of the Health Advocate Competency

It is useful to review the present definition of The RCPSC CanMEDS Health Advocate Competency before making the recommendation which follows: “As Health Advocates, physicians responsibly use their expertise and influence to advance the health and well-being of individual patients, communities and populations” (Frank, 2005, p. 19).

The CanMEDS Health Advocate Competency definition should be clarified and strengthened by adding the following words in italics: As Health Advocates, physicians responsibly use their expertise, influence and knowledge of the co-determinants of health to reduce/and help eliminate health inequities and advance the health and well-being of individual patients, communities and populations.

Rationale for the Recommendation to Clarify the Definition of the Health Advocate Competency

The literature review discussed the challenges of actualizing, teaching and evaluating health advocacy. Many articles provided their definition of the Competency and/or suggested elements of this Competency or attempted to characterize the extent of the health advocate responsibility. Clearly, the present definition is inadequate. The purpose of the additional suggested words is to provide a clearer definition of the expectations of a physician health advocate.

The first set of extra words includes the addition of the concept of the determinants of health which has been part, in different formats, of the information regarding the health advocate from inception. The EFPO definition of the health advocate role was as follows: “The health advocate is aware of all the determinants of health and how to promote health.” This was an active incorporation of the determinants of health notion into the expected role of the health advocate and supported an activism component by implying that understanding
as well as promotion of health was required. Subsequently, The RCPSC Health Advocate Competency did not mention the determinants of health in the definition but relegated this information as one of four key competencies for the Health Advocate Competency which reads: “...identify the determinants of health of the population that they serve” (Frank, 2005, p. 19). This change effectively weakened the application of the concept of the determinants of health in the Health Advocate Competency. It relegated the responsibility to merely identifying the determinants of health without the explicit obligation to act on the knowledge of these determinants in a patient population. Finally, The Medical Council of Canada (MCC) also states that being able to identify the important determinants of health is a component of the attributes of a competent physician health advocate without seeming to extend responsibility beyond awareness.

Adding the words “knowledge of the co-determinants of health” highlights and profiles this new concept and infers that it is part of the tool kit physicians need to be health advocates. Additionally, it is an acknowledgment that physician participants were very clear that the determinants of health terminology is now publicly recognized and accepted. However, in the previously detailed recommendation 2, suggestions for the change in content and nomenclature of this terminology were enunciated. Incorporating this new nomenclature thus adds the complementary social identities dimension, presently lacking, to the responsibilities of the health advocate. As participant #2 said: “...we must recognize that people who are doing well socially tend to have better outcomes...we must include these issues in our lenses.”

Adding the words “to reduce and help eliminate health inequities” acknowledges and sanctions the activist component also presently missing from the health advocate definition. Again, this addition further clarifies the extent of the health advocate mandate. Interview participants were clear that as health providers, they had a duty to act and speak out to address health inequities. However, it is also important to note that the range of advocacy work undertaken by the physician participants underscores the importance of teaching advocacy as an array of activities based on physician’s practice. Gruen et al. (2004) provide an excellent conceptual model of the range of health advocate activities. In the inner circle, health advocacy consists of giving advice to a patient regarding smoking or weight-gain, etc. Helping a patient to access needed care is the second concentric circle. The third circle is concerned with direct socioeconomic influences on health such as: taking a public stand on smoking cessation, on the use of bicycle helmet, or the availability of clean needle exchange
programs to prevent blood borne transmissions. In the fourth concentric circle are factors clearly associated with health status but the evidence of causality of illness is weaker and the efficacy of physician action is less clear. These include, amongst others, disparities of income, education, housing and exposure to environmental pollutants. The authors acknowledge that these broader determinants of health may have a greater overall impact on the health of communities but not all physicians will be willing to take on this type of political advocacy as part of their practice. The last concentric circle is concerned with global health influences. Gruen et al. (2004) argue that all physicians have responsibilities for the first three circles including promoting healthcare system changes to reduce barriers to access as well as addressing the determinants of health. However, the last two circles are areas where physicians may choose to extend their role but, given the open-ended and limitless nature of these areas, this is a matter of choice. They further comment that societal expectations may not demand that political health advocacy be practiced at this level as a professional obligation. However, my physician interview participants spoke of teaching the range of advocacy including political advocacy to support the work of those amongst them who chose to work in this advocacy domain to positively impact health equity at the systems level. Some of the literature (Gill & Gill, 2011) supports this point and suggests that students should be taught how to be politically involved. However, it is important to present health advocacy work as a range of activities emerging from the specific patient profile of a physician’s practice. The physician participants demonstrated this approach in the variety of health advocacy work that they undertook.

In the literature review, the one dissenting voice re political advocacy came from Huddle (2011) who argued that political advocacy should not be part of either medical professionalism or medical education. There was a very spirited response to this article from physicians, many of whom were trainees, and from medical educators who rejected Huddle’s views (Sud, Barnet, Waters & Simon, 2011; Kuo et al., 2011; Schickedans et al., 2011; Palfrey & Chamberlain, 2011; Halliday, 2011; Gottlieb & Johnson, 2011; Stull, Wiley & Brockman 2011; Girard-Pearlman Banack & Byrne 2011). These responses argued in favour of universal training in health advocacy and mentioned a number of areas where advocacy by physicians was important. Examples mentioned included advocating for safe places for children to play, quality food choices in cafeterias, safety caps on medications, infant car seats, etc. These writers lauded the advocacy work of physicians which resulted in tobacco control, safer highways because of seat belt legislation and drunk driving laws.
Recommendation 4: Ensure Experiential Training in the Community (You don’t learn forestry in a lumber yard—Anonymous)

Medical schools should partner with Community Health Centres, local agencies and marginalized communities (including Aboriginal Reserves) to provide community experiences for medical students and residents throughout the undergraduate and postgraduate curriculum. Although some schools are doing this, it should be expanded to all medical schools in Canada and throughout undergraduate and postgraduate training. The experience from NOSM in this light should be emulated more widely.

Rationale for the Recommendation to Ensure Experiential Training in the Community

Thornton Dill (2009) discussed the concept that service learning and community experiences help to illuminate the connections between theory and practice. What is said in the classroom is understood when it is experienced in a marginalized setting with patients who present with a variety of problems which transcend health care treatment but impact health care outcomes.

Additionally, equitable access means that one size does not fit all. Both groups of participants spoke of barriers to access to health care. These included lack of financial resources (for transportation to and from appointments, costs of drugs, food scarcity), legal barriers (access to public insurance by new immigrants), structural barriers (inability for many marginalized women to schedule appointments because of their child care responsibilities and lack of funds), physical barriers (spaces not designated for disabled patients), language barriers, health literacy barriers (including how to navigate the health care system), and cultural barriers (created by insensitive, judgmental or prejudicial providers). In remote settings and Reserves, access issues are compounded by the simple fact of being remote.

By bringing care to marginalized communities, a substantial number of access barriers are reduced related to transportation, transportation costs, child care provisions (these facilities usually have child friendly environments), immigration status, accessing appointments (these facilities usually have extended hours), and language (these facilities usually have trained interpreters). Additionally, community programs and facilities are usually less complex than hospital systems and are easier to maneuver for individuals new to our health care system. If remote communities and Aboriginal Reserves are part of the mandatory experiences for medical students, then access issues are substantially decreased by these medical rotations through these communities.
Language accessibility and the importance of cultural interpreters were discussed by a number of participants. As one participant noted, 47% of Torontonians are foreign born and therefore language barriers can be significant. Moreover, in our cash strapped, patient-safety focused health care system, it is important to understand that interpreter services can reduce costs and increase patient safety outcomes as patients who understand their treatment regimes are less likely to bounce back into the system.

Working with interpreters in a Community Health Centre dealing with marginalized individuals and groups sends a strong message of acceptance and support to the clients of that Community Health Centre. It also is a powerful detractor to the hidden curriculum and the present socialization of medical students within the hospital environment. As discussed in Chapter 4 of this thesis, Boelen (2002) and Nachman and Marzuk (2011) talk about the fact that modern hospitals have the same origins and biomedical roots as medicine and certainly play a significant role in socializing medical students to the science-based culture of medicine.

If a medical school has consulted with its communities, the school will be aware of all the challenges in those communities and will be able to adapt their programs to meet these challenges. Wherever possible, partnerships with remote health centres and Aboriginal Reserves should also be sought to further extend the reach of the medical school into surrounding and remote communities.

In Chapter 2, the literature review exposed the fact that medical schools continue to produce physicians who come from upper middle class and upper income families (Waitzkin, 1989; Dhalla et al., 2002; Association of American Colleges, 2005; Freeman et al., 2007; Carrasquilo & Lee, 2008). The upbringing of these students would make them unaware of the many access challenges faced by marginalized patients. The questionnaire results also suggested that Course Directors did not estimate that health inequities were frequently discussed in their courses. If this topic is not discussed and these students are not exposed to marginalized patients, how will these privileged medical students understand and respond to the plight of vulnerable individuals and populations? Experiential learning in the community provides many opportunities to raise awareness and learn about marginalized communities. Writers such as Wen et al. (2011) suggest that community/service learning can help address the waning of idealism in students as they move through their medical education. The Global Consensus for Social Accountability of Medical Schools (2010) suggests that medical
students should be offered early and longitudinal exposure to community-based learning experiences to understand and act on the determinants of health.

In my own study with colleagues from the Wilson Centre (Girard-Pearlman Banack et al., 2011), we found that 93% of students who had an Ambulatory Community Experience (ACE) placement in a community setting (described as non-academic or rural) were able to describe health advocate activities versus 73% of students whose ACE placements were in ambulatory sites (described as ambulatory clinics in fully or partially affiliated academic settings). A clinically relevant exposure to the community appeared to heighten the awareness and understanding of how to be a health advocate. A comment from one of the student participants in this aforementioned study illustrates this point: “Although I had been taught this before, I now felt more aware of the challenges that the underserved populations face in terms of their health. I see how they present differently to the health care system….” (Student 2L, p. e8).

One participant noted that when dealing with marginalized patients, practitioners need to be knowledgeable and creative about the social supports existing in the community and must build a network of people who help each other out with difficult cases. Without ongoing exposure to the community this network of contacts and support systems cannot be created and maintained.

Many physician participants forcefully expressed their positive opinion on the value of experiential learning in the community. They noted that medical students should know before they enter medical school that, during their training, they will spend extensive periods in inner-city communities as well as marginalized communities, including Aboriginal Reserves.

Experiential clinically relevant learning in community settings can familiarize students with issues that require the support and potentially the activism of physicians to move agendas forward. Oandasan (2005) speaks of advocacy as: “leveraging physician’s societal power in order to speak for individuals who are not heard or are silenced” (p. S40).

The literature review was replete with articles supporting experiential community learning and this exposure was considered important by all the interview participants. For example, O’Toole et al. (2002) did a study to ascertain the influence of medical school towards vulnerable populations. They found that medical students were influenced by a number of factors including the degree of community exposure they experience. Dharamasi et al. (2010) describe a pilot learning experience offered at The Faculty of Medicine at The
University of British Columbia. They note that when evaluating this experience, students indicated a deeper appreciation of the vulnerabilities of marginalized groups as a result of this community experience. Brazeau et al. (2011) found that mean sympathy scores were higher for students who participated in service activities compared to those who did not participate in these activities. Earnest et al. (2010) write that opportunities to practice advocacy through service learning are an essential component of medical education.

Medical training which takes place primarily in the hospital setting inevitably brings with it a focus on the biomedical discourse. Medical training in the community enhances this biomedical discourse and adds the important components related to social influences and community circumstances.

**Recommendation 5: Education and Evaluation**

5a- Educate students about the co-determinants of health informed by an intersectional equity framework which will encourage students to reflect on their privileged intersectionalities. Embed this education throughout the curriculum and reference these teachings with the historical processes which have resulted in marginalization for certain groups.

5b- Educate about the Health Advocate Competency with the goal of improving health outcomes and actualizing social responsibility and accountability. Educate about the co-determinants of health as an important assessment tool. Discuss and explain activism as a component of health advocacy.

5c- Evaluate these domains of knowledge with the same emphasis as the evaluation of the Medical Expert Competency.

5d- Expose the hidden curriculum and its impact on the hierarchy of knowledge.

**Rationale for the Recommendation Regarding Education and Evaluation**

5a- In my experience, denial that there are health inequities or that racism and discrimination exist in Canada have been intermittent but significant comments. I first heard these comments many years ago from physicians who attended the diversity course that I coordinated on behalf of the hospital where I worked. I subsequently read about it in my literature review (Tester, 2007; Gupta, 1999) and heard it from interview participants. The denial usually was linked to the fact that because Canada is a multicultural country with universal health care insurance, health inequities are not very prevalent. The discourse in Canada is not about discrimination and marginalization but about diversity and multiculturalism. One study participant noted that this discourse is so strong and the push
back to more explicit terms so intense that it led to the closure of The Anti-Racist Secretariat which was considered too confrontational for Canadians. Discussions of racism, oppression and marginalization can make privileged individuals and groups uncomfortable but they must occur if we are to deal with these realities.

As previously discussed, participants spoke of The United States which acknowledges that health disparities exist and consequently are developing targeted initiatives for physicians, targeted funding for promotion and prevention, endowed chairs around equity and developing reports such as *The Institute of Medicine’s Unequal Treatment* (2003), all of which are not common in Canada. Four of the participants mentioned The Ontario Ministry of Health equity assessment form as a positive first step in educating and incorporating equity in health care planning. There is no question that intersectionality can help advance the equity agenda.

Study participants and the literature are clear that raising provider self-awareness to their own prejudices and biases and encouraging reflection is a necessary step to moving an intersectional equity agenda forward. As one participant mentioned, sharing information about the impact of language, the: “micro aggressions, the day-to-day, unconscious-to-the-perpetrator, invisible-to-the perpetrator conversations” are an important component of raising consciousness and supporting reflection. Another participant noted: “we don’t problematize or acknowledge putting the gaze on the gaze.” Equally important is that providers must understand that the Westernized analytical objective scientific worldview may colour their approach to health care and minimize the importance of social influences. Robins, Fantone, Hermann, Alexander and Zweifler (1998) did a study on the success of a program designed to increase cultural awareness in students. They found that students were amenable to discuss culture, sexual orientation and power and how these interact as long as these discussions were embedded in clinically relevant scenarios.

To counter the denial discourse, there must be an acknowledgement that there are health inequities and many are marginalized. To deny this and not speak of the historical oppression that certain groups continue to experience because of race, gender/sexual orientation, social class, etc., and their intersections, is to continue the marginalization in a fundamental way.

Rooney (2008) notes that intersectionality encourages us to: “learn to listen to the silences” when working with marginalized groups to ensure that all are heard and knowledge
is not concealed. Intersectionality allows the discussion of an equity agenda which does not privilege one group over the other but tries to address all oppression and marginalization.

Thornton Dill (2009) notes that understanding power is at the heart of intersectional thinking and teaching students to identify and understand concepts of power as they are associated with systems of race, gender and class oppression is a key concept. As a result of these teachings, she suggests that students develop critical thinking skills. Critical thinking skills are valued skills in medical education development.

Many participants noted that there are considerable challenges of awareness and understanding to moving this agenda forward. These are complex topics and there is a need to present this information simply and in a manner that promotes understanding. Table 23 outlines the major co-determinants of health and suggests a reading list that can be incorporated throughout the curriculum to expose students to these concepts and promote discussion and reflection.

**Table 23: Teaching about the Co-determinants of Health**

<table>
<thead>
<tr>
<th>Co-determinants of Health</th>
<th>Suggested Reading List and Talking Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Bierman (2009); Doyal, (2000); Pilote et al. (2007)</td>
</tr>
<tr>
<td>Social class/gradient</td>
<td>Marmot (2004); Henderson and Tickamyer (2009)</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>Mayer et al. (2008); O”Hanlan et al (1997)</td>
</tr>
<tr>
<td>Culture</td>
<td>Taylor (2003); Beagan (2000)</td>
</tr>
<tr>
<td>Social support</td>
<td>Self explanatory but should be discussed</td>
</tr>
<tr>
<td>Education</td>
<td>Ahmed et al. (2007)</td>
</tr>
<tr>
<td>Housing</td>
<td>Adelson (2005); Frohlich et al. (2006)</td>
</tr>
<tr>
<td>Employment type</td>
<td>Discuss who predominantly is hired for temporary work in terms of race, gender, class. Discuss what happens when these individuals face a health problem as these kinds of jobs normally have no benefits (drugs, etc.)</td>
</tr>
<tr>
<td>Poverty</td>
<td>Block and Galabuzi (2011); McKeown et al. (2008)</td>
</tr>
</tbody>
</table>
In order for students to understand the interlocking nature of these co-determinants, initial readings should include McIntosh (1990); Thornton Dill and Zambrana (2009) and Crenshaw (1991).

This co-determinants of health list does not include all the traditional social determinants of health found in The WHO list. The WHO determinants that have been excluded from the co-determinants are: stress, early life, addiction, social exclusion, food and transport. As I explained in my rationale for Recommendation 2, I believe many of these so-called determinants are really the outcome of the root causes of the disadvantage experienced by these marginalized individuals and not the source of the disadvantage. I will use The WHO determinant of health ‘stress’ to elucidate my point. Stress is not a determinant in itself. Stress can result from intersectionalities of employment type, race, gender, poverty, which leads to inadequate housing, impacts education achievement, social gradient, etc. Addressing stress alone will not address the root of the problem. However, addressing stress alone lends itself to a scientific approach which results in a solution which is technology-based, such as stress reducing drugs. I also have not included the following determinants of health from The MCC list in my co-determinants: diet, exercise, lifestyle issues, and genetics.

To make change in society, one must first speak of what needs to be changed. Privileged medical students must be given the opportunity to be exposed and discuss and reflect on these issues and their contribution to the individual patients under their care and to society in general.

5b- There is a requirement to educate about the Health Advocate Competency and ideally, to use the concept of intersectionality to move the social responsibility and accountability mandate of the medical school. If the social responsibility mandate of the medical school is explicitly stated and the social accountability grid is used, then medical students will learn in a culture of social responsibility and the influence of the hidden curriculum which privileges scientific knowledge will be attenuated. Both social responsibility and health advocacy speak of addressing issues in the community as part of their core definition thus clearly linking these two concepts. The use of the additional words: “reduce and help eliminate health inequities” in the Health Advocate Competency definition suggests an added activism dimension to this Competency. Understanding of intersectionality should facilitate recognition of the dimensions of the Health Advocate Competency that can be applied including activism.
Participants suggested that teaching about advocacy was an important curricular component and that health issues must be linked to advocacy work. This involved teaching about public policy, such as a reduction in welfare rates, and the impact of such a policy on patients’ health. This was important because physicians, as members of a privileged and powerful group, had a responsibility to speak out against policies that impact health negatively. However, this kind of teaching can be challenging as it should include information on how to reach policy-makers and how to create succinct briefs. Physician participants also discussed the fact that building trust with marginalized patients was a necessary precursor to advocating for them. The need to build a partnership and obtain the trust of their patient was a vital step in understanding their plight and advocating on their behalf.

Physician participants articulated that the biggest challenge was making medical students want to take the responsibility to help because although now, training in the DOH is part of the curriculum, education about how to address the DOH in a medical practice is not part of the curriculum. This lack of teaching about remedies, including political recourses may be associated with the present definition of the Health Advocate Competency which speaks of developing awareness about the determinants of health in a community or practice setting but does not suggest any action with respect to these DOH. Teaching about the co-determinants of health and incorporating a new definition for the Health Advocate Competency, as suggested in Recommendation 3, may assist in the task of teaching how to be a health advocate.

In a meeting with educators and medical students in the fall of 2012, I asked the final year medical students present to comment on their exposure in the medical curriculum to discussions and theoretical concepts of equity and advocacy. They expressed the view that these discussions were sparse and they felt unprepared for the challenges of these realities.

A number of authors speak to activism in advocacy teaching. For example, Gill and Gill (2011) speak to this issue when they describe a two day course at The University of Calgary and The University of Alberta focused on a Political Action Day. The purpose of this course is to engage students in advocacy and educate them about how to influence policy development. O’Toole et al. (2005) report on an American National Demonstration Program teaching professionalism which also includes a community-based curriculum sensitizing students to activism. Duvivier and Stull (2011) are physicians-in-training who promote the idea of advocacy training as they believe this education will make them better physicians.
Cha et al. (2006) speak of a program which combines researching and developing an advocacy plan as well as teaching techniques of public speaking, coalition building and issue-based campaigning.

One physician participant was concerned that in addition to the challenges about teaching health advocacy, there was an erroneous assumption that teaching advocacy actually changes behavior. This participant was not convinced that medical schools knew how to teach advocacy at the individual and population level with the assurance that this teaching would create/result in change. However, most physician participants said that medical students today are clamoring for this information. One suggested that the issue is the slow pace of medical school administrators in taking up this challenge.

All six physician participants were clear that advocacy was an essential component of their daily practice. All eleven participants felt that teaching health advocacy was essential and should be woven through the undergraduate and postgraduate curriculum. Case-based scenarios and reflection were two tools often suggested to facilitate instructions.

Figure 1 illustrates a conceptual model to teach health advocacy to meet the social responsibility and accountability of medical schools using the co-determinants of health.
Figure 1: Actualizing Social Accountability and Responsibility through the use of the Health Advocate Competency Based on the Knowledge and Application of the Co-determinants of Health in the Community Served.

5c- It is important to evaluate health advocacy and social responsibility with the same emphasis as the evaluation of the Medical Expert Competency. In both the corporate and academic world, what is usually deemed important is measured and evaluated. Maudsley (1999) and Cooke et al. (2006) state that assessment drives learning and that students and faculty understand that what is important is evaluated. Interview participants were unequivocal that “what gets done is what gets measured.” In the corporate world Kaplan and Norton (1992) state that “what you measure is what you get” (p.71). It is obvious that if students and faculty are to conceive of health advocacy as an important skill and core knowledge, mechanisms to evaluate this Competency must be developed. To continue to demonstrate the privileged position of scientific knowledge and its accompanying evaluation without including health advocacy as an assessable priority is to continue to support the
hidden curriculum. Evaluation of the Health Advocate Competency can be through a number of already established medical education evaluation methods such as direct observation, multi-source feedback, portfolios and my personal favourite, reflection tools. The experience of 16 years of reading ACE reflection papers regarding health advocacy and social responsibility as described in the Girard-Pearlman Banack et al. study (2011) has shown me the importance of reflection on action to internalize these important concepts. A defined and publicly measured social responsibility mission, coupled with evaluation of skills in health advocacy will help dispel the idea that only biomedical knowledge is valued enough to evaluate.

5d-The hidden curriculum must be discussed openly so that its impact can be understood. Medical school administrations must set the tone to encourage students to bring up practices or policies which they believe encourage the hidden curriculum. Students should be supported to discuss perceived conflicts in how they are taught in the classrooms versus what they see during their practicum experiences. Portfolio discussions may be a less threatening mechanism to bring up these perceived conflicts.

**Recommendation 6: Faculty Development**

Support faculty development and commitment to health advocacy and social responsibility in order to produce role models who will embody these concepts. Prioritize concepts of equity, health advocacy and social responsibility by establishing endowed equity chairs and resourcing scientists working in this field by giving them recognition and support for their work commensurate with that given to scientists working in the biomedical domain.

**Rationale Regarding Faculty Development**

The importance and impact of role models was frequently mentioned in the section on the hidden curriculum (Hafferty & Franks, 2004; White et al., 2009; Karnielli-Miller et al., 2010; Manson, 1994; Sinclair, 1997; Lief & Fox, 1963). For me, the most powerful of the comments on role models came from a student in the Ratanawongsa et al. (2005) study who said:

> The most important thing was the leadership at the top, was our attending and how he dealt with issues. I think that if he had been very clinical and detached, it would have signaled to me….that’s my role model, that’s how I am suppose to act (p.644).

Additionally, participants spoke of the lack of teachers with the appropriate skill-set to deal with issues of equity and diversity raised during these discussions and thus the need
for faculty development. Again, assuming that the medical school has clearly articulated a social responsibility mandate and that the social accountability grid is being used, developing role models in health advocacy and social responsibility should be feasible. As noted by physician participants, medical education is apprentice style so that one generation teaches and influences the next generation. These participants considered themselves role models for these teachings and were optimistic for the future because medical students are being exposed more extensively to societal factors which impact on health than they were 20 years ago.

All participants spoke of creating research streams that addressed the specifics of equity research as a necessary component of supporting health advocacy and social responsibility. This action requires the understanding of the differences between traditional quantitative ‘scientific’ research and qualitative equity research. For example, one participant mentioned that a study measuring improvement in disparities and/or improvements in people’s experience in relation to discrimination can be more challenging to design and more difficult to explain to potential donors more familiar with quantitative research. Additionally, the kind of work done in equity research often involves observation and ethnography which takes more time.

5.4.2 Recommendations for Future Research

There were other considerations raised during this research such as the clear consensus amongst physicians participating in the interviews that health advocacy was supported by an interprofessional approach. Participants made statements such as: “dealing with marginalized patients requires a team of interprofessionals. Physicians don’t have the skills or the time to deal with the many issues of these patients.” Participant #11 concurred but noted that although treating marginalized patients requires a team approach, “medicine is not well trained to work in teams…medicine trains for individual decision makers, managers of resources.” This participant further elaborated that advocacy also requires team work because group advocacy brings greater creativity, support and allows the work to be spread over a number of people as advocacy takes “lots of time and energy.” Developing interprofessional cooperation across many domains including health advocacy is very important to health care, patient safety, cost-efficiency and health care outcomes. However, how to achieve this is the topic for another study.
Another issue mentioned by the interview participants was the need to develop a selection process for medical students to better reflect the heterogeneity in society. This is a very important issue. However, it will not be part of this analysis except to mention that changes are needed to the present system.

Additionally, almost all participants spoke of introducing different funding models for physician services which would better support health advocacy work. An exploration of this topic should also be the topic of future research.

Future research should also focus on whether introducing topics such as health inequities, health advocacy and social responsibility has an effect on future practice. Another research project would be to see if these changes in the curriculum affect career choices.

There are two important limitations to my study but these could also be seen as areas for future research. First, two medical schools may not be representative of all 17 medical schools in Canada. Research across all 17 Faculties of Medicine about these important topics would be highly useful. Second, without curriculum mapping, the data from the questionnaires can only be understood as the best estimate of what is being taught in courses according to the individual Course Directors. The advantage of curriculum mapping is obvious when one is trying to understand the educational process and curriculum content offered to medical students.

These are all important topics for future research and will not be further addressed in this thesis.

5.5 Conclusion

This thesis was a long journey into new domains of learning and reflection. My overall interest was in helping to address health inequities in Canada. I supported the notion that health inequities were such a challenging problem that only a multipronged approach with many partnerships including governments, professional organizations, medical schools and others could affect positive changes. As a strong supporter and admirer of the medical profession and medical schools, I was interested in the role that medical schools could play in addressing health inequities. The realization that medical schools were committed to social responsibility and that the medical profession had embraced health advocacy as one of the 7 (seven) essential competencies of a capable physician seemed to suggest that improvements in health inequities were just beyond the horizon.
However, I was shaken by the exploration of the roots of health inequities in Canada and the realization that subtle historical systems of oppression were alive and well in my homeland. I was also surprised when I realized that until 2004, the academic literature was largely silent about health inequities in Canada despite the fact that the grey literature had alluded to these issues since *The Lalonde Report* in 1974. As I read more and more on this topic, I began to surmise that one of the reasons for this lacuna might be that the dominant group was able to assuage its conscience by referencing universal health care and multiculturalism as the tools to deal with inequalities or inequities. I also understood that European colonization of Aboriginal peoples, and subsequent establishment of a racially discriminatory immigration system meant that when our health care system was established in the 20th century, the programs, systems, and social structures were developed for a society which has vastly changed in the last 50 decades. As successive immigration waves brought more and more immigrants to Canada, the homogenous character of Canadian society changed. Block and Galabuzi (2011) note that between 2001-2006, the racialized population of Canada grew at a rate of 27.2%, a rate five times higher than the 5.4% increase for the Canadian population. Their study highlighted the discrimination faced by these immigrants which translated into barriers to access stable jobs, increased unemployment and the ensuing problems of inequities which eventually translate into health inequities. In his book *The Tipping Point*, Malcolm Gladwell (2000) defines a tipping point “as a moment of critical mass, the threshold, the boiling point” (p.12). Perhaps the accelerated increase in the heterogeneity of Canadian society was the tipping point that gave rise to the early literature on health disparities in Canada from 2004 onward.

However, as we have seen in the sections about Aboriginal peoples and multiculturalism in Chapter 2, universal health care and multiculturalism were not programs developed to address inequities, including health inequities, faced by Aboriginal peoples. The fact that Canadian society has been willing to accept and turn a blind eye to these inequities for hundreds of years, and that academia has only recently started to discuss these inequities in the literature begs further research into this topic. Why this protracted silence for a group who have been described by Adelson (2005) as the “embodiment of inequity”.

In Canada, we try to avoid discussions on discrimination and marginalization and concentrate on diversity and multiculturalism. However, Gupta, (1999), Carty, (1999) and Arat-Koc, (1999) as well as Bannerji, (2000) are critical of multiculturalism and suggest that it has not addressed the underlying issues of inequity but has given rise to a particular brand
of racism which is subtle but nevertheless systematic. A clear example of this subtle but systematic racism was highlighted in the section discussing Canadian immigration laws in Chapter 2. Although these laws have been relaxed over the past decades, the focus of immigration continues to be to bring labour to market and the commodification of immigrant labour.

The systemic oppression of Aboriginal peoples is a patent indicator of our inability to address discrimination and racism. McMurtry and Curling (2008) state that Aboriginal peoples experience persistent health and income disparities which are exacerbated by racism and discrimination which they describe as “virulent and entrenched” (p.239). Clearly, for the privileged dominant class, there must be willingness to reflect on the historical processes that shaped our country and identify the vestiges of the discriminatory thinking which is still embedded in our national conscience as well as in our society’s structures. There must also be a willingness to address these processes which privilege some and marginalize others.

I was disappointed to find that the literature indicated that both social responsibility and health advocacy were still ideas and not yet a reality in the medical profession. These findings give credence to the poem from T. S. Eliot which opens this thesis and states:

*Between the idea*
*And the reality*
*Between the motion*
*And the act*
*Falls the shadow*

*Between the conception*
*And the creation*
*Between the emotion*
*And the response*
*Falls the shadow.*

On paper, medical schools are clearly committed to being socially responsible. There is a long tradition of espousing principles of social responsibility starting with Hippocrates and continuing to this day. Many organizations nationally and internationally have, over the years and to present day, re-affirmed this commitment. And yet, the literature review indicated that social responsibility is still not a foundational value in medical schools. In other words, as T.S. Eliot notes, between the idea and the reality falls the shadow. Although
most medical schools fulfill their mandate to advance science and improve health, to develop new technologies and advance research, few if any can show that they have produced socially responsible physicians who have been educated in a culture steeped in social responsibility and accountability. Most disturbing is the fact that the literature is replete with articles that show the loss of altruism experienced by most medical students as they progress through medical school. The fact that this loss of altruism seems to surface most strongly in the third year of medical school point a clear finger at the socialization process of medical education.

The literature review of the Health Advocate Competency also showed the discrepancy between the idea and the reality of this discourse. The historical review of the re-emergence of the health advocate discourse indicated that this re-emergence was not necessarily based on altruism but might be linked to the erosion of the medical profession’s profile in society. The ongoing search for an operational definition as well as mechanisms to teach and evaluate this Competency were constant and disturbing elements in the literature. The hierarchy of knowledge which privileges certain CanMEDS Competencies over others such as the Health Advocate Competency was also discussed. And importantly, the propensity of the medical profession to address social problems with technical solutions such as medication was raised.

With this literature review as a backdrop, I embarked on my study. Initially, I approached the Course Directors of two medical schools and asked them to complete a questionnaire about social responsibility, health advocacy and health inequities. I chose this group of professionals as they were the most knowledgeable about what is taught to medical students in the undergraduate medical education curriculum.

The results of the questionnaire I administered to these Course Directors highlighted the biomedical ideology that sustains learning in medicine at the expense of other concepts such as health advocacy and social responsibility. I was fortunate that early on in my research, I found a theory that appeared to explain so much of the information I had gathered to date. Intersectionality helped me not only to understand the subtle and not so subtle systems of oppressions that exist around me, intersectionality also helped me to recognize that the focus on biomedical ideology was hiding the core issues related to marginalization. Intersectionality was also the stepping stone for my interviews with equity leaders in the community whose work evidences health advocacy and social responsibility. Intersectionality helped me to understand what was missing in some of the tools being used
Intersectionality helped me to develop a clearer definition for the Health Advocate Competency. The questionnaires, the interviews, the readings and reflections on intersectionality led to the gradual development of a series of recommendations to support the actualization of social responsibility and health advocacy in the medical curriculum.

As one of the interview participants noted, our health care system was developed in the 1960s when Canada was largely a White country. However, as a result of immigration during the past 50+ years, the reality of our society has changed but the health care system may not have kept up with Canada’s new reality. To address the new reality requires a bold new vision with a unifying and integrating narrative that does not disaggregate the co-determinants of health and their impact on health. Intersectionality, morphed into the co-determinants of health, provides this bold new vision for medical schools to embrace.

Ready and Conger (2008) discuss the frequency of the gap between inspiration and implementation in the corporate world. This is not unlike the divergence between the idea of health advocacy and social responsibility and the reality of these concepts in medical education…what T. S. Eliot calls the shadow. To gain an understanding of the challenges in implementing bold new visions, these authors undertook a study of 40 global companies. They found many reasons that bold visions derail including failing to focus, mismatch between performance measurements and the new vision, skipping the skill building, ingrained company culture and not having a critical mass of people who embody the new vision. Although the set of six recommendations detailed in my research are prescriptive, they are informed by the data from the literature review, the questionnaires and interview data. Additionally they deal with the challenges described by Ready and Conger.

An explicit mission statement will support focus on social responsibility and address health equity in the community. Introducing intersectionality, clarifying and redefining the Health Advocate Competency and focusing on co-determinants of health will add to this focus. The social accountability grid is the ideal measurement tool to keep track of the development of this social responsibility mission. Faculty development will both provide skill building and develop a critical mass of role models to train the next generation of medical students. Educating about health advocacy and the co-determinants of health as well as explicit discussions about the hidden curriculum related to the predominance of the biomedical culture will help to balance the ingrained focus on objective scientific medicine. It may even change the ‘culture of medicine.’
My recommendations are reflective of the caution from a number of participants that actualizing intersectional equity is a complex, multifaceted, and multipronged challenge. Both the interview participants and the literature review spoke of working with other entities to move this enormous agenda forward. Participant #5 suggested starting small and I would submit that my recommendations dealing with medical students and medical schools is an initial small, but purposeful, building block. If physicians are trained to work within an intersectional framework to actualize health advocacy and social responsibility, Canada will have a core of powerful innovators in social justice. As the interviews and the literature review indicated, physicians can be an influential lobby to advance agendas and education is a significant tool to shift understanding, interpretation and action. Recently there has been an increase in the media and in academic articles about the costs of unequal societies and a quest to find solutions to this problem. At the same time, intersectional theory, originally developed and pioneered by Black feminists, is gaining some ground in other domains and is being proposed as an evaluation tool to enhance decision making and support equity and social justice when assessing the impact of public policy (Hankivsky, de Leeuw, Lee, Vissandjee & Khanlou 2011). This is another important building block in the multipronged approach to addressing health inequities.

I am cognizant that there are major forces outside of medicine which contribute to ill health, health care outcomes, and health inequities outside of the scope of this study. Terris (1992) refers to the epidemiological concept of the “web of causation” and how general and specific causes operate together to cause ill health. In a global setting, these include, but are not limited to, global economics, war, famine, pandemics, and health care systems. For example in the economic sphere, there are worrisome developments in countries such as The United Kingdom and The United States, countries with whom Canada shares lineage and values where “an overall increase in aggregate wealth camouflages distributive disparities” (Judt, 2010, p. 32). Judt continues to explain this statement by noting that in these countries increasingly “…economic growth benefits everyone but disproportionately serves a tiny minority positioned to exploit it” (p.32). He alludes to the Gini coefficient (the calculation of the gap between the rich and poor within a country) and shows how severe income inequality impacts many aspects of the lives of those at the lower end of the coefficient. Inequality “…clearly corresponds to pathological social problems” (p. 18). Canada has traditionally had a respectable Gini coefficient but with our position slipping, there is an opportunity for governments to address this slippage. It is not the responsibility of medical schools and their
teaching hospitals to deal with the Gini coefficient but I believe it is their social responsibility, in the context of health advocacy, to raise the issue of severe income inequality and its impact on health.

Many decades ago, Canada positioned itself as a leader in social justice and health equity through *The Lalonde Report* (1974) and *The Epp Report* (1986). *The Ottawa Charter* (1986) crystallized this commitment by noting that: “The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic pre-requisites” (p.18). More recently, *The Institute of Wellbeing Report* (2009) noted: “Canada has been a leader in articulating and exploring the connection between health, money, education, employment and the community” (p.4).

During the past decade, the RCPSC *CanMEDS* Competencies established a new approach to medical education which has been well received worldwide. In fact, these Competencies have been adopted as a framework for medical education in many countries in the world. However, there have been challenges in understanding, teaching and evaluating the Health Advocate Competency. These challenges could be addressed by adopting the new definition for the Health Advocate Competency suggested in this research and incorporating the co-determinants of health into the medical nomenclature. The co-determinants of health provide an assessment tool to assist physicians in understanding and evaluating their patients’ needs and can also guide treatment plans.

A bold new vision incorporating the co-determinants of health into a revitalized Health Advocate Competency as a tool to actualize social responsibility is an excellent platform for Canada to further enhance its commitment to social justice, equity and access.

This vision requires the support of *The RCPSC* and *CFPC* to adopt the suggested new definition of the Health Advocate Competency and to adopt evaluation tools to assess Competency in being a Health Advocate.

It requires *The MCC* to accept the proposed co-determinants of health and set up an evaluation process in their qualifying exams that assesses and prioritizes this knowledge at the same equivalency as biomedical knowledge.

It requires medical schools to fill the gap between the idea and the reality of social responsibility and health advocacy by promoting a culture and organizational practices that clearly prioritize these concepts.
It requires medical school graduates to define and accept their personal social responsibility and health advocate mandate. This means they must first recognize and acknowledge their privileged world of power. Additionally, they must to be cognizant of the social problems underlying many of the health issues in their practices and communities and understand the historical root causes of these issues. It requires physicians to use the co-determinants of health as an assessment tool not only to assess the presenting health concerns but to also apply the correct remedy, even when it is in the realm of social issues.

An improvement in health equity is within our reach.
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Appendices

Appendix 1: The Questionnaire

<table>
<thead>
<tr>
<th>2. Health Inequities/Disparities in Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition:</strong></td>
</tr>
<tr>
<td>Webster's dictionary defines inequities as &quot;instances of lack of justice, unfairness&quot;.</td>
</tr>
<tr>
<td>Health inequities (also referred to as health disparities) &quot;are the differences in health outcomes that are avoidable, unfair and systematically related to social inequality and disadvantage&quot; (Toronto Central LHIN Health Equity Discussion Paper).</td>
</tr>
<tr>
<td>For example, many chronic diseases follow a socio-economic gradient with certain diseases being more prevalent in low income rather than high income neighborhoods.</td>
</tr>
<tr>
<td>1. Keeping the above definition in mind, please answer the following questions.</td>
</tr>
<tr>
<td>In my course, there is formal instruction about health inequities/disparities in Canada</td>
</tr>
<tr>
<td>☐ Never</td>
</tr>
<tr>
<td>☐ Occasionally</td>
</tr>
<tr>
<td>☐ Some of the time</td>
</tr>
<tr>
<td>☐ Most of the time</td>
</tr>
<tr>
<td>☐ Always</td>
</tr>
<tr>
<td>2. Although not a formal component of my course, health inequities/disparities are included if we see or discuss a marginalized/under-served patient.</td>
</tr>
<tr>
<td>☐ Never</td>
</tr>
<tr>
<td>☐ Occasionally</td>
</tr>
<tr>
<td>☐ Some of the time</td>
</tr>
<tr>
<td>☐ Most of the time</td>
</tr>
<tr>
<td>☐ Always</td>
</tr>
</tbody>
</table>
3. What course content on health inequities/disparities is included?

Please check all that apply:

☐ Determinants of health
☐ Socioeconomic factors/poverty
☐ Aboriginal peoples
☐ Access issues
☐ Racism
☐ Stereotyping
☐ Other

4. What instructional methods related to health inequities/disparities do you use in your course?

Please check all that apply:

☐ Lectures
☐ Small group discussions
☐ PBL
☐ Case scenarios
☐ Clinical experiences
☐ Role playing
☐ Other
5. What groups are discussed when instructing on health inequities/disparities?

Please check all that apply:

☐ Aboriginal peoples
☐ Immigrants
☐ Refugees
☐ Undocumented individuals lacking immigrant status
☐ Visible Minorities
☐ Women
☐ The poor
☐ Persons with intellectual disabilities
☐ Persons with physical disabilities
☐ Members of sexual minority groups
☐ Persons with poor literacy levels
☐ The homeless
☐ The under-housed
☐ The elderly
☐ Others ______________________

6. Which of the following are discussed as root causes of health inequities in your course?

Please check all that apply:

☐ Socioeconomic factors/poverty
☐ Education
☐ Structural issues in health care
☐ Self responsibility
☐ Biases
☐ Discrimination
☐ Racism
☐ Other ______________________
7. In your course, are students assigned to specific settings to learn about, and be exposed to, marginalized/under-served populations?

- Never
- Occasionally
- Some of the time
- Most of the time
- Always

8. In your course, does instruction regarding health inequities/disparities address the social responsibility of physicians?

- Never
- Occasionally
- Some of the time
- Most of the time
- Always

9. In your course, are the attitudes of students towards individuals or groups suffering from health inequities/disparities evaluated?

- Never
- Occasionally
- Some of the time
- Most of the time
- Always

10. In your course, is the knowledge of students about the causes of health inequities evaluated?

- Never
- Occasionally
- Some of the time
- Most of the Time
- Always
11. In your course, are barriers to comprehensive actions to deal with health inequities/disparities discussed?

- Never
- Occasionally
- Some of the time
- Most of the time
- Always

12. If you are not currently including the topic of health inequities/disparities in your course, do you plan to include this topic in the future?

- Already included
- Absolutely not. Why not? 
- Unlikely. Why? 
- Maybe
- Probably
- Absolutely
3. Health Advocacy

Definition:

To provide context to help you respond to the questions, brief definitions follow.

Webster’s dictionary defines advocacy as “the act of speaking or writing in support of something”.

The definition of Health Advocacy is taken from both the Royal College of Physicians and Surgeons of Canada’s CanMEDS competencies and the 4 Principles of Family Practice from the College of Family Physicians of Canada.

CanMEDS defines the Health Advocate, one of the seven CanMEDS competencies, as follows: “As Health Advocates, physicians use their expertise and influence to advance the health and well-being of individual patients, communities and populations”.

In the 4 Principles of Family Medicine, physicians are seen as health advocates for their patients in a variety of ways such as mobilizing appropriate resources to address patient needs and advocating for public policy which promotes patient health.

1. The questions which follow can be answered whether or not your medical school has adopted the seven CanMEDS competencies/4 Principles of Family Medicine as a framework for the undergraduate medical curriculum.

In my course, there is formal instruction on Health Advocacy.

☐ Never
☐ Occasionally
☐ Some of the time
☐ Most of the time
☐ Always

2. Although not a formal component of my course, Health Advocacy instruction is included if a marginalized/under-served patient is discussed or presents for treatment.

☐ Never
☐ Occasionally
☐ Some of the time
☐ Most of the time
☐ Always
3. In my course, the following are discussed when instructing about Health Advocacy.

Please check all that apply:

☐ Smoking cessation
☐ Diet
☐ Exercise
☐ Alcohol use
☐ Drug use
☐ Health promotion activities
☐ Navigating the health care system
☐ Advocating for clean drinking water
☐ Advocating for stricter tobacco control
☐ Advocating for specific screening programs
☐ Advocating for Occupational Safety
☐ Advocating for environmental safety/decreased pollution
☐ Advocating for improved education
☐ Advocating for the elderly
☐ Advocating for immigrants and refugees
☐ Advocating for members of sexual minority groups
☐ Advocating for an Aboriginal population health strategy
☐ Initiatives to deal with child poverty
☐ Advocating for Women's issues
☐ Advocating for affordable and safe housing
☐ Advocating for adequate social assistance
☐ Participating in policy development
☐ Other __________________________
4. In your course, is the knowledge and skills of students in Health Advocacy evaluated?
   - Never
   - Occasionally
   - Some of the time
   - Most of the time
   - Always

5. In your course, is the attitude of students about Health Advocacy evaluated?
   - Never
   - Occasionally
   - Some of the time
   - Most of the time
   - Always

6. What do you think are barriers to instructing about Health Advocacy?
   Please check all that apply:
   - Unclear definition of Health Advocacy
   - Unclar learning objectives
   - Inadequate resources (please specify)
   - Insufficient interest
   - Other

7. If you are not currently including the topic of health advocacy in your course, do you plan to include this topic in the future?
   - Already included
   - Absolutely not. Why not?
   - Unlikely. Why?
   - Maybe
   - Probably
   - Absolutely

8. Would you like to comment on any aspects of this questionnaire?
Appendix 2: Questionnaire Consent Form

Principal Investigator:

Jeannine Girard-Pearlman (Banack)
PhD candidate, OISE/University of Toronto
Research Fellow, Wilson Centre for Research in Education
ACE Course Director,
Faculty of Medicine, University of Toronto

I am asking you to participate in a research study. Before agreeing to participate, it is important that you read and understand the explanations which follow about the proposed study. I will be happy to answer any of your questions.

Participation

Participation in this study is voluntary. You may choose not to participate, or you may withdraw from the study at any time without repercussions. You may also refuse to answer any questions in the questionnaire.

Purpose of the research

The purpose of this project is to study what is being taught about health inequities and health advocacy in the undergraduate medical education curriculum and to explore barriers and enablers to teaching about these two topics.

You have been selected to participate in this project because you are an undergraduate Course Director in a Faculty of Medicine in Canada.

Description of the role of participants in the research

There are two phases to this research study.

Phase 1 involves completion of a questionnaire which should take 10 minutes to complete. I will also review your course goals and learning objectives and the forms used to evaluate students. Approximately 60 undergraduate Course Directors will be asked to participate in this phase.

Phase 2 involves only 12 of the original participants who will be asked to take part in a 30 to 45 minute interview. I will interview each of the 12 participants on a one-to-one basis. The purpose of Phase 2 is to provide more in-depth information on the data garnered from the questionnaire. Another invitational letter and consent form will be sent to you, should you be asked to participate in Phase 2.

Potential risks, harms or inconveniences

There are no foreseeable risks, harms or inconveniences associated with your participation.

Potential benefits

Participants and the scholarly community will gain new information about these two topics and how they are being addressed in the curriculum of three faculties of Medicine in Canada. The research may also inform about barriers and enablers to teaching about these two topics. Society may gain as
enablers to teaching about health inequities and health advocacy are identified and incorporated into the curriculum of medical schools, thus ultimately helping to address health inequities in Canada.

Confidentiality

The participating Faculties of Medicine and each participant will be assigned a unique identifier known only to the PI. Neither individual participants nor institutions will be named in this study. Original data will be kept separate from identifiers. The data will be kept in a locked cabinet in a locked office and the identifiers will be kept in a separate locked cabinet in the locked office.

Publication of results

The results will be used to complete the thesis requirements of my PhD. Additionally, the summary results will be shared by email with participants who wish to receive the results of the study. I will also provide overall results to each of the 3 participating Faculties of Medicine and will be willing to come and discuss the results at local meetings of each Faculty of Medicine. Finally, the research findings will be submitted for publication, as well as presentations at meetings.

Questions

If you have any questions about the study, please call me, Jeannine Girard-Pearlman (Banack), the principal investigator at 416-340-4800 ext. 2171. Alternatively, you may contact the Office of Research Ethics at ethicsreview@utoronto.ca or 416-946=3273.

Consent

I consent to take part in Phase 1 of this study, completion of a questionnaire, with the understanding that I may withdraw at any time. Please keep a copy of this form for your records.

______________________________  ________________________  ________________
Participant Name  Participant Signature  Date
Appendix 3: CONSENT FORM (Interviews)

Principal Investigator: Jeannine Girard-Pearlman Banack  
PhD candidate, OISE/University of Toronto  
Research Fellow, Wilson Centre for Research in Education  
416-340-4800 x2171  jeannine.banack@utoronto.ca

Participation

You are invited to participate in a research study which also includes two Canadian Faculties of Medicine. Please note that your participation is entirely voluntary and you may withdraw at any time from the study without prejudice.

Purpose of the research

In light of the Social Responsibility of all Canadian medical schools, this study looks at what is being taught on the topics of Health Advocacy and health inequities in the undergraduate medical education curriculum and explores barriers and enablers to teaching about these topics. Phase one consists of a questionnaire completed by Course Directors in two Faculties of Medicine in Canada on these topics.

Phase 2 consists of semi-structured interviews with equity leaders in the community. The purpose of these interviews is to understand how health inequities are being addressed in practice as well as the impact of intersectional work in the lived experiences of the interviewees. The data from these interviewers will help inform a Health Advocacy curriculum aimed at actualizing the curricular aspect of Social Responsibility of medical schools.

Why you received this invitation

You have received an invitation to participate in interviews for this study because you have been identified as an equity leader in the community.

Description of the role of the interview participants

Participation in Phase 2 of the study would consist of an interview which would last a maximum of 60 minutes.

Potential risks, harms or inconveniences

There are no foreseeable risks, harms or inconveniences associated with your participation.

Potential benefits

Participants and the scholarly community will gain new information about these topics and how they are addressed in the curriculum of two Faculties of Medicine in Canada. The research will also inform about barriers and enablers to teaching about these two topics. Furthermore, the research will highlight intersectional equity work and how this praxis can
be incorporated into a curriculum. Society may gain as enablers to teaching about health inequities and Health Advocacy are identified and incorporated into the curriculum of medical schools thus helping to address health inequities in Canada.

Confidentiality

The participating Faculties of Medicine and each individual participant will be assigned a unique identifier know only to the PI. Neither individual participants nor institutions will be named in the study. Original data will be kept separate from identifiers. The data will be kept in a locked office and the identifiers will be kept in a separate locked cabinet in a locked office. Interviews will be recorded and transcribed and anything that identifies a participant will be removed. Transcriptions will be saved on a password-protected area of the server, and each transcription will be protected by a password.

Publication of results

The results will be used to complete the thesis requirements of my PhD. The research findings may be shared with the participating Faculties of Medicine, as well submitted for publication and presentations at meetings.

Questions:

If you have any questions or desire further information with respect to this study, please contact Jeannine Girard-Pearlman Banack at 416-340-4800 x2171. Alternatively, you may contact the Office of Research Ethics at ethicsreview@utoronto.ca or 416-946-3273.

Consent

I consent to take part in this interview with the understanding that I may withdraw at any time.

______________________________  ________________________________
Participant Name              Signature                  Date

______________________________
Jeannine Girard-Pearlman Banack

Signature                  Date

Please keep this form in a safe place for future reference.
Appendix 4: Completed Questionnaire

After each question, comments from participants from both schools are included and icon(s) in the body of the chart indicates which category the comment belongs to. The icon(s) for medical school A is * whereas comments from medical school B are flagged by ♦.

Question 1: The introduction asked participants to identify the year in which their course is given and the responses follow.

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
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</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>Year 2</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>Year 3</td>
<td>10*</td>
<td>8</td>
</tr>
<tr>
<td>Year 4</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>

* includes longitudinal courses

The introduction also asked participants to comment on when the last major revisions to the course occurred. The responses ranged from the previous year to over 15 years ago.

Keeping the definition of health inequities in mind, (Health inequities also known as health disparities “are the differences in health outcomes that are avoidable, unfair, and systematically related to social inequity and disadvantage” Toronto Central LIHN Health Equity discussion paper, 2009. For example, many chronic diseases follow a social-economic gradient with certain diseases being more prevalent in low income rather than high income neighborhoods) please answer the following question.
**Question 2:** In my course, there is formal instruction about health inequities/disparities in Canada.

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>35 %</td>
<td>32 %</td>
</tr>
<tr>
<td>Occasionally</td>
<td>26 %</td>
<td>26 %</td>
</tr>
<tr>
<td>Some of the time</td>
<td>17 %</td>
<td>18 %</td>
</tr>
<tr>
<td>Most of the time</td>
<td>0</td>
<td>18 %</td>
</tr>
<tr>
<td>Always</td>
<td>22 % *</td>
<td>23 % ♦</td>
</tr>
</tbody>
</table>

*The part of this very large topic which is discussed is the approach to the interview of a patient with problems that come from socio-economically deprived/marginalized groups but as a specific focus, it is a small component. Also all students have geriatric teaching.

*We will add, based on health equity initiatives, a health equity question and change our case-based scenarios to reflect health equity issues in a majority of our structured teaching lessons.

♦ health inequities are a major focus of our course one afternoon/week

**Question 3:** Although not a formal component of my course, health inequities/disparities are included if we see or discuss a marginalized/under-served patient.

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
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</thead>
<tbody>
<tr>
<td>Never</td>
<td>0</td>
<td>18 %</td>
</tr>
<tr>
<td>Occasionally</td>
<td>26 % *</td>
<td>33 %</td>
</tr>
<tr>
<td>Some of the time</td>
<td>22 %</td>
<td>15 %</td>
</tr>
<tr>
<td>Most of the time</td>
<td>22 % **</td>
<td>18 %</td>
</tr>
<tr>
<td>Always</td>
<td>30 % ***</td>
<td>15 %</td>
</tr>
</tbody>
</table>

*very occasionally

** There is formal teaching at the beginning of the year with demonstrations and discussions of interviewing marginalized patients. However, since most of the course is tutor dependent, some tutors may or others may not address this issue and this is not monitored. Social history is an important component of the course and so if these issues are relevant to health issues…however, this is not monitored.

*** if relevant to the discussion.
**Question 4:** What course content on health inequities/disparities is included? Please check all that apply.

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determinants of health</td>
<td>83 %</td>
<td>68 %</td>
</tr>
<tr>
<td>Socioeconomic factors/poverty</td>
<td>89 %</td>
<td>81 %</td>
</tr>
<tr>
<td>Aboriginal peoples</td>
<td>22 %</td>
<td>65 %</td>
</tr>
<tr>
<td>Access issues</td>
<td>50 %</td>
<td>77 %</td>
</tr>
<tr>
<td>Racism</td>
<td>33 %</td>
<td>26 %</td>
</tr>
<tr>
<td>Stereotyping</td>
<td>44 %</td>
<td>42 %</td>
</tr>
<tr>
<td>Other</td>
<td>6 % *</td>
<td>26 % ♦</td>
</tr>
</tbody>
</table>

*Sexuality

♦ Stigma: immigrant health, mental health, alcoholism and psychiatry

♦ addiction, sexual medicine, rural medical ethics

♦ We talk about the differences in prevalence of diseases (i.e. diabetes) but not inequities in access to medical care

♦ Clinical skills course, some of this comes up in conversations but it is not part of the formal curriculum

♦ addiction

**Question 5:** What instructional methods related to health inequities/disparities do you use in your course? Please check all that apply.

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lectures</td>
<td>71 %</td>
<td>53 %</td>
</tr>
<tr>
<td>Small group discussions</td>
<td>48 %</td>
<td>56 %</td>
</tr>
<tr>
<td>PBL</td>
<td>24 %</td>
<td>22 %</td>
</tr>
<tr>
<td>Case scenarios</td>
<td>33 %</td>
<td>421%</td>
</tr>
<tr>
<td>Clinical Experiences</td>
<td>38 %</td>
<td>31 %</td>
</tr>
<tr>
<td>Role playing</td>
<td>14 %</td>
<td>22 %</td>
</tr>
<tr>
<td>Other</td>
<td>29 % *</td>
<td>22 % ♦</td>
</tr>
</tbody>
</table>
* community experiences in the form of field visits and field research

♦ Standardized patients. Patient presentations
♦ On line discussions re plenary material assignment. ½ class do a community profile, ½ class choose another assignment option involving not-for-profit organization
♦ Community service learning, community based projects
♦ Patient presentation
♦ Standardized patients

**Question 6: What groups are discussed when instructing on health inequities/disparities? Please check all that apply.**

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal peoples</td>
<td>52 %</td>
<td>74 %</td>
</tr>
<tr>
<td>Immigrants</td>
<td>62 %</td>
<td>61 %</td>
</tr>
<tr>
<td>Refugees</td>
<td>43 %</td>
<td>29 %</td>
</tr>
<tr>
<td>Undocumented individuals lacking immigrant status</td>
<td>10 %</td>
<td>3 %</td>
</tr>
<tr>
<td>Visible minorities</td>
<td>33 %</td>
<td>42 %</td>
</tr>
<tr>
<td>Women</td>
<td>38 %</td>
<td>52 %</td>
</tr>
<tr>
<td>The poor</td>
<td>57 %</td>
<td>65 %</td>
</tr>
<tr>
<td>Persons with intellectuals disabilities</td>
<td>10 %</td>
<td>29 %</td>
</tr>
<tr>
<td>Persons with physical disabilities</td>
<td>24 %</td>
<td>36 %</td>
</tr>
<tr>
<td>Members of sexual minority groups</td>
<td>33 %</td>
<td>39 %</td>
</tr>
<tr>
<td>Persons with poor literacy levels</td>
<td>19 %</td>
<td>16 %</td>
</tr>
<tr>
<td>The homeless</td>
<td>62 %</td>
<td>55 %</td>
</tr>
<tr>
<td>The under-housed</td>
<td>38 %</td>
<td>36 %</td>
</tr>
<tr>
<td>The elderly</td>
<td>62 %</td>
<td>74 %</td>
</tr>
<tr>
<td>Others</td>
<td>29 % *</td>
<td>16 % *</td>
</tr>
</tbody>
</table>
* undocumented individuals
* psychiatric patients, substance abusers, adolescents, those with stigma from mental illness.
♦ rural/secluded regions
♦ Geographically isolated population (rural/northern communities)
♦ The mentally ill
♦ A two hour lecture covers these issues. I can’t say exactly how deeply any particular is addressed

**Question 7:** Which of the following are discussed as root causes of health inequities in your course? Please check all that apply.

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
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</thead>
<tbody>
<tr>
<td>Socio-economic factors/poverty</td>
<td>89 %</td>
<td>89 %</td>
</tr>
<tr>
<td>Education</td>
<td>67 %</td>
<td>44 %</td>
</tr>
<tr>
<td>Structural issues in health care</td>
<td>50 %</td>
<td>56 %</td>
</tr>
<tr>
<td>Self-Responsibility</td>
<td>6 %</td>
<td>26 %</td>
</tr>
<tr>
<td>Biases</td>
<td>50 %</td>
<td>52 %</td>
</tr>
<tr>
<td>Discrimination</td>
<td>17 %</td>
<td>44 %</td>
</tr>
<tr>
<td>Racism</td>
<td>11 %</td>
<td>15 %</td>
</tr>
<tr>
<td>Other</td>
<td>28 %*</td>
<td>15 %*</td>
</tr>
</tbody>
</table>

* “language and cultural practices” and “any of these that come up for an individual patients but there are no formal lectures”.
♦ rural and remote
**Question 8:** In your course, are students assigned to specific settings to learn about, and be exposed to, marginalized/under-served populations?

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
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<tbody>
<tr>
<td>Never</td>
<td>48 %</td>
<td>51 %</td>
</tr>
<tr>
<td>Occasionally</td>
<td>9 %</td>
<td>29 %</td>
</tr>
<tr>
<td>Some of the time</td>
<td>13 % *</td>
<td>11 %</td>
</tr>
<tr>
<td>Most of the time</td>
<td>17 %</td>
<td>6 %</td>
</tr>
<tr>
<td>Always</td>
<td>13 % **</td>
<td>3 %</td>
</tr>
</tbody>
</table>

*elderly and psychiatric patients can be marginalized. There are specific blocks in the course in these settings.

**a clinical teaching unit always has a significant portion of its patient population in this grouping (as would be surmised by knowledge about the determinants of health). We see the end consequences of this marginalization. We do not “specifically assign” students to this—it is our reality.

**Question 9:** In your course, does instruction regarding health inequities/disparities address the social responsibility of physicians?

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<tr>
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<th>Medical School A</th>
<th>Medical School B</th>
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</thead>
<tbody>
<tr>
<td>Never</td>
<td>38 %</td>
<td>29 %</td>
</tr>
<tr>
<td>Occasionally</td>
<td>19 %</td>
<td>32 %</td>
</tr>
<tr>
<td>Some of the time</td>
<td>19 %</td>
<td>18 %</td>
</tr>
<tr>
<td>Most of the time</td>
<td>0</td>
<td>13 %</td>
</tr>
<tr>
<td>Always</td>
<td>24 %</td>
<td>8 %</td>
</tr>
</tbody>
</table>
Question 10: In your course, are the attitudes of students towards individuals or groups suffering from health inequities/disparities evaluated?

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>48 %</td>
<td>63 %</td>
</tr>
<tr>
<td>Occasionally</td>
<td>26 % *</td>
<td>18 %</td>
</tr>
<tr>
<td>Some of the time</td>
<td>17 %</td>
<td>13 %</td>
</tr>
<tr>
<td>Most of the time</td>
<td>0</td>
<td>3 % ♦</td>
</tr>
<tr>
<td>Always</td>
<td>9 %</td>
<td>3 % ♦♦</td>
</tr>
</tbody>
</table>

* Occasionally, reflective paper- this is hard to do.
* depends on case students may have on the exam
♦ in tutorial groups and community service stream
♦ ♦ new quiz introduced this year
♦♦ as part of tutorial participation

Question 11: In your course, is the knowledge of students about the causes of health inequities evaluated?

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>44 %</td>
<td>50 %</td>
</tr>
<tr>
<td>Occasionally</td>
<td>30 %</td>
<td>24 %</td>
</tr>
<tr>
<td>Some of the time</td>
<td>9 %</td>
<td>11 %</td>
</tr>
<tr>
<td>Most of the time</td>
<td>17 %</td>
<td>5 % X ♦</td>
</tr>
<tr>
<td>Always</td>
<td>0</td>
<td>11 %</td>
</tr>
</tbody>
</table>

♦ There is a lot of formative assessment through written reflections and feedback by tutors. These are difficult topics to evaluate in a cumulative way-they figure out what is the right answer.
♦ Where relevant as part of tutorial participation
**Question 12:** In your course, are barriers to comprehensive actions to deal with health inequities/disparities discussed?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>39 %</td>
<td>29 %</td>
</tr>
<tr>
<td>Occasionally</td>
<td>35 % *</td>
<td>37 %</td>
</tr>
<tr>
<td>Some of the time</td>
<td>4 %</td>
<td>21 %</td>
</tr>
<tr>
<td>Most of the time</td>
<td>22 %</td>
<td>8 %</td>
</tr>
<tr>
<td>Always</td>
<td>0</td>
<td>5 %</td>
</tr>
</tbody>
</table>

* Individual discussions by the clinical teachers at the point of care

**Question 13:** If you are not currently including health inequities/disparities in your course, do you plan to include this topic in the future?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Already included</td>
<td>35 % *</td>
<td>30 % ♦</td>
</tr>
<tr>
<td>Absolutely not. Why not?</td>
<td>0</td>
<td>3 %</td>
</tr>
<tr>
<td>Unlikely. Why?</td>
<td>13 % **</td>
<td>24 % ♦ ♦</td>
</tr>
<tr>
<td>Maybe</td>
<td>30 %</td>
<td>27 %</td>
</tr>
<tr>
<td>Probably</td>
<td>4 %</td>
<td>12%</td>
</tr>
<tr>
<td>Absolutely</td>
<td>17 % ***</td>
<td>3 %</td>
</tr>
</tbody>
</table>

*always included but plan to increase exposure to aboriginal health and other topics.

** Due to nature of our course, it would be difficult to include. However, we will be starting an international health program and will include students in this (however, not as part of the formal course)

** time constraints, this is a one week course

*** Plans to introduce a seminar on global health with the new curriculum—will include international health and underserved/marginalized populations in Canada and immigrant/refugee health

♦ But very peripherally. It is not on the ‘radar’ for much increased inclusion though perhaps it should be.
♦ ♦ not relevant to course objectives: not adequate time in my course to address this; students get the material elsewhere in the curriculum. There is not enough time in the curriculum to repeat this material.

♦ ♦ we concentrate on …..conditions as we only have a week in year. If we had more time, than yes.

♦ ♦ Already strongly critical because too much content.

♦ ♦ Have few contact hours to cover large knowledge base. Other courses designed and mandated to address this type of topic.

♦ ♦ At the moment, teaching in the MD undergraduate program is not fully integrated so my block focuses purely on the ‘biophysical’ rather than on the ‘bio-psychological’ aspects of medicine. Social Advocacy is taught in other blocks.

♦ ♦ Content does not lend itself well to this issue. Would require major effort in re-addressing PBL cases.

♦ ♦ Basic science course.

♦ ♦ Not pertinent to my course. Little time to cover a lot of important stuff already.

♦ ♦ The topic is discussed clinically. There are so many ‘medical expert’ competencies that students must learn to be competent physicians. New themes should not take away from core medical knowledge. If something is added, it must be at the expense of something being taken away…

♦ ♦ in the…curriculum, a lot of these issues are located in the course…in the first two years.

The questions which follow can be answered whether or not your medical school has adopted the seven CanMEDS Competencies/4 Principles of Family Medicine as a framework for the undergraduate medical education curriculum.

**Question 14: In my course, there is formal instruction on Health Advocacy.**

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>50 % *</td>
<td>37 %</td>
</tr>
<tr>
<td>Occasionally</td>
<td>14 %</td>
<td>324%</td>
</tr>
<tr>
<td>Some of the time</td>
<td>5 %</td>
<td>21 % X ♦</td>
</tr>
<tr>
<td>Most of the time</td>
<td>9 %</td>
<td>3 %</td>
</tr>
<tr>
<td>Always</td>
<td>23 % **</td>
<td>5 % XX ♦ ♦</td>
</tr>
</tbody>
</table>
*not formally
*there will be in the future with smoking cessation, narcotic management-potential prevention for chronic abuse.
** students at the point of care take direct responsibility to mobilize appropriate resources to address patient needs.
♦ the ratings don’t work well for a course like mine. It’s a broad course we “always” include it, i.e. every year, but not in every session. Ex. There are sessions to very specifically teach how to interpret an X-ray. That is why I am choosing “some of the time”
♦ ◆ Health advocacy is a thread that runs throughout the course in parallel with discussions of marginalized populations.

**Question 15:** Although not a formal part of my course, Health Advocacy instruction is included if a marginalized/under-served patient is discussed or presents for treatment.

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>5 %</td>
<td>15 %</td>
</tr>
<tr>
<td>Occasionally</td>
<td>25 %</td>
<td>49 %</td>
</tr>
<tr>
<td>Some of the time</td>
<td>25 % *</td>
<td>15 % ◆</td>
</tr>
<tr>
<td>Most of the time</td>
<td>5 %</td>
<td>12 %</td>
</tr>
<tr>
<td>Always</td>
<td>40 %</td>
<td>9 %</td>
</tr>
</tbody>
</table>

*guess so, depends on the tutor
♦ we have a session called physicians as advocates and the specific discussions will depend on the facilitators and students. It could be any of these.
**Question 16:** In my course, the following are discussed when instruction about Health Advocacy. Check all that apply.

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking cessation</td>
<td>84 %</td>
<td>63 %</td>
</tr>
<tr>
<td>Diet</td>
<td>74 %</td>
<td>72 %</td>
</tr>
<tr>
<td>Exercise</td>
<td>68 %</td>
<td>72 %</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>74 %</td>
<td>59 %</td>
</tr>
<tr>
<td>Drug use</td>
<td>58 %</td>
<td>59 %</td>
</tr>
<tr>
<td>Health promotion activities</td>
<td>57 %</td>
<td>50 %</td>
</tr>
<tr>
<td>Navigating the health care system</td>
<td>58 %</td>
<td>31 %</td>
</tr>
<tr>
<td>Advocating for safe drinking water</td>
<td>21 %</td>
<td>6 %</td>
</tr>
<tr>
<td>Advocating for stricter tobacco control</td>
<td>21 %</td>
<td>9 %</td>
</tr>
<tr>
<td>Advocating for specific screening programs</td>
<td>37 %</td>
<td>25 %</td>
</tr>
<tr>
<td>Advocating for occupational safety</td>
<td>37 %</td>
<td>9 %</td>
</tr>
<tr>
<td>Advocating for environmental safety/decreased pollution</td>
<td>16 %</td>
<td>16 %</td>
</tr>
<tr>
<td>Advocating for improved education</td>
<td>5 %</td>
<td>9 %</td>
</tr>
<tr>
<td>Advocating for the elderly</td>
<td>37 %</td>
<td>41 %</td>
</tr>
<tr>
<td>Advocating for immigrants and refugees</td>
<td>53 %</td>
<td>16 %</td>
</tr>
<tr>
<td>Advocating for members of sexual minority groups</td>
<td>26 %</td>
<td>16 %</td>
</tr>
<tr>
<td>Advocating for an Aboriginal population health strategy</td>
<td>21 %</td>
<td>25 %</td>
</tr>
<tr>
<td>Initiatives to deal with child poverty</td>
<td>26 %</td>
<td>13 %</td>
</tr>
<tr>
<td>Advocating for Women’s issues</td>
<td>26 %</td>
<td>19 %</td>
</tr>
<tr>
<td>Advocating for affordable housing</td>
<td>21 %</td>
<td>13 %</td>
</tr>
<tr>
<td>Advocating for adequate social assistance</td>
<td>37 %</td>
<td>6 %</td>
</tr>
<tr>
<td>Participating in policy development</td>
<td>26 %</td>
<td>9 %</td>
</tr>
<tr>
<td>Other</td>
<td>3 % *</td>
<td>3 % **</td>
</tr>
</tbody>
</table>

*Seat belt use and helmets for biking/skiing.

♦ not enough-this is to my mind one of the most important Achilles heels of the health care system

♦ ♦ advocating for stronger public health measures to control alcohol abuse and its effect on health
**Question 17:** In your course, is the knowledge and skills of students in Health Advocacy evaluated?

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>68 %</td>
<td>60 %</td>
</tr>
<tr>
<td>Occasionally</td>
<td>5 % *</td>
<td>27 %</td>
</tr>
<tr>
<td>Some of the time</td>
<td>9 %</td>
<td>5 % ♦</td>
</tr>
<tr>
<td>Most of the time</td>
<td>5 %</td>
<td>3 %</td>
</tr>
<tr>
<td>Always</td>
<td>14 %</td>
<td>65 %</td>
</tr>
</tbody>
</table>

*Rarely. Not never but not occasionally either
♦ Mostly as a formative process through journal reflection and feedback
♦ As part of tutorial participation

**Question 18:** In your course, is the attitude of students about Health Advocacy evaluated?

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>48 % *</td>
<td>64 %</td>
</tr>
<tr>
<td>Occasionally</td>
<td>19 %</td>
<td>24 %</td>
</tr>
<tr>
<td>Some of the time</td>
<td>10 %</td>
<td>5 %</td>
</tr>
<tr>
<td>Most of the time</td>
<td>5 %</td>
<td>3 %</td>
</tr>
<tr>
<td>Always</td>
<td>19 % **</td>
<td>3 % ♦</td>
</tr>
</tbody>
</table>

*I worry about evaluating attitudes.
*students are expected to demonstrate the ability to advocate on behalf of individual patients
** on rotational ITER
♦ As part of tutorial participation. Students are expected to demonstrate the ability to advocate on behalf of an individual patient.
**Question 19:** What do you think are barriers to instruction about Health Advocacy? Please check all that apply.

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unclear definition of Health Advocacy</td>
<td>18 %</td>
<td>14 %</td>
</tr>
<tr>
<td>Unclear learning objectives</td>
<td>23 % *</td>
<td>37 %</td>
</tr>
<tr>
<td>Inadequate resources (please specify)</td>
<td>32 % **</td>
<td>23 % ♦</td>
</tr>
<tr>
<td>Insufficient interest</td>
<td>5 %</td>
<td>17 %</td>
</tr>
<tr>
<td>Other</td>
<td>59 ***</td>
<td>54 % ♦♦</td>
</tr>
</tbody>
</table>

*A lot is due to unclear learning objectives

**curriculum time and community experiences

**not enough faculty comfortable with handing discussion on this topic

**one week course-limited time

***time in the curriculum

***mostly time, so much to cover

***brief course, unlikely to provide all instructions due to time limitations.

***inadequate space/time in the curriculum

***limited curriculum time although some will be added to the curriculum

***too little time given other content to cover therefore can’t teach formally

***the objectives of the course are to teach information gathering not action plan

***lack of specific faculty skills other than skills that exist experientially in practice

***seems tangential to the course

***often students do not have the opportunity to participate in this realm

***physicians may not realize the amount of influence that they can exert

♦time in this course

♦Experiential learning is the best way to do it couple with reflection and feedback
Little understanding of specific needs/issues
Clinical instructors already pressed for time

**Beyond scope of this course**

Patient advocacy and health advocacy are not the same. Physicians need the former and less of the latter

How to evaluate

Total lack of relevance to my course
Not part of course objectives
Never thought of focusing on this aspect
Siloization of curricular content
Lack of hands on experiences for students
Lack of student interest and support for other courses
Insufficient student interest
Not responsible for this. Not given the time to add this to my current course
Basic science course
Have not considered a priority for the course
To make it practical, useful, interesting for students
Medical expert is what medical school should focus on-not enough hours in the day for formal teaching

**Time**

Clinical instructors are already pressed for time
Insufficient time in a busy basic science curriculum
Inadequate time
Given shortness of the course and large number of objectives to cover, unable to increase formal teaching
No time-only one week
Focus of course is history and physical exam skills. Advocacy relevant in this context.
Question 20: if you are not currently including the topic of health advocacy in your course, do you plan to include this topic in the future?

<table>
<thead>
<tr>
<th></th>
<th>Medical School A</th>
<th>Medical School B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Already included</td>
<td>33 %</td>
<td>29 % ♦ ♦</td>
</tr>
<tr>
<td>Absolutely not. Why not?</td>
<td>5 % *</td>
<td>3 %</td>
</tr>
<tr>
<td>Unlikely. Why?</td>
<td>0</td>
<td>27 % ♦</td>
</tr>
<tr>
<td>Maybe</td>
<td>43 % **</td>
<td>29 %</td>
</tr>
<tr>
<td>Probably</td>
<td>10 %</td>
<td>9 %</td>
</tr>
<tr>
<td>Absolutely</td>
<td>10 % ***</td>
<td>3 %</td>
</tr>
</tbody>
</table>

*low priority given time constraints, other pressing curriculum priorities

**will likely include in our global health seminars. But not formally. However, it is discussed around subjects like smoking and alcohol cessation

***will likely increase this component

***through additional health equity material

♦ outside of scope of course
♦ basic science course
♦ better time in another course
♦ Siloization of curriculum content
♦ no direction/requirements in the curriculum
♦ insufficient time in a busy basic science curriculum
♦ clinical instructors already pressed for time
♦ no time-course is so short

♦ ♦ already included but at a very superficial level
♦ ♦ but could be more explicit
♦ ♦ to the degree that is desired
Question 21: participants were given the opportunity to comment on any aspects of the questionnaire. The following comments were made.

Medical School A
- “This is a very thought provoking activity for me- it makes me think we should be doing more in both areas addressed. Many thanks for the chance to answer the questions”.
- “Interesting. These areas we don’t generally devote a lot of teaching or assessment around”.

Medical School B
- This is highlighting some deficiencies. Carry on and good luck
- To put these issues in the context of clinical competence would be helpful. If a physician is not clinically competent, the rest is much less important”.
- These topics are important for medical students. However, they are utterly and completely irrelevant to the objectives of my year 02 course in much the same way that basic medical science objectives would be out of place in a clerkship course on marginalized patients and navigating the health care system. PLEASE do not ask medical schools to ‘emphasize’ social responsibility any more than they already do. All new ‘emphases’ always seem to take time away from teaching basic medical science. “
- This is an important topic and at the moment it is lack of integration in the overall course structure that is preventing teaching of content such as this in my course”.
- PBL discussions provide a useful platform to include these discussions while still emphasizing basic science objectives”.
- The course is the teaching of the clinical examination.
- I have not thought about advocacy and inequities as distinct entities to be taught. If I thought about the importance of these issues, these could be better emphasized”.
- “There is a danger for added topics/concepts to erode the core learning that is so critical for students to acquire in their four years of medical school. What good is it to have students who are great Communicators, Collaborators, Managers, Health Advocates and Professionals if there are serious deficiencies in their knowledge and skills. Unfortunately, this is happening more often. The full CanMEDS scope is best
left for postgraduate training. Undergraduate training should focus on Medical Expert Competencies".