

Advocacy and Community Engagement: Perspectives from Pediatric Department Chairs

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The health of children is profoundly impacted by their environments, their lived experiences, the communities they live in, and the policies that shape them. Children are not in a position to advocate for their own needs and depend on adults to promote their interests. It is no wonder that physician advocacy, defined as “action by a physician to promote those social, economic, educational, and political changes that ameliorate suffering and threats to human health and well-being,” and the practice of pediatrics have always been deeply interwoven.^{1,2} The need to advocate for child well-being has increased in recent years with a growing focus on the assessment and management of social drivers of health, intensifying efforts to promote health equity, and expanding awareness and urgent concern about a range of foundational influences on health such as racism, global warming, and immigration. The COVID-19 pandemic has shined a spotlight on existing disparities and exacerbated some of them, including unequal learning loss and food insecurity.³⁻⁵ Many experts believe that the ramifications of the last 18 months on child and eventual adult well-being will be felt for decades to come.

Our nation’s 158 academic departments of pediatrics play an essential role in the future of child health and well-being. They drive our child health research agenda, advancing children’s health and generating knowledge to guide evidence-based practice. They deliver specialty care for the sickest and most vulnerable children in our communities and provide acute and well-child care for large numbers of publicly insured children. Finally, they play a central role in training the next generation of pediatricians. Given those vantage points, pediatric departments as “anchor institutions” in their communities are well-positioned to bear witness to the challenges facing children.⁶

The confluence of profound child health needs and disparities, the crescendo of concern about societal factors driving poor health and developmental outcomes, and movement towards value-based care payment models suggest a turning point in the evolution of pediatric advocacy. The transformative shift from activities that complement the work of pediatric academic departments to ones that are increasingly central will impact many departmental areas, from faculty affairs to resident education. Upon this backdrop, we sought to

understand the perspectives of pediatric academic chairs regarding the role advocacy plays in their departments.

Methods

In collaboration with the Association of Medical School Pediatric Department Chairs (AMSPDC), we conducted a brief, mixed-methods survey of academic pediatric department chairs. The cross-sectional survey was created by an expert in pediatric advocacy and an expert in appointments and promotion considerations for advocacy and reviewed by a national leader in pediatric advocacy.

An established definition of physician advocacy and examples of specific advocacy activities (eg, engagement of policy-makers, community outreach and education, advocacy teaching and mentoring) were included in the survey instructions to orient the respondent. A 4-point Likert scale assessed 6 domains: overall importance of advocacy, relevance for various faculty types and trainees, considerations for career advancement and promotion, how advocacy is operationalized in resource allocation, the importance of advocacy skills, and how advocacy is reflected in departmental goals. Each domain included a standardized prompt and an open-ended text box where respondents could share additional thoughts. This free text generated the content for qualitative exploration. The survey was reviewed and approved by the AMSPDC Board of Directors. The Stanford University Institutional Review Board approved the study as exempt.

An invitation to the online, anonymous survey was first emailed by AMSPDC to all academic pediatric department chairs in April 2021. The survey was sent to pediatric department chairs a total of 4 times, with reminders sent at 1-week intervals. Surveys were collected without any identifying information besides the AMSPDC geographic region of the respondent, to maintain institutional anonymity. Quantitative data were analyzed using descriptive analyses.

The qualitative data were summarized and reviewed by all members of the research team. One member of the team

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created a preliminary codebook. A review of the codebook was conducted by 2 research team members with expertise in pediatric advocacy. A final codebook was created after 3 rounds of adjudication, with 100% agreement achieved.^{7,8} Three team members with content expertise coded all responses. Representative themes were iteratively developed by all team members.⁹

Results

Sample

The overall response rate was 32% (50/158), which is consistent with response rates for prior AMSPDC surveys of similar length in recent years (20%-30%) (personal communication, email, July 22, 2021). The percentage of total responses coming from each of the 9 AMSPDC regions ranged from 5% to 18%, with the greatest proportion coming from the South Atlantic and West South Central regions and the lowest from programs in the West North Central region.

The Perceived Importance of Advocacy Activities Over Time

Four out of 5 chairs (39/49 [80%]) perceive an increasing importance of advocacy in their academic departments compared with 5 years ago (Table I; available at www.jpeds.com). Further, when asked about the importance of advocacy activities for the faculty in their pediatric departments 5 years from now, 80% predicted that advocacy would be “more” or “much more” important.

Exploring the Perceived Importance of Advocacy within Academic Pediatric Departments

More than three-fourths of respondents (39/50) believe advocacy activities are important or very important in the general responsibilities of faculty members overall, 94% (47/50) for general pediatric faculty, 76% (38/50) for subspecialty faculty, and 74% (37/50) for hospital medicine faculty (Table II; available at www.jpeds.com). More than one-half of respondents (27/49) reported that advocacy is important or very important for career advancement and promotion of clinically oriented faculty, whereas only 20% (10/49) believe it is important for research-oriented faculty. Three-fourths of respondents deemed developing advocacy skills important or very important for faculty in general, with a higher percent (86%) believing it to be important or very important for residents. In considering resource allocation in managing a pediatric department, 62% (31/50) stated supporting advocacy is important or very important. Finally, there were diverging perspectives that distinguished between legislative and community advocacy: although 64% (32/50) reported that legislative advocacy is important or very important in department goals, a higher percentage (86%) stated community advocacy is important or very important. Echoing this finding, respondents reported greater perceived success in training for, engaging in, and supporting community advocacy (59%) compared with legislative advocacy (42%).

Qualitative Insights

Survey respondents provided free-text comments to further characterize their perspectives and qualitative analysis revealed 2 overarching domains: the increasing importance of advocacy over time, which included 5 themes, and key barriers and facilitators of advocacy, containing 4 themes (Table III; available at www.jpeds.com).

The first domain centered on the increasing importance of advocacy over time. Several respondents noted a sense of duty as pediatricians to promote children's interests through advocacy and commented specifically on the need to intentionally integrate advocacy efforts into the broad academic mission of pediatric departments. One pediatric department chair explicitly referred to advocacy as “the fourth leg of the academic stool.” Specifically, the importance of community-based factors, such as social drivers of health and resulting health inequities and the political structures and processes that shape those factors, was highlighted. Further, several respondents noted that advocacy was of increasing personal importance to trainees and faculty members, in turn, increasing its importance to departmental leaders seeking to cultivate rewarding experiences for department members and nurture future academic pediatric leaders.

A second domain focused on perceived facilitating factors and barriers to advocacy. Challenges in providing sustainable funding for advocacy activities was a prominent theme, with several respondents noting a lack of mechanisms available for training and ongoing participation in advocacy by faculty members. Educational funds and extramural grants were a common source of support for advocacy activities, although limited in scale and sustainability. Several departments also operate within complex health system structures, and many are state entities, further complicating pathways for advocacy activities. One pediatric department chair commented: “Since most of our advocacy is with the state legislature, I am still unsure of our role as a state university department of pediatrics. [We] don't want to bite the hand that feeds us.” Another common theme was a differentiation between clinically oriented and research-oriented faculty with regard to the perceived relevance of advocacy to their core faculty activities, and the importance of advocacy in considering professional development and promotion.

Discussion

Academic pediatric chairs describe an increasing importance of advocacy in recent years and anticipate a continued increase in importance over time. Chairs also cite a range of factors that have promoted or hindered advocacy activities in academic pediatric departments, and a general uncertainty about the ability of pediatric departments to respond adequately to the ever-increasing demand for child health advocacy by academic pediatricians. Although advocacy is deemed important overall, the perspectives of chairs include some fundamental dichotomization between research-oriented and clinically oriented faculty, general pediatric and specialty pediatric faculty, faculty members and trainees,

and the role of advocacy in promoting community change versus legislative engagement.

A key tension involves sustainable funding of advocacy activities given the primary means of sustainability in academic pediatrics—clinical revenue and research grant funding—do not align well with the usual mechanisms of community and legislative advocacy. Typically, business models are built to ensure an expected return on investment. Given that the value of advocacy entails community-based improvements and longer term shifts in population health, a tenable business model may not be possible within typical time horizons of annual budgets and the current frameworks of cost and revenue. Emerging alternative payment models such as accountable care organizations may create opportunities for innovative funding streams that could support community engagement and advocacy activities that drive health improvements.¹⁰ Other creative solutions may include partnerships with payer entities, foundations, local governments, other private organizations, or local communities themselves in developing mechanisms to support advocacy activities. In addition, advocacy-focused residency training pathways have addressed a critical need for trainees desiring this specific focus, and have also created 1 pathway for sustainable funding within the educational mission of departments. For many, the value proposition of advocacy is clear regardless of financial considerations, but this must be balanced against the real-world financial pressures that pediatric department chairs face. Within pediatric departments, some divisions generate profits while others operate at a loss, yet all are considered essential. As academic departments and health systems broaden their focus to include health equity and community engagement, advocacy may increasingly generate essential value while operating at a “loss.” If we are to address child health inequity, intentionally integrating advocacy within the broader context of the department’s budget, in addition to innovative healthcare financing models, will be required.

Importantly, although advocacy activities were deemed by respondents to be less relevant for research-oriented faculty, advocacy around research funding priorities is a critical aspect of child health advocacy overall. Research funding drives inquiry that can shed light on key factors that can ultimately shape policies. As such, all faculty members have key roles to play. Academic pediatric professional societies have long been active partners of academic departments in promoting the interests of children within the research funding landscape.

Faculty who participate in community engagement and advocacy activities need mentorship, leadership opportunities, and recognition of the academic value of advocacy in pathways for promotion. Quantifying advocacy scholarship to recognize the academic value within the confines of traditional scholarly metrics has been challenging, because there has been a lack of systematic methods to document and measure advocacy contributions, such as community impact or media impact. The standards of advocacy scholarship are maturing, creating a foundation for measurable

impact by faculty members, which will allow appointment and promotion committees to evaluate candidates’ “advocacy portfolios” in much the way they now commonly review medical education portfolios.¹¹ The advocacy portfolio seeks to create objective criteria to enable evaluation of the scholarly contributions of physician-advocates in the areas of “advocacy engagement, knowledge dissemination, community outreach, advocacy teaching and mentoring, and advocacy leadership and administration.”¹¹ Given the shift described by the survey respondents toward inclusion of advocacy as a pillar in the overall missions of pediatric departments, the work of advocacy should accordingly be weighted equally in assessing academic scholarship for promotion alongside the traditional domains of clinical care, research, and education. Further work is needed to refine these meaningful metrics for both general pediatric and specialty faculty to illustrate both impact and value to the broader health system as the work of advocacy continues to grow in importance. Additionally, incorporation of such metrics will necessarily require changes at the broader school and university levels as well, highlighting the need for consensus building beyond pediatric departments themselves.

An unanticipated finding was that some chairs articulated that 1 way in which advocacy activities differ from other aspects of academic pediatrics is the degree to which it exists outside of the realm of the department, and thus beyond the control of the chair. Often respondents described that their advocacy activities were dependent upon adjacent entities, such as the schools of medicine, the universities, and children’s hospitals. Although this finding emerged as an important consideration, it was not one the survey was designed to explore. Because broader health systems generally have a vested interest in the mission and mandate of advocacy activities, there are opportunities to diversify mechanisms of support, achieve economies of scale, and leverage shared lessons learned. Establishing clear alignment between the academic and clinical enterprises of academic health centers around advocacy priorities is an area of great potential as well as a future important next direction of study.

When the interests of children or an individual advocate cannot be fully promoted within the context of a specific academic department or health system, professional societies can act as a key vehicle for advocacy engagement. As an example, during the COVID-19 pandemic, academic pediatricians leveraged their professional networks through the American Academic of Pediatrics to mobilize support for regional eviction moratoriums and advocate nationally for children to return to school.^{12,13} Further, professional societies can be key partners with academic institutions in advancing broader advocacy standards and practices in the field given their vantage points transcend local contexts and constraints.

Finally, the political volatility of our communities creates a tenuous situation for academic pediatric departments tasked with caring for all children while also promoting specific policies and actions. Although advocating for children should

not be controversial, effective advocacy does require the promotion of specific policies that diverse communities will inevitably disagree about (eg, immunizations). Given the myriad of threats to child health in our communities, it may no longer be possible for departments to rise above the fray and avoid controversy. As a group, pediatricians are more progressive than most other medical specialties and sometimes are not aligned with the state legislatures in parts of the country.¹⁴ This point raises an advocacy dilemma, especially for those academic centers that are also state institutions. As stated by 1 pediatric department chair, "As things change rapidly, especially on the political horizon, ability to understand advocacy will be crucial." Reckoning with this new reality and developing new "rules of engagement" will be critical if pediatric departments are to rise and meet the inevitable challenges they will face in coming years. Establishing new "standard practice" across peer institutions may cultivate increasing engagement and effectiveness over time.^{15,16}

A key limitation of the survey methodology is the challenge of precisely and efficiently defining a complex concept, such as advocacy, to orient diverse respondents around a single understanding of the concept. We quoted an established definition of physician advocacy in the survey instructions and complemented it with examples of specific advocacy activities of interest, while being mindful of the length of the survey overall. Despite these steps, we recognize that respondents may have still had somewhat differing understandings of advocacy. Another key limitation of this survey is that it represents a subset of academic pediatric chairs. Our response rate (32%) was consistent with recent, similarly fielded surveys by AMSPDC. The response rate should also be considered in the context of very busy leaders answering a voluntary survey during a pandemic. However, in addition to the busyness of prospective respondents, the response rate may have been impacted by differential attitudes and perspectives between respondents and nonrespondents creating

a degree of selection bias that may have impacted the results. In addition, we did not collect descriptive information about respondents to ensure anonymity, which precludes assessment of how respondents may have differed from nonrespondents. Further, the survey methodology is prone to various self-report biases. The focus on academic departments also artificially narrows the perspective around a domain that typically includes a range of stakeholders, such as children's hospital CEOs and medical school deans. Finally, the perspectives of chairs, although essential in understanding how the field is likely to evolve going forward, may not fully represent the broader experiences and perspectives of departments as a whole.

Conclusions

Child health advocacy is at a turning point. Its importance in every aspect of the work of pediatric academic departments is apparent, as are the manifold barriers to true integration and sustainment of these activities for academic pediatricians. Meanwhile, an array of societal and global factors pose ongoing challenges to the health of our nation's children, and our pediatric leadership face fundamental changes to our healthcare system and academic medicine. Child health disciplines may evolve incrementally or in a transformative fashion, and leaders in academic pediatrics have an opportunity to define the course of the field in the coming years. This cross-sectional view of the role of community engagement and advocacy within pediatric departments reveals both opportunities and challenges ahead as pediatricians grapple with their role as child advocates. Further work needs to explore how academic departments, children's hospitals, schools of medicine and universities can harmonize their work to improve the lives of children. ■

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Table I. The importance of advocacy activities in academic pediatric departments over time as assessed by department chairs

Questions	Unsure	Less important	Same importance	More important	Much more important
Compared with 5 years ago, how important are advocacy activities among faculty in academic pediatric departments?	0	0	10 (20%)	23 (47%)	16 (33%)
Looking forward, how important do you think advocacy activities will be among faculty in your academic pediatric department 5 years from now?	2 (4%)	1 (2%)	7 (14%)	21 (43%)	18 (37%)

Table II. The variation of advocacy importance by faculty type, for learners, by academic pediatric departments chairs

Questions	Not that important	Somewhat important	Important	Very important
In considering the faculty in your department, how important, if at all, are advocacy activities in the core responsibilities of:				
Faculty members in general	0	11 (22%)	25 (50%)	14 (28%)
General Pediatrics faculty	0	3 (6%)	19 (38%)	28 (56%)
Subspecialty Pediatrics faculty	0	12 (24%)	30 (60%)	8 (16%)
Pediatric Hospital Medicine faculty	4 (8%)	9 (18%)	21 (42%)	16 (32%)
In considering faculty career advancement and promotion, how important, if at all, are advocacy activities for:				
Clinically oriented faculty	4	18	19	8
Research oriented faculty	20	19	5	5
In considering resource allocation and competing priorities in your department, how important, if at all, are advocacy activities?	1 (2%)	18 (36%)	21 (42%)	10 (20%)
In considering education and training, how important, if at all, is advocacy skills development for:				
Faculty	2 (4%)	11 (22%)	25 (50%)	12 (24%)
Residents	1 (2%)	6 (12%)	17 (34%)	26 (52%)
How important, if at all, are the following to your department's mission and goals:				
Legislative advocacy	4 (8%)	14 (28%)	17 (34%)	15 (30%)
Community engagement	1 (2%)	6 (12%)	9 (18%)	34 (68%)

Table III. Summary of qualitative analysis of chairs' perceptions on the state of advocacy within their department

Themes		Examples
Domain 1: Increased Value in Advocacy		
Sense of duty: Advocating for children viewed as part of the charge of being a pediatrician		"I think as pediatricians we have a duty to advocate for children, who don't vote and have a very limited ability to advocate for themselves." "It is a time of increased advocacy for many areas in the society that affect child well-being. As health leaders it is our obligation to step it up." "We consider advocacy as the fourth leg of the academic stool." "The next generation of pediatric faculty member will view advocacy as critical to the academic mission—more so than even today when advocacy is more important than it was even 5 years ago." "The bipartisan nature of our world and the importance of being an advocate for those without a voice has never been more critical between the recognition of abuse, climate change, poverty and educational disparities, among others." "As things change rapidly, especially on the political horizon, ability to understand advocacy will be crucial." "We need accurate and knowledgeable advocates to combat misinformation and anti-science activities and news." "The issues of insurance, infant mortality, equity, and access to expensive therapies will become critical over the next 5 years." "We continue to grow our advocacy and policy platforms, and are incorporating social determinants of health and ACEs screening and intervention programs into all aspects of clinical care." "This is an issue in everything we do – [social determinants of health] impact everything from NICU, PICU, floor, general ped and subspecialty clinic. We can only be as successful as we support our communities we serve." "[Advocacy] is part of the shift from the concept of Gen Peds to Community Peds which necessarily includes advocating for the health of the community." "We need to be working outside of the traditional clinical venue to work outside and upstream to address social impactors of health. It is about supporting health of communities, not just providing health care to communities."
Incorporation within Academic Medicine: Advocacy specifically viewed as a component of academic medicine		
Politics driving need: Evolving political landscape as a driver of increased pediatric advocacy		
Disparities and push for equity: Increasing inequities as a driver of increased pediatrician advocacy		
Emphasis on community health: Shifting responsibility beyond individual to community health to address disparities		
Domain 2: Facilitators and Barriers to Advocacy		
Need for funding: Success reliant on department or external sources for funding		With support: Emphasis on education and training Limited protected time Reliance on extra-departmental funding "Primarily in the educational realm, we have budgeted resources for resident and faculty advocacy and small grants to do research projects." "FTE is given to teach our advocacy pathway for our residency." "[There is] a small amount of protected time for a few faculty who are actively involved in advocacy at national level." "Numerous faculty have protected time for advocacy. Typically, this is funded by the hospital and is in conjunction with hospital-based outreach programs." "Fortunately, we have been able to fund several advocacy projects with external funding." "Advocacy is an unfunded mandate that is essentially tied to clinical margins in our departments...It is hard to push faculty into advocacy roles with protected effort without external funding sources (like there are for research efforts)." "The Children's Hospital CEO controls all resources including faculty time allocation and funding. Only those activities with a financial "return on investment" are supported; thus, we have been unable to get any support for advocacy." "Many competing priorities for resources and a limited pool. Best to partner with hospitals or state/local/national societies and faculty has to have a passion for this." <i>(Continued)</i>
		Without support: Need for external sources Reliance on hospital

(Continued)

Table III. Continued

Themes	Examples
Support for A&P success reliant on department considerations of advocacy in A&P	With formal A&P considerations "Specifically, testifying before the legislature and authoring legislative language has been included in tenure/promotion discussions because it demonstrates external credibility." "Advocacy may be related to research, service, education or clinical activities. All are recognized for promotion but are best considered when clearly rounding out a career focus that defines promotional trajectory." "Advocacy activities are a major part of the promotion portfolio... for many faculty. There remain minimum requirements for publication of manuscripts to achieve promotion, but once minimums are hit, the contribution of the faculty to the Department in areas such as advocacy becomes more important." Without formal A&P considerations "This area needs to have scholarly activity and demonstrating outcomes from interventions and QI projects. I have advocated that this is an important part of building your CV and preparing for promotion and working with intent. This is always good work that does not always get acknowledged." Perceived subsets for advocacy: Advocacy seen as the charge of certain subset of pediatricians (ie, medical education, clinical faculty) Systematic barriers: Advocacy stalled by structural barriers between institutions Department vs hospital "Advocacy is more commonly (but not exclusively) complementary to clinical or educational scholarship than to research." "Our hospital commits aggressive resources to advocacy, including faculty FTEs, but these are hospital based, not department based." "There are tensions between [the] Department and the School of Medicine and hospital regarding the value of this sort of work. The Department embraces it and the hospital has a department of community outreach but it still remains challenging to fund substantive efforts towards improved advocacy." Private vs public "We are a State Institution and as such prohibited from direct legislative advocacy in our Medical School Faculty roles. We can participate as private citizens, but without mentioning our Faculty positions. Thus, we focus more on community advocacy." "Since most of our advocacy is with the state legislature, I am still unsure of our role as a state university department of pediatrics. Don't want to bite the hand that feeds us"

ACEs, adverse childhood experiences; A&P, advancement and promotion; FTE, full-time equivalent; NICU, neonatal intensive care unit; PICU, pediatric intensive care unit; QI, quality improvement.