# Are Australian junior doctors failing to act as health advocates? A qualitative analysis

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## Abstract

**Objective**: To explore junior doctors' attitudes towards and experiences of health advocacy practice and teaching in Australia.

**Methods**: Semi-structured interviews were conducted with 15 junior doctors across Australia. Data were thematically analysed.

**Results**: Three themes were identified: i) participants inconsistently understood and practised health advocacy, with many failing to conduct any advocacy work; ii) distinct factors motivated and enabled participants to undertake health advocacy; however, these were largely unrelated to any formal medical education; iii) the current medical workplace and education system is non-conducive to health advocacy practice given the numerous barriers faced by junior doctors when engaging with health advocacy.

**Conclusions**: Health advocacy is generally poorly taught, weakly understood, and rarely performed despite being one of the four core graduate competencies of the Australian Medical Council (AMC). The AMC must clearly define health advocacy and its scope in their outcome statements, and this must be translated into medical education curricula and advocacy opportunities in the workplace.

**Implications for public health**: Doctors are well-placed to act as public health advocates, yet they are denied the encouragement and training to do so. With the growing burden of complex and sensitive public health issues, junior doctors should be trained and encouraged in health advocacy.


Key words: medical education, health advocacy, medical curricula

Health advocacy by doctors can be defined as "any action by a physician to promote social, economic, educational and political changes that ameliorate the suffering and threats to human health and wellbeing that they identify through their professional work and expertise".[1] Local and international medical accreditation bodies expect doctors to perform health advocacy alongside their clinical and other responsibilities.[2-4] Several international bodies have ratified health advocacy as a core medical graduate competency, and in Australia, health advocacy is one of the four main graduate outcome criteria.[2-4] The Australian Medical Council (AMC), Australia's peak medical accreditation body, determines these core medical graduate competencies and considers the role of health advocate as being as important a skill for medical graduates as being a biomedical scientist, clinical practitioner and leader.[4] Therefore, just as junior doctors are expected to practice clinical medicine competently, they are also expected to act as health advocates.

Growing international evidence suggests that many or most junior doctors fail to meet these expectations.[5-7] Across all specialties, junior doctors have been found to be unfamiliar with health advocacy and fail to meaningfully engage in advocacy work.[8-10] This implies a profound disconnect between what accreditation bodies expect of medical graduates, and what graduates themselves are capable of doing, or are even willing to do. This disconnect can be partially explained by the many barriers junior doctors may face when attempting to engage in health advocacy.[8-11] These include a lack of time, poor or minimal training in advocacy skills and a fear of ostracization as a consequence of engaging in potentially controversial advocacy work.[11] Conversely, circumstances that foster advocacy engagement can include the presence of effective role models.[7,12]

There has been a lack of substantial research on health advocacy by doctors in Australia. One Australian study included five junior doctors, all of whom were alumni from the same medical school.[7,13] This study examined experiences of advocacy teaching in medical school, but there was little exploration of practising health advocacy from the perspective of the junior doctors.[7,13] There is a need for more Australian-based research to determine whether Australian medical graduates are meeting the health advocacy core graduate competency expected of them by the peak accreditation body, and investigation into any associated enablers and barriers to junior doctors practising health advocacy.

The effective practice of health advocacy by junior doctors has significant public health implications. In Australia, physician advocacy has been inextricably linked to public health efforts for decades, as doctors have drawn on advocacy skills to achieve significant

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action and reform in tobacco control, climate change, road trauma, skin cancer, gun control, the abolition of nuclear weapons and myriad other important areas of public health.[14-18] Doctors are uniquely placed to contribute to such efforts given their broad scientific and medical training, their intimate knowledge of patient needs and their historically strong influence over health policy and broader political decision-making.[1,6,19] In that sense, doctors can be an invaluable public health advocacy resource. However, international data suggest that doctors are unlikely to become effective health advocates unless they are engaged in advocacy early in their career, ideally in medical school, and receive appropriate education and training in health advocacy.[1,5,7,11-13] The years immediately following graduation thus represent a critical opportunity in which advocacy efforts should be fostered. Therefore, the aim of this study is to describe the attitudes and practices of health advocacy by junior doctors in Australia and identify the perceived enablers and barriers to meaningful engagement with health advocacy.

## Methods

We conducted a qualitative descriptive study and report our approach according to the Consolidated Criteria for Reporting Qualitative Health Research.[20] We adopted an empirical phenomenological approach, conducting one-on-one semi-structured interviews with recent medical graduates to acquire an in-depth understanding of participants' attitudes and experiences.[21] Our population was doctors-in-training, also known as junior doctors, throughout Australia. Doctors-in-training, henceforth referred to as junior doctors, refers to doctors, such as residents and registrars, who have completed medical school but are yet to complete a specialised training program. We included junior doctors working in any clinical specialty or setting.

A triangulated sampling approach was adopted, allowing us to reach participants who possessed varying experiences of health advocacy. Initially, purposive sampling was used to recruit participants who were known to have pre-existing health advocacy experience, such as those prominently involved in advocacy societies for junior doctors. From these interviews, further participants were recommended via snowball sampling. In addition, volunteer sampling was employed; we reached out to all junior medical doctor societies and medical education officers in Australia whose contact details could be obtained. These societies and officers then circulated an invitation email to junior doctors within their respective health services. Participant correspondence was conducted via email. Three participants were known to Author 4. However, there was no relationship with Author 1, who contacted any potential participants, invited them to participate and conducted the interviews. We developed an interview guide (Supplementary File 1) that focused on health advocacy knowledge, barriers and enablers to practising advocacy, experiences of advocacy teaching, and future directions for advocacy in medicine. Participants' age range, gender, years of experience, and area of specialty training were recorded prior to the interview with a questionnaire.

The total number of interviews was determined by information power.[22] Interviews were conducted between 19 July 2020 and 20 April 2021. All interviews were held over the software platform Zoom except for one, which was conducted in person at a participant's workplace. Interviews were conducted by Author 1, who was a medical student at the time of interviewing. No one else was present during the interviews. Audio recordings were taken using Zoom recording software or Apple iPhone Voice Recorder. Field notes were taken by Author 1. Interviews were transcribed by Author 1 with the aid of the software Otter.ai. Software-aided transcriptions were validated by Author 1.

We thematically analysed the data.[22] All transcripts were read and re-read several times by Author 1 before being coded line-by-line using NVivo. A selection of transcripts was independently coded by Author 1 and Author 4 and then compared to ensure coding consistency. A coding framework was developed and used to code the data. Elements of the coding framework were derived inductively from the data, and the framework was constantly reviewed and analysed in line with constant comparison.[23] The codes were discussed by Author 1, Author 4, and Author 2 to establish themes and sub-themes. Coding disagreements were settled by Author 2. All authors agreed on the final themes.

Ethical approval was granted by the Melbourne School of Population and Global Health Human Ethics Advisory Group (ID: 2056151.1). A bespoke distress protocol was developed, but not required. Written informed consent was obtained from all participants prior to each interview. All authors had full access to all of the data in the study.

## Results

In total, we interviewed 15 participants who were alumni from eight different medical schools and worked across three states in Australia at the time of interviews (Table 1). While 19 potential participants initially responded to the recruitment process, four did not respond to subsequent requests to schedule an interview time and so were not interviewed. We included one doctor whose

**Table 1: Participant characteristics.**

| | Age | Gender | Years of Experience | Medical School Location | Area of Specialty Training |
|---|---|---|---|---|---|
| P1 | 26-40 | Male | <5 | Victoria | General Surgery |
| P2 | 26-40 | Male | <5 | Victoria | Rural Generalist |
| P3 | 26-40 | Male | <5 | Victoria | Haematology |
| P4 | 26-40 | Female | 5–10 | Victoria | Psychiatry |
| P5 | 26-40 | Female | <5 | New South Wales | Rural Generalist |
| P6 | 26-40 | Female | 10-15 | Overseas | Psychiatry |
| P7 | 26-40 | Female | <5 | Victoria | Paediatrics |
| P8 | 26-40 | Female | 5–10 | New South Wales | Medical Oncology |
| P9 | 26-40 | Female | <5 | Queensland | Urology |
| P10 | 26-40 | Female | <5 | Victoria | Basic Physician Training |
| P11 | 26-40 | Female | 5–10 | New South Wales | Rehabilitation |
| P12 | 26-40 | Female | <5 | New South Wales | None - Resident (PGY-2) |
| P13 | <26 | Male | < 5 | New South Wales | None - Intern (PGY-1) |
| P14 | 26-40 | Male | 5–10 | Australian Capital Territory | Psychiatry |
| P15 | 26-40 | Female | 5–10 | Victoria | Public Health |

*Note: PGY = Postgraduate year*


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medical training was completed overseas. Most participants had between two and 10 years of experience as a doctor. Interviews lasted between 20 minutes and one hour. Three key themes and seven sub-themes were identified. Themes and sub-themes are supported by verbatim participant quotes (P1-15) provided in Table 2.

### Theme 1: Inconsistent understanding and practices of health advocacy

*Subtheme 1: Differing definitions of health advocacy*

There was inconsistency in participants' definitions of health advocacy. Most participants described health advocacy as a spectrum, extending from patient-level advocacy to broader, community-level advocacy. Others defined advocacy in narrower terms; for example, some conceptualised health advocacy as a form of health promotion, or health literacy, or included advocacy for one's specialty, or for doctors' working conditions, as health advocacy. These descriptions differ from the earlier definition of health advocacy provided.[4] In total, five participants were aware that health advocacy was one of the AMC's four graduate outcomes and 10 were unaware.

*Subtheme 2: Varied levels of advocacy practice*

Participants differed significantly in their self-reported health advocacy participation. For some, health advocacy was an "essential" tenet of their work, and they participated in health advocacy almost daily. Their advocacy work often extended beyond individual patients into population health, in that they were often involved in political lobbying, sitting on relevant committees, conducting policy-relevant research or liaising with media. In contrast, other participants, particularly those who struggled to define health advocacy, were less likely to engage in advocacy or consider themselves health advocates. Such participants also believed that health advocacy was less important than their other responsibilities as a doctor.

*Subtheme 3: Mixed beliefs of the medical profession's attitude towards advocacy*

Participants expressed mixed beliefs about the wider medical community's attitudes towards health advocacy. Around half felt that health advocacy was not held in high regard, or practised, by most doctors despite being a

**Table 2: Themes and supporting participant quotes.**

| Sub-theme | Quotes |
|---|---|
| **Varied understanding and practices of health advocacy** | |
| Differing definitions of health advocacy | "I think there's two levels of health advocacy. There's health advocacy for the individual patient, and then there's broader health advocacy." P7 |
| | "I guess health advocacy is trying to promote health. That's what it means to me. At work, we tried to do that with our patients." P12 |
| | "I think health advocacy is giving a voice to issues or large topical things that you think are important. Whether you are sort of a voice to an inequity or something that you think needs to change. That's what I think, advocacy's about." P5 |
| | "So when I say health advocacy, so this is making sure that all patients are receiving an adequate standard of care. And a part of doctor's job is to advocate for your patient's health and wellbeing and also the best clinical outcome. That's what my understanding is, which I don't think its correct." P8 |
| Varied levels of advocacy practice | "I think it's extremely important. I would say that a large part of why I am a doctor is to enable me to do health advocacy work." P4 |
| | "I pretty much consider it a very exciting, essential part of my, my working life to be able to contribute to these things." P5 |
| | "I think my engagement [with health advocacy] is probably below average. I don't think it's enough… I just don't have time to think about it." P8 |
| | "I guess not really. I don't really do anything outside of interacting with patients in the hospital." P13 |
| Mixed beliefs of the medical profession's attitude towards advocacy | "I think there's a pretty widespread feeling amongst many doctors that it's not their, or our, responsibility to advocate outside of the clinical sphere." P3 |
| | "I don't think there is any medical student or junior doctor for the most part who wouldn't be able to recognize that health advocacy was an important part of our work." P4 |
| | "I certainly don't think [health advocacy] is at the forefront of most doctor's minds." P7 |
| | "I think most people I talk to have very strong feelings about one topic or another in health and would like to advocate for it, but just don't have the time." P11 |
| **Motivators and enablers** | |
| What motivates the advocates? | "I've grown up knowing that there is so much more to healthcare than just the hospital itself. And so, very early on, I got interested in trying to explore this pre-hospital aspect of healthcare." P1 |
| | "The more you realize some of the health inequities and the almost injustices in our society, I think, the more likely you are to engage in advocacy." P5 |
| What enables advocacy? | "We keep in touch with each other, and that kind of creates a network across the board of people who are interested, and opportunities come up, and you get to engage and partake in those opportunities, which reinforce your interest and improves your skills or experience in [health advocacy]." P1 |
| | "And there were people who were able to train me informally. And I am no more or less trainable than anybody else in the profession. And so if I can be provided with the skills, having had no skills at the beginning of my medical degree, so can everybody else." P4 |
| | "And you know, in medicine, there's a lot of hierarchies. So, like, you know, if my bosses don't speak out, then why should I?" P8 |
| | "Also having mentors in this area has been instrumental, because it gives you confidence that this is something that's worthwhile; you've seen them do and achieve so much in the way of impacting reforms for the greater good in society." P1 |
| **Non-conducive medical system** | |
| The quality of advocacy education in medical school is poor | "I don't feel like we were taught to do much of that [health advocacy] in medical school. I feel like in med school the focus was a lot of time sort of learning the science or learning the signs or learning the examinations." P10 |
| | "I think that we teach people that health advocacy is important. I don't necessarily think we provide people with the skills to actually participate in health advocacy." P4 |
| | "So I think in psychiatry, there is a focus [on health advocacy teaching], but before coming to psychiatry, it seemed to me to be totally absent." P14 |
| | "We don't, as part of medical training, receive media training, at any point. But in order to, in many cases, do justice to the issues that we need to advocate on, there will be a level of engagement with media." P4 |
| The working life of junior doctors leaves no room for advocacy | "Other than the 10 minutes or 15 minutes you squeeze for lunch, many or most days, you don't have any time to even call the bank or do some essential life tasks, let alone engage in advocacy" P3 |
| | "As a junior doctor, you're flat out, so tired, you've got all these shifts, there's no way you can advocate for yourself or anyone else. Unless you're a superhuman." P11 |
| | "Yeah, I think lobbying is very hard when you're a junior doctor." P8 |
| | "As a junior doctor, I honestly have worked in Australia since 2013… I've never heard anyone talk about health advocacy. I've heard about it in the college for college exams. But I've never heard of that at the workplace as part of what we should be learning." P6 |


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core graduate competency. Others believed that the medical community generally considered health advocacy favourably, at least to the extent that they believed most doctors had the desire to engage in advocacy work but lacked the time or skills to do so in practice.

### *Theme 2: Motivators and enablers*

*Subtheme 1: What motivates the advocates?*

Self-described advocates reported distinct factors that motivated them to undertake advocacy work. These included a sense of social justice, an adherence to ethical values and particular circumstances of one's upbringing. For example, childhood exposure to poor health infrastructure or issues of medical accessibility were recalled as inspirations for learning about and engaging with health advocacy. Many self-described advocates felt morally obligated to engage in health advocacy. These participants believed that, given the unique societal privilege afforded to doctors, they had a duty to use their platform to influence politics and policy insofar as they affected health.

*Subtheme 2: What enables advocacy?*

Participants described several factors that enabled their ongoing health advocacy work. Role models and mentors, who inspired and guided advocacy practice, were frequently mentioned. Similarly, participation in a network of advocacy-oriented colleagues was a useful way to keep informed of advocacy opportunities, as well as being a motivating factor in itself. Other enablers included having a workplace that supported advocacy, such as a hospital that encouraged advocacy among its staff. Additionally, particular specialties fostered an advocacy culture. One participant training in rehabilitative medicine, for example, described the need to lobby for policy changes that affected their patient population and was thus driven to advocate by virtue of their specialty.

Finally, one's own knowledge or skill in health advocacy was crucial in enabling meaningful advocacy work. Doctors who had learned specific advocacy skills, such as writing 'op-eds', or those who had undertaken additional postgraduate studies, such as a Master of Public Health, felt better prepared and empowered to engage in advocacy than their colleagues who had not. Self-reported health advocates believed that advocacy itself was a learned, teachable skill. However, medical school was not identified as an enabler of health advocacy, as described in the next theme.

### *Theme 3: Non-conducive medical system*

*Subtheme 1: The quality of advocacy education in medical school is poor*

Despite being one of the AMC's core medical graduate competencies, participants had overwhelmingly negative opinions on advocacy teaching in medical school. Nearly all participants recounted poor or no advocacy teaching. Where any formal advocacy teaching was recalled, it was lacking in depth, failed to provide any practical skills, was not assessed, and was largely overshadowed by the burden of biomedical learning. Such advocacy teaching was often reported to have been present in the early years of medical school but not continued during clinical years. Some participants identified that health advocacy was viewed by themselves and their peers as a more peripheral component of their education in comparison to the high volume of biomedical and clinical content and was therefore engaged with poorly by students. Other participants could recall no specific health advocacy teaching at all, believing that the concept was "totally absent" during their formal education until they had reached registrar training.

Only one participant could recall any positive formal advocacy teaching in medical school that influenced their current advocacy practice. Other positive influences cited were extra-curricular activities, such as volunteering on committees, rather than formal components of curricula.

*Subtheme 2: The working life of junior doctors leaves no room for advocacy*

All participants cited the long and busy working hours of junior doctors as a major impediment to health advocacy engagement. Such hours required doctors to be "superhuman" in order to undertake advocacy work. Additionally, junior doctors described working hours that overlapped with times when advocacy activities could be conducted, such as early-morning meetings clashing with ward rounds. This left doctors largely unable to participate in the advocacy spaces they desired. One participant recounted only being able to attend an important health advocacy meeting at their hospital during the day because they agreed to undertake an overnight shift that evening.

Finally, participants suggested that the inherent juniority of being a doctor-in-training makes meaningful advocacy engagement difficult. This is in part due to the restricted logistical freedom afforded to junior doctors compared with consultants, but also because of a fear of reprimand associated with advocacy work, which often involves pushing against the status quo.

## Discussion

There is a profound and concerning disconnect between what the AMC expects of junior doctors and what junior doctors are capable of doing in reality. We found that junior doctors often struggle to define health advocacy, many engage in little or no advocacy practice, almost none can recall any effective advocacy training in their education and all experience multiple barriers to participating in advocacy work.

Some participants accurately defined health advocacy and its many forms, but others narrowly and incorrectly conceptualised advocacy as health promotion or literacy. This knowledge discrepancy is consistent internationally but contrasts with an Australian study in which many participants, all alumni from the University of Notre Dame, had a good understanding of health advocacy.[6,7,24,25] This difference is likely explained by our broader recruitment of doctors without pre-existing advocacy experience, and that the University of Notre Dame sample of participants had come from a relatively new course with an unusual focus on advocacy-related issues, which may indeed help to demonstrate the art of the possible. Our participants reported mixed advocacy participation, with many failing to engage in any advocacy work at all. This is again consistent with the international literature.[6,26,27] Our study illustrates that in Australia, as internationally, many junior doctors lack a clear understanding of health advocacy and fail to engage in any advocacy work.

We identified a range of factors that encouraged junior doctors to engage in health advocacy work. Many of these factors, such as role models and advocacy-oriented networks, have been reported previously.[7,12,28] Establishing advocacy role models and


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networks is therefore crucial in facilitating future generations of health advocates. Ideally, such role models will increase as more students and doctors are better trained in advocacy. Participants also highlighted specific advocacy skills they had learned outside of their formal medical training that enabled their advocacy. Such explicit skills might be effectively integrated into medical education curricula.

We found several barriers to advocacy practice throughout all stages of a junior doctor's career. These included poor or minimal health advocacy training as a student and doctor, long and difficult working hours and having one's workplace discourage advocacy. All have been discussed previously internationally, but not substantially explored in an Australian context.[5-7,11,26] Acting as a health advocate is therefore an unrealistic expectation to hold of junior doctors currently; only those extraordinarily motivated, or with pre-existing advocacy experience, could be expected to meaningfully engage with health advocacy. Possible amendments may include reforming and improving health advocacy education in medical schools and the provision of protected advocacy time at hospitals, similar to protected teaching time.

## Implications and limitations

These findings should prompt changes to the health advocate description in the AMC graduate outcome statements and, crucially, major changes to the way health advocacy is taught in Australia. The AMC asserts that graduates should have a foundation in each graduate outcome, including health advocacy, yet the current AMC's description of health advocacy is vague, lacking both a clear definition of health advocacy and a discussion of the expected scope of advocacy practice. Additionally, given that nearly all participants across eight medical schools failed to recall any effective health advocacy teaching, training institutions across Australia appear to be failing to instil any enduring health advocacy knowledge, in stark contrast to the AMC accreditation expectations. It is unreasonable to expect junior doctors to grow into confident and effective advocates if they have never been exposed to, or taught, health advocacy in a way that is meaningful. Not only must the AMC clearly define health advocacy and its scope, including which skills or activities are considered essential, but this information must also be translated into medical education curricula. There are many paths to improving the teaching of health advocacy to medical students and junior doctors, with research having been conducted internationally on various curricula interventions.[13,24,28-31] Whatever specific changes are introduced, health advocacy must be taught in such a way that provides a clear understanding of the definition and scope of advocacy practice, confers practical advocacy skills and imparts the importance of health advocacy as a key competency for any doctor alongside biomedical and clinical skills.

Future research into health advocacy training in Australia is needed to examine the efficacy of novel health advocacy curricula, and/or the perspectives of medical students, as has been done internationally.[8,10,13,28-31] A mapping study of medical school curricula might also be conducted to identify the state of advocacy teaching. To date, this has only been performed at one Australian university.[7] Greater understanding of how the AMC currently assesses and accredits advocacy education and training in medical schools is also needed. The role of advocacy, and advocacy training, should also be considered in current discussions on the further development of the Australian public health workforce.[32]

To our knowledge, our study is the first Australian study to include junior doctor alumni from several medical schools. However, these findings are based on the experiences of a relatively small sample size, and a selection bias associated with our sampling methods may limit the generalisability of our findings. Our purposive sampling method is likely to have included junior doctors who are more likely to be involved in the health advocacy space; it is therefore likely that a broader sample of doctors would reveal even less understanding and practice of advocacy than our sample. Therefore, in addition to research examining novel curricula, we also believe that additional research with greater numbers of participants, perhaps adopting quantitative methodologies, would help in developing a more robust understanding of the state of advocacy knowledge and practice throughout Australia.

## Conclusion

Australian junior doctors are expected to act as health advocates, yet it is a role that is generally poorly taught, weakly understood and rarely performed. Those doctors who are particularly motivated to engage in health advocacy are often required to go to extraordinary lengths to do so, such as teaching themselves the necessary skills and overcoming numerous logistical and social barriers. The AMC must better outline the scope and skills of health advocacy in its accreditation standards and ensure that these are translated into medical education, training and assessment. Workplaces and colleges must also provide time for junior doctors to meaningfully engage in health advocacy. Given the growing burden of complex and controversial public health issues, such as climate change, global pandemics and non-communicable disease, we must encourage and train future generations of doctors to advocate effectively for the social, economic, educational and political changes necessary to tackle these health crises.

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## Supporting Information

Additional supporting information may be found in the online version of this article:

**Supplementary File 1**: : Interview guide.


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