Physician advocacy in Western medicine: a 21st century challenge
Philip Bagshaw, Pauline Barnett

ABSTRACT
Physician advocacy occurs when doctors speak up for the health and healthcare of patients and communities. Historically, this was strong in some Western countries with doctors finding that it enhanced their authority, prestige and power. But it weakened in the 20th century when the biomedical model of health triumphed and medicine became a dominant profession.

In the second part of the 20th century, this dominance was threatened by political, technological and socioeconomic forces. These weakened medicine’s state support, brought it under managerial control and undermined the social contract on which trust between doctors and the community was based. Defence of the profession was assumed by medical colleges, societies and associations. They had some success in retaining professional autonomy but did not undertake open advocacy, particularly on social justice issues, and did not therefore enhance their standing in the community.

Opinion is divided on the level of advocacy that it is ethically proper for the medical profession to employ. Some contend doctors should only advise authorities when expert opinion is requested. Others contend doctors should speak out proactively on all health issues, and that collective action of this type is a hallmark of professionalism. This lack of consensus needs to be debated.

Recent developments such as clinical leadership have not revitalised physician advocacy. However, continued deterioration of the UK National Health Service has led some English medical colleges to take up open advocacy in its defence. It is to be seen whether medical colleges elsewhere follow suit, as and when their healthcare systems are similarly threatened.

What is physician advocacy?
Physician advocacy (PA) occurs when doctors speak up for the health and healthcare of patients and communities.1 There is an extensive scientific literature on PA, originating mostly in the US, UK and some commonwealth countries, much of which is relevant to New Zealand. There is, however, continuing debate on the role of PA and how it should be incorporated into professional practice.2–5

PA is a complex topic, for which no accepted model has been published.6 We see it as best described under three domains: subjects; methods; and moral/ethical tensions. The subjects are traditionally divided into cases (doctors advocating for the needs of individuals or group of patients; a role now frequently assumed by nurses and others) and causes (public health specialists and others advocating for population health measures).6

The methods of PA can be divided into three distinct types: policy advice, and what we call here ‘closed’ and ‘open’ PA. First, there is policy advice which is requested by governments and other organisations from medical experts. Second, is closed PA when doctors advocate for cases or causes with authorities behind closed doors, largely unknown to the general public. Lastly, there is open PA, when doctors advocate with authorities for cases or causes employing open communication, frequently using the public media.6 The 21st century challenge is to decide which aspects of PA are legitimate functions, if not obligations, of medical professionalism.
The moral and ethical tensions frequently associated with PA reflect the balance between, at one end of the spectrum, complete doctor self-interest and pure altruism at the other end, between the relative power of physician advocates and the beneficiaries of advocacy, and the balance between individual and group benefit arising from advocacy. This last commonly involves the issue of distributive justice and how resources can be allocated to ensure equity within populations.

The rise and fall of physician advocacy

PA has a long history in Western medicine, mentioned first in Hippocratic writings. In modern times, it began in Europe, including the UK, then spread to North America but changed with prevailing culture and circumstances. During the 19th century, when medical treatments were often ineffective or harmful, doctors built up the trust of the community by frequently engaging in PA on issues concerning both cases and causes. This added to their authority and status, giving them some degree of autonomy over their own area of work. Rudolf Virchow was the embodiment of 19th century PA. Besides being one of the fathers of modern pathology he was also a man who led an “extraordinarily civic-oriented life”, and frequently engaged in both open and closed PA. He famously captured the spirit of the time when he said “Medicine is a social science, and politics nothing but medicine on a grand scale.”

During the first half of the 20th century, the situation changed. Medicine became more scientific, effective and safe, and a period began that became known as the “golden age of doctoring”. It was also the time, however, when PA started to decline. Medicine had become a dominant profession with (i) state-protected authority over its own area of work; (ii) control over associated areas of work; and (iii) massive public support and trust. As explained by Richard and Sylvia Cruess, this last was underpinned by a strong social contract, a largely implicit agreement between the medical profession and society about the expectations and obligations each had of the other. With the success of the individual biomedical model of health, doctors, as purveyors of effective medical care, occupied a powerful and secure position in society. In this environment, doctors saw PA as unnecessary, undesirable and politically risky, and tended to withdraw from participation.

The exception to the withdrawal from PA was the persistence of advocacy on some key public health issues of the time. This included, in the second half of the 20th century, physician advocacy against nuclear weapons and tobacco use, and into the 21st century advocacy for regulation of obesogenic products and addressing climate change and health. These initiatives, while generally led by public health physicians, have recently become increasingly multidisciplinary. When clinicians chose to become involved, they were encouraged by the perception that these issues could be seen as ‘safely distant’ from areas of employment and clinical practice. In our view, they did not, therefore, invite the risks to personal position that raising patient safety issues, challenging local resource decisions or criticising institutional management might carry.

Challenges to medicine and the profession’s response

In the second half of the 20th century, the dominance of the medical profession was challenged by countervailing political, technological and socioeconomic forces. First, there was increased demand for healthcare, fuelled by developing technology, increased medicalisation and consumer preferences. This was accompanied by governments and private sector organisations, such as insurance companies, making funds available to meet this demand. By the 1970s, ‘New Right’ ideologies had become dominant, endorsing a corporate or managerialist model for managing the tension between growing demand and available funds. In this model, doctors became ‘proletarianised’, that is, they became ‘workers’ subject to the managerial control of company or government rules, and no longer independent professionals. In the predominantly privately funded US, doctors in both secondary and primary care experienced similar early loss of autonomy through corporate managerialism. In countries with stronger public funding, this control occurred later and in New Zealand, for example, general practitioners maintained...
relative autonomy through private practice until the late 1990s.25

At the same time, as described by Marie Haug, ‘de-professionalisation’ of the medical profession occurred.26 Technological advances, such as the Internet, which made previously privileged information freely available to the public, were accompanied by the socioeconomic changes that led to the establishment of an increasingly consumer-oriented medical marketplace. Furthermore, the rise of ‘Rights’ organisations (in women’s health, psychiatric care, disability services, etc) increased public awareness that medical self-regulation was failing.27 The combined effects of proletarianisation and de-professionalisation were failure of the social contract, loss of public trust, loss of state support, reduced autonomy and power, and public debate about the role of the medical profession in society.28

The medical profession proved remarkably resilient to these challenges.28 In a series of seminal publications, Eliot Freidson described how the profession strengthened itself with respect to governments by a process of restratification, becoming more hierarchical and bureaucratic.28 He described two emergent groups that he called controlling elites, which exercised control over their much larger rank-and-file membership. ‘Knowledge elites’ came from the universities and other academic institutions, and controlled the content of medical knowledge. ‘Administrative elites’ came from the medical colleges, societies and associations, and ensured, as carefully as any professional or craft-based guild ever did, that the activities of their organisations reflected and protected the interests of their rank-and-file members.29

In order to reassure governments that the medical profession was capable of self-regulation, the medical colleges and other controlling elites started programmes of continuing education and professional development, and supported initiatives such as evidence-based medicine and the development of clinical guidelines. In these ways they retained some degree of professional autonomy but at a cost to the clinical autonomy of their rank-and-file.30,31 They had only limited success, however, in countering state and corporate dominance of healthcare, and maintaining control over their own areas of work.32 Furthermore, they rarely used open PA and avoided comment on social justice issues, thereby failing to strengthen their relationship with the community or increase public support.32 By the 21st century, the controlling elites had become increasingly specialised, stratified and dispersed throughout the medical workforce, occupying professional-managerial hybrid positions in both public and private healthcare organisations.33 They have therefore become unlikely to engage in open PA because their blurred employment boundaries lead to divided loyalties, and they are often gagged by employment contracts, commercial sensitivity issues and concerns about personal professional consequences.

Prospects for physician advocacy

It was expected that recent developments such as new professionalism and clinical leadership might enhance professional autonomy and even PA. So far, published evidence shows some increased influence on low-level control over work activities but no increase in PA.34 Many health systems remain in a continual state of change, with persistent unmet healthcare need.35,36 Doctors are well-qualified to advocate on these issues, and there are examples where they have done so with some degree of success.37,38 In New Zealand, the 1997 report entitled “Patients are Dying” (unpublished but often cited) is an example of effective PA.39 A recent example of publicised PA occurred when local orthopaedic surgeons complained Waikato Hospital was an unsafe place for elective surgery.40

As noted above, there is still a lack of consensus in the medical profession on what type of PA is appropriate and who should do it. There are two schools of thought, as demonstrated by the reactions to the 9/11 attacks on the Twin Towers in New York. At that time, an editorial in the New England Journal of Medicine implored doctors not to react to terrorism but to get on with their jobs.41 In contrast, an editorial in the Lancet argued that health professionals should be concerned with prevention as well as healing, and medicine cannot escape politics.42
One school of thought on PA has been well espoused by Thomas Huddle of the University of Alabama. He claimed that ‘traditional medical ethics’ requires competent and ethical performance but that doctors should only provide advice when asked. He argued that PA is not a component of professionalism and that it should not be fostered or taught in academic institutions. Another supporter of this ‘traditional medical ethics’ position was the late, well-known ethicist Edmund Pellegrino who said “…the assertion of some progressives that activism and public policy can, or should, displace professional ethics is mistaken.” Other commentators have pointed out that doctors are too busy to engage in PA or are likely to engage policy makers to advance their own self-interests. Research from the US and Australia showed ambivalence to the concept of social justice among some of the medical rank-and-file.

In opposition to the traditional medical ethics approach is the open advocacy school. This has been espoused by Russell Gruen and colleagues who suggested that PA is a professional responsibility and includes political advocacy not only for public health but also for social justice issues, including health resourcing and inequalities. They claimed that individual action is laudable, but collective action is a hallmark of professionalism and an opportunity to regain public trust. There is support for the open advocacy school from some senior medical academics. For example, Mark Earnest from the University of Colorado and colleagues produced a widely-quoted definition for PA as: “Physicians promoting those social, economic and political changes that ameliorate the suffering and threats to human health and wellbeing that doctors identify through their professional work and expertise”. The debate on PA continues, with a recent exchange between Jon Tilburt who argued that doctors must uphold the best interests of patients while ensuring the just use of health resources, and Huddle who argued that these cannot be reconciled. Despite this tension, PA is now a successful part of the undergraduate and postgraduate curricula in many universities, particularly in the US, and under some university charters it is both a right and responsibility of staff to speak out in the public interest in their areas of expertise. Martin McKee and colleagues agreed, noting that raising so-called ‘political’ issues, such as the consequences of conflict and the precursors of Type 2 diabetes, in fact appropriately draws attention to available scientific evidence.

In recent times, individual or small groups of healthcare professionals have raised concerns over serious health issues that were well known to, but largely ignored by, the wider medical community. These people, sometimes referred to as whistleblowers, have often paid a high price for their actions; they have even occasionally been censured by their own disciplinary bodies. In future it is likely such debates and disclosures will increasingly occur through blogs and other social media, particularly if such issues are not addressed by the relevant controlling elites.

It is noteworthy that some of the medical colleges in the UK have recently become exponents of open PA, in response to current threats to the future of the UK National Health Service. For example, the Royal College of Surgeons of England now issues a weekly political update, which records when they have managed to get their concerns mentioned in the regional or national public media. Furthermore, the Royal College of Physicians of London, considered by some to be a quite conservative organisation, has joined in the public fight. They have realised that contemporary politics is less about ‘leadership’ and more about ‘followship’ (ie, pursuing the vagaries of shifting popular public opinion), and so open PA is becoming increasingly influential with governments. They have therefore recently released a public document “Underfunded, Underdoctored, Overstretched: The NHS in 2016”. It will be interesting to see whether the controlling elites in other countries act in this way when their healthcare systems are similarly overtly threatened.

The history of PA has some important lessons for us on the relationships among doctors, patients, society, governments and health authorities. The role of PA has evolved over the last two centuries along with the political, technological and socioeconomic landscape of Western society. The challenge for doctors, individually and collectively, is to debate the vital question of whether or not PA is a desirable or even...
obligatory component of medical professionalism. If it is, then PA should be a core topic in undergraduate and postgraduate medical curricula. Despite the extensive literature and discussion there is, as yet, no consensus on PA. A positive response to this challenge from doctors and their controlling elites could have many beneficial effects for Western healthcare.

Competing interests:
Nil.

Author information:
Philip Bagshaw, Clinical Associate Professor, University of Otago, Christchurch; Pauline Barnett, Health Sciences Centre, University of Canterbury, Christchurch.

Corresponding author:
Philip Bagshaw, Canterbury Charity Hospital Trust, PO Box 20409, 349–353 Harewood Road, Bishopdale, Christchurch 8054.
philipbagshaw@gmail.com

URL:

REFERENCES:
18. Cruess RL, Cruess SR. Expectations and obligations: Professionalism and medicine’s social contract


23. Block JP. A substantial tax on sugar sweetened drinks could help reduce obesity. BMJ. 2013; 347:f5947.


46. Gruen RL, Pearson SD, Brennan TA. Physician-citizens – public roles and...


