

# Becoming a Health Advocate: An Interview with Erica Frank, MD, MPH, UBC Professor and Canada Research Chair in Preventive Medicine and Population Health

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Citation info: UBCMJ, 2015: 6.2 (8-10)

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## When did you first recognize that you were an advocate?

We all have repeated childhood experiences that encourage us either to be noisy or quiet. And I was always encouraged to be noisy, to speak up if something bothered me. Probably my most seminal event was when I was 11 and I went to Nepal with my parents. We were driving through Kathmandu, and saw some children who were amputees. When I asked our guide why they didn't have any limbs, he said their parents cut their arms and legs off at birth to make them better beggars.

It was just so clearly wrong to me that a parent could be so certain of a child's dreadful trajectory that the best they could hope for was to make them the best beggars they could be. That was the first time I can remember that I was struck by something that was so burningly wrong and inequitable, where I knew I had some substantial responsibility to try to fix it. I knew their parents had made the wrong decision, I knew that I had to try to fix a world where that was the best hope for someone. There was no other way I could be there and witness that, as a North American kid, able to leave whenever I wanted to, with all the attendant privileges that came with my being able to fly there for fun and learning.

## What in your family's background and character encouraged that kind of clear mission-driven advocacy?

My father particularly enjoyed my being a loud iconoclast and speaking up when rules were stupid, and my working

to make good rules—I imagine that some of this was a celebration of the liberation of our living in the United States in the late twentieth century, rather than

## I've always been a compulsive volunteer

where my parents grew up, in Hitler's Germany. My father was a renaissance man: an engineer, sculptor, painter, and civic volunteer. When I was 12, he was a volunteer member of our local environmental design review commission (in Princeton, New Jersey), and he got me on it as a volunteer also; this was an early lesson about the opportunities and obligations of civic engagement. Relatedly, most recently, I've been elected thrice here at the University of British Columbia (UBC), serving as a city counsellor for the University Neighbourhood Association (UNA) for the last six years, which has been a magnificent way to learn about and contribute to the practice, study, and promotion of positive social determinants of health. And I've passed the lesson forward—from age 14-16 my son was my volunteer Co-Chair for the UNA Emergency Preparedness Committee.

## How do you decide what to work on?

I've always been a compulsive volunteer, and about a decade ago, when we were contemplating moving to Canada, I came up with ten principles to help me prioritize. I decided that activities that are good choices for me capitalize on my drive:

1. Drive to work on important problems
2. Desire to make a substantial contribution to fixing those problems
3. Unique and/or greatest skills/strengths
4. Experiences and credentials
5. Interests
6. Networks and alliances
7. Drive for autonomy and leadership
8. Desire to learn, grow, and be prepared for future steps
9. Need for things to feel right, ethical, logical, and loving
10. Desire for efficiency

I'm not suggesting that other people should adopt those rules, but it's useful to consider what your own set of priorities are; it's helped me a lot with transitions. How it's played out for me is that typically I said yes to everything where I thought it was important (characteristic number 1) and felt like I brought something particular to the table, or I could take something particular away from the table (numbers 2-4). It means volunteering for causes that you believe in and that feel nurturant, and sticking with them and adding more. I started volunteering my research expertise with the Canadian Medical Association as soon as I got to UBC, but I still work with the American Medical Association, and a lot with Physicians for Social Responsibility (PSR) [Dr. Frank was PSR's President in 2008].

## How can we contribute as future physicians?

I think it's pretty easy to contribute both time (likely more after you're out of school) and money, because most doctors in North America can fairly rapidly acquire everything they could reasonably want, or at least need; my Maslow's hierarchy is completely full, all the way to right livelihood.

When we lived in Atlanta, I asked a revered colleague why he practiced so much clinical medicine instead of doing more of the transformative research and advocacy for his findings that really interested him, perhaps hiring others out of pocket or with grants to help him with that. He said it was because he lived in a gilded cage—his manicured home and grounds had a big mortgage, his spouse loved living there, and he didn't know how to get out. That struck me as a profoundly undesirable and completely avoidable outcome. I think there are a lot of things to do with your time and money that can bring you joy and pleasure and that also bring other people joy and pleasure. Even the Scroogiest amongst us knows that, right?

## It seems like you're really interested in caring for others, and sharing what you have, and it seems like you want to do it on a large scale.

I think that if being a good doctor to a patient is a positive outcome, then being a good doctor to a whole lot of people is a whole lot better. So that's why I've always been interested in population health, because its scalability makes it both efficient and beneficent. If it's good, I want it to be good for everybody. If you can, why not? That's what prompted me to specialize in preventive medicine, and to come up with and prove the "Healthy Doc = Healthy Patient"<sup>1</sup> principle, and to conceive of and implement NextGenU.org.

I think another characteristic of those interested and effective in population health, especially preventionists<sup>2</sup> (doctors specializing in Preventive Medicine), is that we don't see ourselves as "other", that we often have low boundaries and long horizons. In my experience, we are invested

in efficient beneficence and therefore tend to create evidence-based interventions at scale, and hug each other when we're done.

## Maybe this would be a good time to tell us about NextGenU?

Sure. NextGenU.org is essentially the world's first free university—all our courses are for credit, for free, unlike any other organization. We collaborate with leading universities, professional societies, and government organizations including the Accreditation Council on Graduate Medical Education, American College of Preventive Medicine, Grand Challenges Canada, Harvard Institute for Lifestyle Medicine, North Atlantic Treaty Organization (NATO), Science for Peace program, U.S. Centers for Disease Control and Prevention (CDC), and the World Health Organization (WHO).

We've started with a focus in the health sciences, and our courses span from college-level pre-health sciences and community health worker trainings through medical and public health graduate training, residency programs, and continuing medical education. The courses are competency-based, and include online knowledge transfer, a web-based global peer community of practice, and local, skills-based mentorships. Our accredited partners are North American universities that are outstanding in each particular course topic, and that give learners credit for this training (or institutions can adopt the courses and use them with their students), all for the first time ever cost-free, and also advertisement-free, barrier-free, and carbon-free.

We now have over 3,000 registered users in 128 countries, and over 130 trainings in development. I conceived of NextGenU in 2001, and we globally launched our first full course in March 2012, Emergency Medicine (EM) for Senior Medical Students, in partnership with Emory University's WHO Center for Injury Control, the International Federation of EM, and the Society of Academic EM. This course, and other NextGenU courses, have now been demonstrated (including in a public health course pilot at Simon Fraser University)<sup>3</sup>

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to imbue students spanning from North America to Kenya with as much knowledge gain and greater satisfaction than with traditional courses.

In 2014, we are focusing on Graduate and Continuing Medical Education. In June we began our first residency program, Family Medicine, with the first 130 of the 10,000 residents we have agreed to co-train in the next five years with the Sudanese government and the University of Gezira. Our next two residencies will be in Preventive Medicine and Occupational/Environmental Medicine; we will pilot these starting at Pacific Northwest University (in Washington state), University of the Incarnate Word (in Texas), and Universidad San Francisco de Quito (in Quito, Ecuador). We are developing these with the American College of Preventive Medicine, Association of Prevention Teaching and Research, Accreditation Council on Graduate Medical Education-International (ACGME-I), Harvard Institute of Lifestyle Medicine, and others

to create the first globally-available and ACGME and ACGME-I accredited residencies.

In addition, NextGenU has a sustainable business model. Like most founders, I helped jumpstart us (don't be afraid to spend your own money for your prize causes!), but we have just received a \$16 million endowment (from the Annenberg Physician Training Program) that covers our core expenses, and receive additional grants from governments (e.g., \$1.4 million from Grand Challenges Canada), quasi-governmental organizations (e.g., the NATO Science for Peace program, WHO), individual benefactors, and our biggest donors, our volunteer course developers, advisors, and mentors, and the thousands of experts who have generously shared their learning resources online, providing this unprecedented opportunity for democratized education.

**That's great that you've found or created all these sustainable outlets for your time and resources. A big question for medical students is their career choice. Might you have any advice on what else to consider besides income, location, and prestige?**

Think about what you want to do with the entirety of your life; consider how you want to be known. Reflect on what you want to accomplish with your personal and professional life as if they are intertwined in one life, because they are: the compartmentalization and boundaries that we're often encouraged to erect in medical training have their limits. Think about what you really need and want; as any kind of physician in Canada, you're likely going to earn way more money than what you really need to support yourself and a family, and your earning potential also buys you time to spend on whatever seems most important to you. And appreciate our privilege—in an ideal world, everyone would be able to have a job where they could spend a bunch of time learning in their twenties and know that it would launch them into a right livelihood and a good living for the rest of their lives. I think that with the amount of privilege

that we have been given as physicians that we have an obligation beyond just doing a competent job seeing patients: I believe we have an obligation to give back with our time and our kindness because we have so much given to us. We could all be in others' shoes if we hadn't had the multiple pieces of personal good fortune that we all must have had (in addition to other attributes) to get into medical school.

**Can we close with my favorite advocacy story, the cigar story on your surgery rotation? It's encouraging!**

Back in the dark ages (I graduated from med school in 1988), we finally managed to get a prohibition on smoking on the hospital wards. I was proud to be part of that effort, so I followed up, circulating (as a third year med student) a highly scientifically-referenced petition to get the hospital gift shop to no longer sell tobacco. It was an obvious embarrassment to me and my classmates, faculty, and staff co-signers that our hospital would make money from selling tobacco, so I gave the petition to the CEO of the hospital. This precipitated some conversation between the Dean and the CEO, and the Dean and me, but my Dean was highly supportive (he was a psychiatrist who had been Georgia's Commissioner of Health and understood our sense of moral clarity here).

Following those wonderful successes, I'm walking down the wards one day on my junior surgery rotation, and there's this guy walking in front of me, with a white coat on, smoking a cigar. So I politely said to him "excuse me sir, do you know the rules about smoking in the hospital?" And he responded, "Young lady, do you know who I am?!". I replied, "no, sir, I don't." He said, "My name is Dr. Ellis Evans and I'm the Chief of Surgery in this hospital", to which I quietly replied, "well, sir, then you should know the rules", and he extinguished his cigar.

Since you're seeking inspiration, I should tell you the consequences. My Dean of course also heard about that, but it only solidified our bond, and my comfort and pleasure at being "out" as an advocate for public health. And at the end of the surgery rotation, my assessment said all

sorts of nice things, and under weaknesses, there was only one listed: "Erica has interests other than surgery" — and I was rather willing to own that weakness!

**Weren't you scared?**

In moments like the one in the hallway, I feel exhilarated, like a conquistador going into battle on a holy crusade—I suppose I seize my lance and spear his cigar! I saw that cigar, and I saw that white coat walking down the hall, and I guess it struck me in the same clear way as those limbless children. Those two things, that white coat and that cigar, or those children and no limbs, do not belong together. That dissonance matters, and I feel urgently compelled to fix it. Absent a lance, I prefer the tools of science, justice, humor, and compassion.

**Surgeons live for that moment when patients need emergency appendectomy. It seems like you're similarly drawn to those public health emergencies.**

Yes, hah, that's right—that surgeon was my hot appendix, spreading his very own sepsis down the hallway! You and your colleagues have the opportunity to stop that kind of disease promotion every day—those public health emergencies/urgencies—in a score of ways that go beyond learning the facts and skills of physician-hood. If your classmates want to be part of such a community at UBC, they could of course join our mentorship group on advocacy, or should do whatever motivates them. But perhaps anyone reading all the way to here needs no further words of encouragement to create and fix something beyond a well-feathered gilded cage!

## references

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