

Perspective: Physician Advocacy: What Is It and How Do We Do It?

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Abstract

Many medical authors and organizations have called for physician advocacy as a core component of medical professionalism. Despite widespread acceptance of advocacy as a professional obligation, the concept remains problematic within the profession of medicine because it remains undefined in concept, scope, and practice. If advocacy is to be a professional imperative, then medical schools and graduate education

programs must deliberately train physicians as advocates. Accrediting bodies must clearly define advocacy competencies, and all physicians must meet them at some basic level. Sustaining and fostering physician advocacy will require modest changes to both undergraduate and graduate medical education. Developing advocacy training and practice opportunities for practicing physicians will also be

necessary. In this article, as first steps toward building a model for competency-based physician advocacy training and delineating physician advocacy in common practice, the authors propose a definition and, using the biographies of actual physician advocates, describe the spectrum of physician advocacy.

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In 2002 the American Board of Internal Medicine, in its charter on medical professionalism, called for a “commitment to the promotion of public health and preventive medicine, as well as public advocacy on the part of each physician.”¹ There was not an isolated entreaty. The American Medical Association (AMA) endorses a similar commitment: Physicians must “advocate for the social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.”² Numerous authors have also argued for the importance of public physician advocacy and its place in medical professionalism^{3–8}; several specialty societies now include advocacy in their definitions of professional

responsibilities,^{9,10} and the Accreditation Council for Graduate Medical Education (ACGME) Pediatrics Residency Review Committee (RRC) now requires advocacy training and experience for all pediatric residents.¹¹

Despite widespread acceptance of a physician’s duty to advocate, the concept remains problematic because it remains undefined. Although the Pediatric RRC requires advocacy training, the committee does not define physician advocacy, nor does it delineate its scope or describe its competencies.¹¹ Others who have called for professional advocacy have likewise gone no further. In this article, we propose a definition and describe the spectrum of physician advocacy as first steps toward building a model for competency-based physician advocacy training and delineating advocacy in common practice.

requires working to address the root causes of the problems they face. Nevertheless, all physicians’ obligations to advocacy are grounded in their professional experience and expertise and their duty to their patients. Each physician’s obligation to advocacy must also include a recognition of the limits of his or her expertise (e.g., to expect an adult ophthalmologist to advocate children’s oral health needs is unreasonable).

We therefore build on the AMA’s endorsement² to propose the following definition of physician advocacy: 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.

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Defining Physician Advocacy

Physicians are well acquainted with their roles as advocates for the individual patient. Most, if not all physicians, have taken extra steps to ensure a patient receives a needed service. Physicians consider advocacy for an individual an accepted component of ethical practice, yet this alone does not meet the requirement for “public advocacy on the part of each physician.” Advocacy, according to this broader perspective, requires more than helping individual patients get the services they need; it

Physicians’ Unique Capacity for Advocacy and the Barriers That May Keep Them From It

Physicians are uniquely positioned to function as public advocates for health. They understand the medical aspects of issues better than any sector of society, and they are poised to observe and delineate the links between social factors and health. Public trust of physicians is very high; to the public, doctors are a credible source of information.¹² Given their social standing, physicians enjoy an unusual degree of access to policy makers, to local and national leaders, and to citizens; thus, they possess a great deal

of leverage in influencing public processes and priorities.

Although physicians seem to endorse the idea of civic engagement as a professional responsibility,^{13,14} there is less evidence that physicians engage in these activities. The limited evidence available shows that physicians are more likely to engage policy makers on issues affecting their own economic well-being^{7,15–18} and that, on the most basic measure of civic involvement, that is, voting, doctors vote less often than other professions or the even public at large.¹⁹ Others have observed that often a discrepancy exists between the professional values physicians endorse and the behaviors they demonstrate.¹⁴

Little empiric evidence exists to explain why physicians have not more fully embraced the role of advocate. A number of hypotheses might explain it. The gap between endorsing and engaging in advocacy may be illusory; because the attitudes cited are socially desirable, physicians may endorse them in polls without holding them very deeply. Maybe the admissions process for medical schools favors academic success to a degree that admissions committees admit too few service-oriented students. Medical training, which is long, intense, and isolating, largely removes physicians from the community while they attain clinical competence; perhaps these severed ties are too difficult to rebuild. Maybe the contrast between the competence and control physicians feel in a clinical setting and the uncertainty and ambiguity they experience in an advocacy role is too stark for most to overcome. Physicians have busy, demanding clinical lives—perhaps their time is too scarce. Doctors are trained to keep personal opinion and preferences out of the clinical encounter; they address religion and politics at the bedside with caution, if at all. Perhaps physicians tend to generalize this soft, interpersonal clinical boundary and become reluctant to engage in the processes required for effective advocacy. As one observer noted, leaving “the mountain of equipoise for the valley of advocacy” is difficult (John F. Steiner, MD, personal communication, 2000). An advocate’s agenda may at times conflict with the priorities of institutions to which he or she must be accountable; fear of political fallout may keep physicians, especially

those with more junior status, away from these activities; the culture of medicine and “hard” science may be the culprit as well. Few randomized controlled trials have tested community health interventions—much less public policy—and public decision making may often seem a chaotic and ill-informed process. Even our grammatical preferences may hold a clue here; perhaps a culture that so stubbornly clings to passive-voice-verb construction is simply averse to the proactive, declarative nature of advocacy.

Despite these barriers, doctors do engage in advocacy, and many are very effective in that role. Their real-life examples best demonstrate the broad range of physician advocacy.

The Spectrum of Physician Advocacy

Medical society affiliation: State health care reform

Dr. L became increasingly concerned about the lack of health insurance coverage available for his patients and the growing systemic inefficiencies in health care that he saw eroding access to and quality in health care. At a meeting of his state medical society he stood up, voiced his concerns, and made a motion that the members move comprehensive health care reform to the top of their agenda. His action redirected the meeting; 90% of the membership voted to suspend the planned agenda and take up his question. When the medical society convened its Physician’s Congress on Health Reform, he joined, and he has since contributed to the processes of health care improvement. The medical society is now providing leadership and advocating comprehensive health care reform at the state level, and Dr. L has taken a leadership role in the process.

Practice management: Coalition and board leadership

Dr. K reorganized his practice so that he could care for more uninsured patients. When the need grew so great that he was turning away large numbers of patients, he began researching local groups that were working to improve the plight of the uninsured. He volunteered his time with a statewide coalition working to bring about state health care reform. He ultimately joined the organization’s board and became one of the group’s leaders.

Parent education: School board advisor

Dr. B recognized an extraordinary rate of obesity among his school-aged patients while practicing in rural Washington. After discussing the issue with several families, he concluded that a contributing factor was the poor food choices found within the local schools. He decided to bring the issue before the local school board, requesting action on the children’s behalf. School board members agreed with Dr. B and felt empowered by his medical expertise to take action. They encouraged Dr. B to become a member of the board to follow this project to completion. On the basis of his commitment to these children, he agreed. His advocacy successfully effected changes in nutrition policy in the schools.

Policy advocate: Coalition building and leadership

Dr. L is a pediatrician who oversees a nonprofit practice. He cares for a largely uninsured and underinsured population. Frustrated by the lack of insurance for kids and the lack of action on the part of policy makers, he worked to build a coalition focused on expanding access to health insurance. He helped to organize a statewide coalition of 40 organizations interested in expanding health insurance coverage to all children. Dr. L uses his experience as a clinician to “tell the story” of why more kids need coverage. The collective advocacy and political capital of this newly formed coalition have effectively moved policy makers at a state level. Over the course of three years, the coalition outlined the necessary steps to cover all children in the state, and the members have, to date, successfully worked to pass several pieces of legislation leading toward that goal.

Patient advocate: A health care advisor for a policy maker

When Dr. S learned of a bill pending in the U.S. Senate that would adversely affect her patients, she called the office of her U.S. senator and spoke to the legislative aide who worked on health issues. The aide noted her concern and then asked her advice on another health-related matter. Dr. S spent several minutes offering a thoughtful opinion and left her number with the aide, offering to help in the future. Dr. S now meets quarterly with her U.S. senator and his legislative aide, and she has become a trusted advisor on health-related issues.

She uses the opportunity to advocate solutions to the needs she sees in her practice and community.

Hospital physician: Leader in injury prevention

Dr. R was sickened by the number of emergency department visits of children suffering injuries related to falls from high-rise windows. She sought a small grant to place window guards on apartment building windows in the surrounding neighborhood. When she demonstrated the dramatic decrease in injuries, the city council passed a law requiring protective guards on all high-rise windows. This initial effort led to a national change in laws promoting injury prevention from falls.

Patient advocate: Liaison to media and health reporter

Incensed by the injustice he saw in his daily care of patients without health insurance, Dr. M felt that change would come only if the public, too, could see what he saw. One particular patient's story seemed to perfectly illustrate some of the problems faced by the uninsured. With the patient's permission, he contacted a reporter who covered the story. Dr. M began gathering illustrative stories and pitching them to media outlets which then covered many of the stories. He also wrote and published frequent opinion pieces, editorials, and letters to the editor on health matters. In the process, he developed relationships with the local media and advocacy communities. He began coordinating his efforts with local health care advocates to link media coverage with their policy-change and organizing efforts. He also became an advisor on health matters to a number of local reporters.

Practice management: Reallocation of resources

Working in a hospital-based ambulatory care clinic, Dr. W recognized that the majority of her patients were not successfully accessing the social services they needed. When she voiced her observations, her colleagues confirmed her experience. Dr. W collected basic information documenting the magnitude and impact of these unmet needs. She then proposed a redistribution of social work services within the hospital to provide a full-time social worker to the clinic who would direct patients to social

services and assist them in overcoming barriers in accessing the services. This simple change dramatically improved access to social services for the clinic's patients and also led to the identification of a new layer of unmet patient needs. Dr. W is now organizing a system to facilitate legal referrals for patients to help them address many of the nonmedical barriers to health, such as housing and environmental risks.

Physician advocates—Discussion

The examples above illustrate some of the skills and competencies (e.g., identifying a problem amenable to advocacy, defining the problem and its scope, identifying and engaging strategic partners, developing a strategic action plan, communicating an effective message) necessary for effective advocacy. All of these physicians grounded their advocacy in their professional experience and work life. Each sought and developed critical strategic relationships that leveraged his or her own expertise and experience to achieve broader effect. In these examples, the physicians all acted locally—working with partners who served their own communities and institutions. None of these physicians changed jobs or moved. Most devoted only a few hours a month to their advocacy work. These examples illustrate the powerful effect physicians can have if they, as collaborators and leaders, strategically share their expertise with the community. They also illustrate the fact that every physician has a contribution to make and that, in all likelihood, a place exists in the physician's own community where those contributions would be both meaningful and welcome.

While each of these examples illustrates an instance of effective physician advocacy, each, to some degree, developed accidentally. None of these individuals received special training to take on these roles, and in many cases these physicians learned by trial and error the processes required to be successful as advocates. Because of the current paucity of formal physician advocacy training, successful physician advocacy tends to be exceptional.

Training Physician Advocates

If the profession of medicine considers advocacy a professional imperative, then advocacy must cease to be

exceptional. For this to occur, physicians and medical educators must become thoughtful and deliberate about training advocates. If left to chance, the charge to serve as public advocates rings hollow and will not be met. Furthermore, if advocacy is a professional imperative, its competencies must be well defined, and *all* physicians must meet them at some basic level—these competencies must not be relegated to a new specialty called “advocacy.” Whereas a minority of doctors practice cardiology, every physician must understand the circulatory system and its place in his or her clinical area of expertise. So it should be with advocacy.

What would medicine need to do to achieve this? What would advocacy training look like? We believe that sustainably fostering physician advocacy requires some modest changes to both undergraduate and graduate medical education while also developing advocacy training goals and opportunities for practicing physicians.

Historically, both undergraduate and graduate medical education have focused purely on developing clinical competence. Advocacy training would require that training reliably occur in a broader context. Medical students and residents would gain a basic understanding of the world beyond the clinical encounter. Ideally, this would begin in undergraduate courses with instruction in both the determinants of health and the production of health from an ecological perspective. Residents would develop competence in the preventive and population health perspectives that relate to their specialty. Training in the theories and practices of both leadership and social and organizational change would be new areas for competency, but this training would be closely related to training in systems-based practice. Physicians-in-training would develop the interpersonal and leadership skills needed to work collaboratively in teams in order to participate in, develop, and lead groups and coalitions. They would practice basic skills in developing and delivering clear messages and using the media effectively. Training in the processes of policy making within trainees' own institutions as well as institutions in the community and the

government would also be necessary. Finally, students and residents would need the opportunity to practice these skills through service learning, and they would also need to see their mentors effectively use and truly value these skills.

For training like this to develop and thrive in academic medical centers, an infrastructure must be available to support it. Accrediting bodies like the Liaison Committee on Medical Education and ACGME must endorse advocacy competencies as necessary components of medical training. Just like any area of competence, some physicians must devote a significant portion of their time and effort to practicing the skills. Campuses would need to develop stronger, more productive partnerships with their communities. Deans and other administrators would need to encourage and reward faculty advocacy activities. Neither developing partnerships nor rewarding faculty advocacy is likely to occur if funding is not available to support advocacy. Although the National Institutes of Health (NIH) has recently begun to emphasize the importance of translational work,²⁰ to date there has been little investment in supporting translation from clinic to community. Advocacy is fundamentally a translational activity. The application of preventive strategies in populations, the practice of community-based participatory research, and the use of process improvement and outcomes research in community health are all methods that translate interventions from individual patient health to broader public wellness. Effective advocacy may require seeking resources and regulations from the same political bodies that fund medical schools and traditional research. These activities can become politicized, so academic institutions and practices must consider and prepare for the political ramifications of advocacy activities.

Although federal funders have not supported the activities we call advocacy in their funding priorities, private funders have. In a time of diminishing dollars from the NIH, the growing resources and influence of private health foundations represent an opportunity for advocacy activities. Many of these foundations espouse health promotion and the elimination of health disparities

as their highest priorities. They fund community-based organizations, and many would welcome productive partnerships between those organizations and the medical community, providing opportunities for funding and strategic partnerships.

The medical community itself could do much more to foster advocacy as an expression of professionalism. Attorneys have long recognized the importance of pro bono work. Many law firms allow their members to devote hours to community service as part of their practice. Medical practices could do the same, encouraging their physicians to offer their services as volunteers in the community for a few hours each month. Even small practices could afford this level of investment. Larger, multispecialty groups and staff-model organizations could even sponsor rotating fellowships, and doctors in the organization who have more ambitious goals could apply for funding to support a project that might involve a more significant time investment.

The advocacy training that is currently available to practicing physicians is largely available through professional societies. Often local, state, or specialty medical societies will offer some basic training in lobbying and will organize trips to the state capitol or to Washington, DC, for the opportunity to apply those skills. These efforts are valuable, though limited. Expanding the training and broadening the agenda to better include the concerns of those in the community while seeking broad partnerships with patient groups and community leaders and advocates would create robust new opportunities for physicians and their communities.

If advocacy is a core element of professionalism, it should not become the parochial concern of a subspecialty. If we intend to train physicians as advocates, we must create a home for these activities in academic medicine and in medical practice. Funding for advocacy research, training, and activities is required to make advocacy a sustainable activity. Successful advocacy is achievable with both a clearer understanding of its components and deliberate practice from committed physicians.

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