Advocacy: The Ethical Duty of Every Physician

A Thesis
Submitted to
the Temple University Graduate Board

In Partial Fulfillment
of the Requirements for the Degree
MASTER OF ARTS

by
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May 2019

Thesis Approvals:

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ABSTRACT

The American medical profession has publicly pondered its roles and duties since its inception in the 18th century. Recently, that discussion has included whether or not advocacy by physicians is a responsibility of the profession. The following work is an argument and plan to support the ethical, professional imperative of physician advocacy. The historical underpinnings of the American medical profession suggest a responsibility to patients and interactions with society. In addition, there is a strong bioethical argument in favor of physician advocacy as an essential duty. Although there is a well-recognized set of barriers to physician advocacy, this article details solutions to help implement advocacy as a daily practice in the lives of all physicians. This piece will describe a way forward for physicians to take on their professional responsibility to advocate.

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CHAPTER 1: THE EVOLUTION OF THE AMERICAN MEDICAL PROFESSION

In order to understand why physicians have the duty to advocate for their patients, one must first understand how the role of the medical profession has evolved within American society over time.

Individualist Medicine in Early America

Starting in the late 18th century, the medical profession was largely non-existent in America. The role of healer did not require extensive medical training or an intricate knowledge of the body. Therefore, medical care, like many aspects of society at the time, was often structured around family providers. Additionally, the knowledge of treatment and disease came from common books, such as William Buchan's *Domestic Medicine,* written in the vernacular and founded on a disease ontology featuring nature, humors, and miasma. When a medical provider was needed, they could be found in multiple occupations such as allopaths, homeopaths, surgeons, herbalists, bonesetters, and botanists. Allopaths were the original practitioners of allopathic medicine and would eventually become the physicians of the modern medical profession (Starr, 1982).

At this time, the American medical profession was in its infancy. Much of the structure and knowledge of the medical profession came from Britain at this time. However, the physicians in Britain were of a small, elite group who had wealth, power, and stability. The benefits of practicing in Britain gave these physicians no reason to leave their homeland. Thus, American physicians often started as lay practitioners in America and then sought medical education at the schools across Europe, especially in Britain (Starr, 1982). Therefore, the American medical ethics of the late 18th and early

19th century strongly reflect those of Britain. At this time, the moral philosophy of Adam Smith was shaping the British economy as well as the medical establishment to promote individualism and competition within a free-market. These ideals translated well into the newly liberated United States of America as its mistrust of centralized governments allowed free-market medical practice to continue with minimal government intervention. Additionally, the premier British medical ethicists at this time, John Gregory and Thomas Percival, determined that the character of a gentleman was representative of a physician's goodness. As long as a physician exhibited virtuous behavior in his relationships with other doctors, patients, and the public, then that physician was adherent to moral medical practice (Baker, Caplan, Emanuel, & Latham, 1999). The individual characteristics of a physician and his ability to succeed within a free-market determined the integrity of medical professionals.

The strong sense of individualism and competition that pervaded the fledgling American medical profession undoubtedly set up American medical education to follow the same path. The first medical school in the colonies opened in 1765 at the College of Philadelphia. Over the following decades, many new medical schools were founded, and by 1850, there were 42 medical schools in the United States. Standards were non-existent, though, as there was no centralized medical education regulatory body. Medical education examinations were less demanding as professors of medicine were only paid when students passed. Theses required for graduation were often hastily written with little meaningful content. The competition of medical schools depended on which

institution could produce physicians as quickly and cheaply as possible (Starr, 1982; Rothstein, 1972).

At the same time that American medical schools were degrading the status of the medical profession through competition, the first medical professional societies were also competing for members and licensing privileges. Medical societies strived to attain licensing power from state and local governments. However, licensing laws were rarely enforced, and thus, unlicensed practitioners such as osteopaths, apothecaries, and botanists could practice with impunity. This led medical societies to lower their professional standards so as to include more practitioners and gain power. Otherwise, they would have become obsolete from a lack of members. The dearth of power and influence that medical societies wielded at this time came from a scarcity of public support. In this time of democratization, the public believed that democracy should permeate most aspects of society, including medicine. Therefore, as physicians attempted to establish themselves as a specialized profession with an intricate knowledge of science, the public saw the professionalization as an attempt to obfuscate medical knowledge and establish exclusive privileges. Said differently, public opinion and societal influence greatly affected the American medical education and licensing during much of the 19th century (Starr, 1982).

The Beginning of a Cohesive Medical Profession

By the middle of the 19th century, the competition between medical schools and the animosity between different medical practitioners created the need for physicians to strengthen and consolidate their profession. In 1847, the American Medical Association

(AMA) was founded in response to this need (Starr, 1982). In the same year, the AMA created its Code of Ethics. This set of ethical guidelines effectively renounced the previous system in which a physician's status and character solely determined morality. Instead, the new code focused on the medical practice of physicians (as opposed to their personal conduct and behavior) as the basis for determining morality. This anti-elitist, egalitarian shift was very much consistent with the Jacksonian democratic ideals that influenced much of American society at this time (Baker et al., 1999).

It took time for physicians to rally behind one professional banner, but by the end of the 19th century, physicians and even other practitioners such as homeopaths had merged into a singular medical profession for strength and unity. Along with this convergence came special licensing privileges for local and state medical societies which were rapidly growing in membership. By association, the AMA also gained influence as these local and state medical societies were given representation in the AMA's House of Delegates. This consolidation of power was not unique to the medical profession, however. It reflected the societal rise of labor unions and corporations at this time of American history. The consolidation of a singular medical profession was also an early sign of the coming Progressive Era and society's growing allegiance to science. The practices of homeopathy and herbalism were found to be stagnant and scientifically unsupportable. These practices, although newly intertwined with the medical profession, became obsolete and largely abandoned. Furthermore, society began to place more trust in the medical profession as new scientific advances began to arise. In a similar vein, medical education reform was underway as university-associated medical schools strived

to elevate medical education to the rigorous standards of other scientific fields such as chemistry. This aspiration was simultaneously desired by the AMA, and through its involvement, it became the first national accrediting body for medical schools. By the early 20th century, the medical profession had become consolidated, organized, and credentialed (Starr, 1982).

The Golden Era of American Medicine

Into the 1930s, the medical profession further solidified its position and gained a prominent place within society. This was accomplished largely through quashing competing fields of medicine such as public health, and forming a system that largely supported the medical profession as the sole provider of medical care to most of society. As its power grew exponentially, further scientific advances in medicine also boosted societal trust in the profession. Thus, the profession wielded strict autonomy at this time. With the rise of corporations and coordinated specialization in industry and other areas of American society, medical care was expected to follow suit. However, the medical profession resisted such influences to incorporate. This was partly due to the sanctity of the physician-patient relationship which was heralded as a private, untouchable bond that was not to be interfered with by corporations and the state (Starr, 1982). Additionally, in 1934, the AMA stated that it was unprofessional for anyone but a physician to make money off of a physician's work (Shoulders, Hunsberger, Macatee, Hines, & Sensenich, 1934). Therefore, a precedent was set to reject capital and investment in medicine from corporate America. These safeguards would keep the profession free from state and corporate influence as well as ensure continued autonomy for the profession for a while.

Unfortunately, as medical science advanced, medical care became more valuable and also more expensive. It would not be long until the price of medical care precluded the common American from attaining it. This problem would then become the basis for the future government and corporate intervention into medicine (Starr, 1982).

The rising costs of American healthcare in the early 20th century would ignite the series of events that led to the current complex relationship between the government, corporations, patients, and the medical profession. At the time, Europe was experiencing waves of socialism and autocracy which led to the increased prevalence of governmental social insurance programs. However, the United States adhered to its roots of classical liberalism and capitalism (Starr, 1982). Finally, in 1916, organized labor forces had built significant momentum towards creating a form of national health insurance. However, World War I created a hesitation toward ideals perceived to be socialist in nature such as national health insurance. In the end, the decisive blow to this movement came from the medical profession and the AMA. Physicians feared that national insurance would lead to less autonomy and decreased earnings. Utilizing its influence and wealth, the American medical profession defeated the movement towards social insurance (Numbers, 1978). Coming into the height of its power and influence, this was one of the first episodes in which the American medical profession realized its potential to advocate for an issue and change the course of public policy. The AMA would continue to utilize its social and cultural position to solidify its grasp on the issue of national insurance and mold the development of the burgeoning private health insurance industry.

The American Medical Profession's Fall from Grace

In the post-war Era of the 1940s and 1950s, the US medical system saw increased governmental involvement starting with an investment in medical research by the newly formed National Institute of Health. The advancements in science and medicine brought by World War II created a public support of medical research, and this support was only furthered by major strides in medicine such as the successful development of the polio vaccine. American society was beginning to see medical science as a public good. Furthermore, in the 1960s, a strong liberal political movement and the push for greater governmental social services led to the creation of Medicare and Medicaid to ensure that elderly and impoverished Americans would have health insurance. Continuing in opposition to governmental involvement in medicine, the AMA and the medical profession largely opposed the formation of Medicare and Medicaid, but they did not have the political strength to prevent the passage of these new government insurance programs. This was a major loss for the AMA and one of the first omens of the decline of the medical profession (Starr, 1982).

Towards the end of the 20th century, the United States began to enter a healthcare crisis. Costs were growing at unsustainable rates and large swaths of society were uninsured or underinsured. The decision table was crowded with a number of non-physician players that included government officials, commercial insurers, and hospital administrators. Additionally, the AMA made a series of political decisions that were viewed negatively by liberal parts of society. Thus, AMA membership fell dramatically as in-fighting increased and young physicians refused to join the professional society.

The problems with the health care system and the AMA led to a strong public skepticism of the medical profession. This phenomenon was consistent with the national disillusionment of many Americans in institutions (Starr, 1982). It has been argued that the American medical profession lost even more professional legitimacy than other American institutions at this time (Blendon, Hyams, & Benson, 1993). Furthermore, an analysis of Congressional hearings shows that politicians used medical professional references much less frequently in Congressional sessions in the 1980s and 1990s as compared to the late 1960s and early 1970s. It is evident that the medical profession quickly lost its power and authority through these key years (Schlesinger, 2002).

A qualitative analysis of public opinion regarding the decline of medical authority during this time period has illuminated some possible etiologies. These include: "the failure of physicians to preserve their altruistic image treating the poor…and a lack of trust in the political involvements of the medical profession" (Schlesinger, 2002, p. 224). This analysis goes on to suggest that the authority of the American medical profession is deeply tied to the public's perception of the institution to act in the public's interest. The final conclusion is that the political authority of physicians is dependent on the symbiotic relationship between advocacy for the public good and public trust of the profession—as one increases, so does the other. Said another way, public support of the medical profession's involvement in politics will likely increase as long as physicians' political leanings are aligned with the public good (Schlesinger, 2002).

Thus far, it can be seen how the American medical profession has evolved with America itself. Both find their roots in individualism and British society, but over time,

they have grown to become more cohesive, centralized, and collectivist. Furthermore, advancements in science have heavily influenced both society and medicine. In these ways, society and the profession influence one another and change together. It follows that medical professionalism and ethics will evolve as well. This is likely why physician advocacy on a systemic and political scale is currently becoming a part of many medical professional and ethical codes. Additionally, as Schlesinger has suggested, advocating for our patients at the political level may be the best option for the profession to regain authority and public trust. The current medical professional societies likely also see this and are adjusting their professional duties accordingly. These new codes and duties, although in place, have not been completely accepted or enacted upon. The following chapters will explore the case for physician advocacy and the steps needed to achieve it.

CHAPTER 2: THE ARGUMENT FOR PHYSICIAN ADVOCACY AS AN ETHICAL, PROFESSIONAL IMPERATIVE

Following the historical description of the American medical profession's rise and fall within society, this chapter will discuss the current debate regarding whether or not physicians have the duty to advocate. It will first display the overwhelming international consensus that advocacy is a responsibility of every physician. Next, the ethical impetus for this responsibility will be put forth. Finally, arguments against this responsibility will be explored.

The International Professional Consensus for Physician Advocacy

As previously stated, multiple medical professional societies and medical education associations have enshrined some semblance of a duty or role for physician advocacy in their guidelines, codes, and competencies. Perhaps most notably, the AMA has recognized the responsibility of physicians to contribute to community and public health as well as "support access to medical care for all people" (American Medical Association, 2001). Furthermore, the American College of Physicians, the American Board of Internal Medicine, and the European Federation of Internal Medicine signed the Physician Charter which calls for every physician to engage in individual, institutional, and public advocacy for equity and efficacy in health care ("Medical Professionalism," 2005). In the sphere of medical education, the Accreditation Council for Graduate Medical Education includes advocacy for "quality patient care and optimal patient care systems" as a residency program educational requirement (Accreditation Council for Graduate Medical Education, 2016). Outside of the United States, the Royal College of

Physicians and Surgeons of Canada (Frank et al., 2015), the Canadian College of Family Physicians (n.d.), and the General Medical Council (2018) in the UK all support physician advocacy in their competencies.

There is a strong sense of international agreement among medical institutions that physicians have a duty to advocate. The scope of the required advocacy is often a point of contention, although, many of the aforementioned organizations support a level of public and political advocacy in addition to individual patient advocacy. A solid definition of physician advocacy has been suggested: "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" (Earnest, Wong, & Federico, 2010). Furthermore, if physician advocacy is an ethical, professional imperative, then all physicians must be competent and knowledgeable on the subject. This should be similar to the basic understanding of the cardiovascular system that each physician is expected to know, even if they aren't going to be a cardiologist. In this way, a physician does not have to commit their career to advocacy but instead should be able to utilize advocacy in their daily practice when the need arises (Earnest et al., 2010). This is the degree of advocacy that will be argued as an ethical, professional imperative in this chapter.

The Bioethical Argument in Favor of Physician Advocacy

The strong international support of the medical profession's duty to advocate is a helpful marker of the general consensus towards this issue. A fair consensus does not

make it ethical, though. In this section, three bioethical arguments supporting physician advocacy will be detailed, and the necessity of physician advocacy will be posited.

Society Demands Advocacy

As was explained in the previous chapter, the medical profession, medical ethics, and society have evolved together throughout American history. This observation is the result of the deep connection that medicine shares with society. In fact, medicine is embedded within society. Thus, the medical profession is also deeply connected to society. Furthermore, before the modern medical profession existed, medicine had already been in existence as a societal institution for centuries. The role of physician is relatively new in the history of medicine, and it only came to legitimacy when society acknowledged it. This lends credence to the idea that society determines the purpose and ethics of the medical profession.

A contemporary medical ethicist, Robert M. Veatch, agrees with this position. He believes that the ethical norms that govern the medical profession are not derived from the profession itself. Instead, the medical profession exists within a society that draws on an ethical epistemology including religion, reason, and culture. He explains that the physicians are no more enlightened on the ethics of medicine than generals are on the ethics of war. Rather, these issues should be grounded in more basic, fundamental societal values (Baker et al., 1999).

Following this reasoning, the case for an ethical imperative of physician advocacy lies with society. American society has undoubtedly become more collectivist and socially oriented over the past century. Certainly, with the creation of Medicare and

Medicaid as well as the passage of the Affordable Care Act, American society values centralized policy to protect and improve health. Therefore, society likely also values the medical profession working in policy and advocacy towards improved health. In recent discussions of society's social contract with the medical profession, physicians have acknowledged the belief that society demands that the medical profession foster and promote societal health, including physician advocacy (Gruen, Pearson, & Brennan, 2004; Banack & Bryne, 2011). Thus, there is ample evidence that society defines the medical profession's duty to include advocacy, and in turn, the medical profession is obligated to perform that duty.

Political Influence in Medicine Requires Advocacy by the Medical Profession

In another point derived from the history of the previous chapter, it is clear that the medical profession is currently one of many players in the American healthcare arena. Today, healthcare decisions—individually and nationally—are made by politicians, hospital administrators, and insurance companies in addition to physicians. Government is already heavily involved in healthcare and thus, the medical profession must respond by advocating on all levels for patients (Schickedanz A., Neuhausen K., Bennett H., & Huang D, 2011; Halliday, M. & the members of the Indiana University Emergency Medicine Scholars in Advocacy Track, 2011). Taking a consequentialist view for a moment, if physicians fail to advocate for their patients, then other players with differing motives will control conversations and decisions. Such players could be insurance companies and pharmaceutical companies, both of which are primarily motivated by profits instead of increases in human health. By engaging in advocacy, the medical

profession can ensure that patients and advances in human health remain at the forefront of policy decisions.

The Social Determinants of Health Necessitate Advocacy

From Chapter 1, it can be understood that science has had major impacts on the medical profession. Thus, another element of support for physician advocacy can be found in the advancements in the understanding of pathophysiology over the recent decades. It is now clear that a plethora of socioeconomic factors have major effects on the health of a person, and it is likely that these factors affect one's health even more than the treatments of modern medicine. This includes factors such as gender, race, sexual orientation, income, education, geography, and many more. Thus, if the medical profession is to continue to best serve patients and improve their health, then physicians have to work to alleviate the detrimental impacts of the social determinants of health. The only effective way for physicians to accomplish this is through advocacy.

Not only do physicians have an ethical responsibility to address the social determinants of health through advocacy, but the medical profession is well-situated to address such health issues. Firstly, physicians are experts on human health. Additionally, physicians interact with a diverse set of patients which gives them the perfect vantage point to make observations and recognize issues in the population. Finally, physicians have the education, money, and power to leverage influence and access to administrators (Earnest et al, 2010). All together, these qualities enable physicians to serve as a connection between patients and policy makers. These qualities enable advocacy.

One physician, Thomas Huddle, has argued that the medical profession has traditionally focused solely on clinical work and should continue to do so (Huddle, 2011a). However, as others have pointed out, this stance explicitly ignores the science that demands a broader view of a physician's duties. The traditional role of a physician that provides clinical medical care does not fully address the complexity of the determinants of human health, and thus, the duty to advocate is required (Kuo, 2011; Gottlieb & Johnson, 2011). The duties of the medical profession must continue to evolve based on the growing knowledge of disease. To ignore this new information would be unethical.

Discussion of Counterarguments

Finally, in the last section of this chapter, two arguments against the ethical imperative for physician advocacy will be explored and refuted.

The Medical Profession has No Special Knowledge of Justice

To begin, it has been argued that the medical profession has no special insight into the just allocation of societal resources into communal health. Thus, the medical profession, with its solid knowledge of disease, should be called upon as societal advisors (Huddle, 2011a). Further explained, the claim is that physicians have an expertise of medical knowledge but do not have a robust understanding of the normative judgements used to ascribe the societal value of medical initiatives (Huddle, 2011b). This is essentially an argument stating that physicians do not have insight into the discussion of societal justice.

As has been pointed out by others, physicians have a deep knowledge beyond the biological basis of disease that includes the interactions of human health with socioeconomic and environmental issues (Gruen et al., 2004). Physicians are also the frontline providers that observe how resource inputs affect outcomes. Furthermore, physicians are accustomed to drawing on the bioethical principle of justice in daily medical practice to ensure the appropriate distribution of healthcare resources. Physicians have an intimate understanding of the value of medical resources and thus, an important voice in the discussion of societal justice. If physicians have this special knowledge and are not qualified to make these normative judgements of societal resource management, then who is qualified for this task? In order to make such normative judgements, a good understanding of the competing interests must be present. Even a politician will not have a full understanding of health resources just as physicians may not have a full understanding of other societal resources. It will take physicians and other players working together to make these decisions. This does not support the role of societal advisor for physicians, though. Passively providing knowledge when requested would allow for the manipulation of health knowledge. The medical profession must actively disseminate its expertise in health knowledge—and advocate—in order to ensure that accurate information is utilized in policy decisions. Therefore, physicians have an important understanding of the value of health resources and the ethical responsibility to ensure that knowledge is translated into appropriate policy.

Physician Advocacy Requires an Unethical Political Conformity

Another argument against the ethical imperative of physician advocacy is the claim that it necessitates a specific political stance and thus cannot be a required duty of the medical profession (Huddle, 2011a). The thought process is that, in most instances, physician advocacy is a call for physicians to advocate for more societal resources to be used for health initiatives. An example of this is evident as the AMA has called for physicians to "support access to medical care for all people" (American Medical Association, 2001). If the medical profession insists that physicians must advocate for resources to be allocated in this way, then it is tying physicians to the political stance that resources must be put into healthcare and public health above other societal needs. The argument then follows that it is not ethical to require the medical profession to follow one political stance.

This train of logic, in part, makes sense. Political advocacy, stated in this way, is tied to a political stance that sets human health as the top priority, above other societal needs. However, the fallacy in the argument is the assumption that requiring this political stance and worldly viewpoint is unethical. Instead, this is an important stance that should unify physicians. The medical profession is not merely a job where one can act independently from and contrary to the betterment of human health. The profession is a vocation requiring a commitment to improving human health. This is especially true as the profession has broadened its scope to include the social determinants of health. It is essential that when discussing matters of societal resource allocation, physicians should be advocating for the plan in which human health is most improved.

The reasoning that assumes the politicization of the profession is inherently unethical stems from an antiquated expectation that the profession must remain fully objective. The result of this thinking has led a generation of physicians to be brought up as apolitical in an attempt to remain faithful to objectivity and science. However, the politicization of medicine is a by-product of the evolution of society and the medical profession. It is neither good nor bad. It is a fact of the current state of medicine. To remain scientific and address the multiple facts of human health, physicians must advocate and act politically. Objectivity will not lead to improved health in this instance.

In this chapter, the case for the ethical imperative of physician advocacy has been made. Society determines the ethical obligations of the medical profession, and as society demands physician advocacy for the improvement of health, physicians must comply. Additionally, as politics have become ever more intertwined in medicine and the medical profession, physicians must become active in policy-making to continue to serve the best interests of patients. Furthermore, to remain scientifically bound to the betterment of human health, physicians must advocate to alleviate the detrimental impacts of the social determinants of health. Not only is the medical profession well-suited to advocate, but it has a special knowledge of the value of health initiatives which makes it essential for physicians to utilize that knowledge in advocacy. Lastly, the ethical requirement of physician advocacy demands that the medical profession accept the position that human health is of paramount importance in society. Taken together, these points speak to the ethical significance of the physician advocacy role.

CHAPTER 3: BARRIERS TO PHYSICIANS PERFORMING ADVOCACY

Now that the bioethical argument for the medical profession to engage in every level of advocacy has been established, it is crucial that the philosophical discussion be applied to the actual circumstances of the medical profession today. In this chapter, the ubiquitous aspiration of physician advocacy will be compared to the genuine performance of physicians in this task. The discrepancies will explored and some possible causalities will be discussed.

Professional Ambitions vs. Physician Actions

Although the ideal of physician advocacy is a fairly well established professional and educational precedent, multiple papers that have discussed this topic have been sure to mention that there is a discrepancy between this precedent and the actual actions of physicians. Namely, physicians do not appear to engage in activities related to community, advocacy, or policy nearly as often as professional aspirations would suggest (Dobson, Voyer, & Regehr, 2012; Gruen, Campbell, & Blumenthal, 2006; Earnest et al., 2010; Huddle, 2011a).

Multiple studies have looked for signs of this phenomenon. One study showed that physicians are significantly less likely than the general population to vote in national elections when controlling for socioeconomic factors (Grande, Asch, & Armstrong, 2007). This is, of course, a simple marker of societal and political involvement. However, if physicians fail to enact change at this basic level, it seems less likely that physicians are involved at deeper levels of advocacy. In another study, more than 90% of surveyed physicians rated community participation, political involvement, and collective advocacy

to be important. However, only 65% of those physicians had participated in at least one of those three domains within the past three years. Furthermore, only around a quarter of those physicians had advocated politically or within their professional society for a health policy position—arguably the two most effective ways to enact change at higher levels of policy (Gruen et al., 2006).

There is clearly evidence for the failure of physicians to engage in advocacy. This is perhaps due to a difference in belief between the professional guidelines and the general physician. However, in the Gruen et al. paper, the vast majority of physicians think that advocacy is important (2006). Additionally, another study showed that when measuring attitudes towards professionalism, 86% of the 3504 surveyed physicians agreed that the medical profession should advocate for legislation to ensure universal health care coverage in the United States (Campbell et al., 2007). Being that these high rates of concurrence with professional guidelines exist, the difficultly of the medical profession enacting advocacy likely does not lie in the unwillingness of physicians. Instead, it is more likely that there are significant barriers that prevent the medical profession from achieving the desired outcome.

The Barriers to Realizing Physician Advocacy

Multiple physicians, scientists, and educators have written about the possible barriers to physicians practicing advocacy. Most of the identified barriers are based on expert opinion and educated speculation. In the following section, these obstacles will be elucidated.

Confusing Definitions of Advocacy

To begin, it has been mentioned that the very definition of physician advocacy in the professional and educational guidelines has been vague, confusing, and inconsistent. Thus, this paper attempted to define and utilize a broad definition in the beginning of Chapter 2. Some authors believe that the definition of physician advocacy is too broad and intimidating. Thus, they believe that refining the definition and creating distinct divisions within physician advocacy will help physicians better understand and engage in the advocate role (Dobson et al., 2012; Gruen et al., 2004). However, this also may serve to further confuse physicians as to what the role truly entails.

The Great Demand of Clinical Work

Another obstacle that has been noted by multiple authors is the lack of time. It is plausible that the extraordinary demand of clinical work, coupled with charting and billing work, may not allow for time to be spent on advocacy related activities (Earnest et al., 2010; Grande et al., 2007). In a small qualitative study of family medicine residents, time constraints and lack of control over their schedules were two of the main factors that impeded the ability of those physicians to advocate (Mu, Shroff, & Dharamsi, 2011). However, to the contrary, one study showed that hours spent in the clinic by physicians was not correlated with activity in advocacy (Gruen et al., 2006).

A Paucity of Institutional Support

Yet another hypothesized barrier is the lack of institutional support for advocacy related activities. Specifically, this can be felt as a lack of mentors which was another main barrier found in the previously mentioned qualitative study (Mu et al., 2011).

Certainly, if an institution does not cultivate advocacy, faculty members are not going to pursue such activities. This, in turn, does not allow for learners to be exposed to advocacy, and the cycle continues. Even worse, one article has proposed that a physician advocate's agenda may conflict with the priorities of an institution which leads to a fear of political fallout (Earnest et al., 2010). Such a culture could actively quash a desire to advocate.

Medical Education

Finally, medical education itself has been heavily theorized to create barriers to physician advocacy. As multiple authors have already pointed out, this begins with the medical school admissions process as it often favors academic success in science-related fields over experience in civics and other social sciences (Earnest et al., 2010; Grande et al., 2007). Then, during medical school, there is a dearth of health advocacy education. This was found to be a main barrier to advocacy in the qualitative study of family medicine residents (Mu et al., 2011). Finally, the rigor and social isolation that medical education often forces on medical students may destroy connections to communities outside of medicine (Earnest et al., 2010).

It is apparent from the preceding discussion that although most physicians support the idea of advocacy, few actually participate in such activities. This is likely due to a constellation of cultural, institutional, and educational barriers. Some of the possible obstacles have been discussed, but it is by no means an exhaustive list. Going forward, solutions to these problems will be proposed so that physicians may enact their ethical responsibility of advocacy.

CHAPTER 4: ACTIONS TO INCREASE PHYSICIAN ADVOCACY

Thus far, this manuscript has attempted to make the case for physician advocacy as an ethical, professional imperative. A large majority of physicians and medical organizations have indicated that there is widespread agreement with this proposition, however, the medical profession has yet to enact such advocacy activities into daily practice. In order to remain committed to ethical medical practice, the medical profession must engage in advocacy. This chapter will focus on the actions that the medical profession should take to overcome the previously discussed barriers and fulfill its duty to advocacy.

Unifying the Definition of Advocacy

Firstly, as was already mentioned, some authors believe that a barrier to advocacy is the ill-defined definition itself (Dobson et al., 2012; Gruen et al., 2004). However, the reason that advocacy has been so difficult to perform is not because the definition is too broad or demanding. It is because of the many other barriers already listed, and certainly, higher levels of advocacy require much more education and support than physicians have been given. Thus, it is not helpful to draw arbitrary lines of distinction between which topics are and are not within the purview of physician advocacy. If physicians are given the tools they need, then these distinctions will no longer be necessary to make physician advocacy seem more manageable. Physician advocacy should not be limited by topic or level of government. Instead, it should be relatively unrestricted—bound only by the knowledge that a physician has and the duty of that physician to advocate for improved human health. The definition of physician advocacy should remain unified as a broad

definition to enable the medical profession to advocate for a whole host of socioeconomic, political, and educational issues.

Collaboration in Advocacy

Another important aspect of advocacy that has been identified by multiple studies is collectivism and teamwork (Law, Leung, Veinot, Miller, & Mylopoulos, 2016; Gruen et al., 2004). Another paper discussed the fact that medical education competencies are usually based on an individual's ability to perform certain tasks. Medical education in general often focuses on the individual. The authors proposed that this has led to a medical culture that looks at large-scale advocacy as insurmountable. Indeed, when they performed a qualitative study of strong physician advocates, they found that collective advocacy was a hallmark of their success. Specifically, they identified that the studied physicians utilized multidisciplinary teams, professional networks, and collaborative think-tanks in order to achieve success in advocacy. In fact, independent advocacy activities were scarcely found in this study population (Hubinette, Dobson, Voyer, & Regehr, 2014). In adjusting medical education and culture, the medical profession must step away from individualism in this instance and prioritize collaboration as a tenet of successful advocacy.

Medical Education

Unsurprisingly, in order to change the future of the medical profession, the standards of medical education must change to better train future physician advocates. The proposed changes will be described under two umbrella topics: medical school admissions and medical school curriculum.

Medical School Admissions

In order to increase the ability of physicians to advocate, medical education must select for medical students who will carry out this task. Multiple qualitative studies looking at trends in physician advocates have found that early-life exposure to health inequities and socioeconomic disparities is a common theme. Many times this exposure occurred before these physicians entered medical school. Furthermore, these experiences were identified as a strong source of motivation for their participation in advocacy as a medical professional (Law et al., 2016; Mu et al., 2011; Gallagher & Little, 2017). Additionally, another study found that the likelihood of a physician participating in civic activities, such as advocacy, was independently associated with being a physician of an underrepresented race/ethnicity (Gruen et al., 2006). Taken together, the strongest physician advocates have been exposed to systemic inequities and are also of underrepresented minority groups. This conclusion makes intuitive sense. Those that have personally witnessed the detrimental impact of the social determinants of health are more likely to enter medical school with the passion to advocate for disadvantaged communities. Thus, if the medical profession is to train better physician advocates, then medical education institutions must change its admissions policies appropriately to select for the students that will likely become strong advocates. This will require more heavily prioritizing students with backgrounds in civics, politics, and advocacy. Furthermore, the data displayed here adds an additional reason to continue to heavily pursue increased medical student diversity, especially that of disadvantaged and medically underserved communities.

Medical School Curriculum

In addition to training students that are more likely to advocate for their patients, medical education must give every student the theoretical toolbox to perform advocacy work. As was previously mentioned, successful advocacy demands collective action. However, collaboration is not currently a natural phenomenon in medical school. Curricula must change to foster such teamwork skills. Beyond that though, advocacy as a cooperative task requires interprofessional knowledge, network building skills, and other specialized abilities that are not currently covered in medical education. This knowledge should be integrated into education if collaborative advocacy is to be a global expectation of physicians (Hubinette et al., 2014; Law et al., 2016). Moreover, a qualitative study of physician advocates found that health advocacy research and activities were not given the same financial and time allotments in medical education as other scholarly pursuits (Mu et al., 2011). Thus, institutions must be sure to give learners adequate support when pursuing advocacy related research. By thoroughly selecting for future physician advocates, adjusting the medical school curriculum, and propagating student interest in advocacy, medical education will lay the groundwork for a stronger future of physician advocacy.

Institutional Policy and Mentorship

In the last section, the needed change from the base of the medical profession was described. However, in order for that to succeed, change from the top of the medical profession will also be needed. Thus, in this final section, the necessary transformation of medical leadership and institutional policy will be discussed. Research has shown that

physician advocates had mentorship in advocacy throughout their education and early career (Law et al., 2016). This is not surprising as strong mentorship often inspires learners to pursue similar interests. It follows that if the medical profession is to cultivate future physician advocates, mentors in advocacy are needed. However, at this time, medical institutions do not have the proper policies in place to reward and encourage such mentors. This is a debilitating cycle. Without good mentors in physician advocacy, it is difficult for future physicians to foster an interest in that area or to plan a career involving that area. Even then, if a physician manages to get into advocacy, there is little academic institutional support for advocacy roles, which continues to contribute to the lack of mentorship. Medical institutions must break this cycle by forming tenured positions based on advocacy and similar activities. Traditionally, medical institutions often follow a tripartite mission of education, research, and patient care. Thus, tenured positions are often heavily focused on traditional medical education topics and medical science research. However, advocacy spans each of those three areas and should be rewarded properly with position advancement and financial compensation. Furthermore, protected time should be allotted for advocacy related activities as it is for traditional research and educational pursuits. By creating positions for mentors and leaders in advocacy to flourish, the medical profession will further enable itself to engage in its ethical responsibility to advocacy.

Final Thoughts

Throughout this manuscript, the case for ethical, professional physician advocacy has been made. The first chapter explored the historical underpinnings of the medical

profession's interactions with society and aimed to briefly describe the rise and fall of the medical profession's power. Within that narrative, it can be seen that an evolved, collective American society wants the medical profession to advocate for improvements to human health. Thusly, the second chapter explored the bioethical argument for the medical profession's responsibility to advocate. It showed that the medical profession is mandated by society to continue to evolve alongside culture, government, and science. The third chapter described the difficulty that the profession has experienced in transitioning to its advocacy role, and finally, the fourth chapter illuminated a path that will allow the profession to embrace this new role. Through advocacy, physicians can further improve the health of patients, communities, and populations.

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