Evidence-based advocacy: the public roles of health care professionals

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Scientific evidence and the relationship between the medical profession, politics and the public are dynamic and inter-related

In 1848, Rudolf Virchow asserted that "medicine is a social science, and politics nothing but medicine on a grand scale".[1] Regarded by many to be the father of modern pathology, Virchow saw clear responsibilities for doctors to engage with the broader social concerns that cause illness and harm.

A century and a half later, human health faces threats ranging in scale from terrorism and climate change to the consequences of violence, substance misuse, poverty and environmental hazards that we deal with every day in our emergency departments and our clinics. On a handful of issues, such as smoking, health care professionals have been instrumental in changing public policy. But, with many ongoing social ills, is civic action a duty of modern clinicians?

Following the September 11 terrorist attacks in the United States, the world's leading medical journals expressed opposing views on this question. The editors of the *New England Journal of Medicine* implored doctors not to react directly to terrorism, but instead to treat injured patients, continue with medical research and ensure that the medical community is prepared for future terrorist attacks.[2] In response, the *Lancet's* Richard Horton argued that anyone working in the health professions is concerned with prevention as well as healing, that medicine cannot escape politics, and to reduce the burden of harm caused by violence, doctors must address how the political determines the clinical.[3] Putting aside legitimate practical concerns — after all, few doctors think they have the time or skills to be effective political agents — the real question is whether or not we should nurture interest in addressing the health of communities among health care professionals, arming them with appropriate skills and promoting opportunities for engagement.

If we examine the dual historical trajectories of scientific medicine and the place of professionals in society, we realise that this is not just a question of individual political or moral persuasion. Instead, it is one that depends on prevailing culture and circumstances of the time. In the 19th century, for example, doctors found professional distinction difficult to attain, largely because the scientific basis of medical practice was rudimentary and their treatments were often harmful. Public health activism was one way in which doctors could achieve status and authority. While not all doctors embraced it, public health was at least deemed to be complementary to the work of medicine.[4]

This changed rapidly early in the 20th century as scientific and clinical evidence evolved, and, in mastering this body of evidence, doctors became valuable to the public.[5] Based on new understanding of bacteriology, germ theory and specific disease-based treatments, the biomedical model of disease triumphed. The new medical schools focused on diseases more than on people or populations, and on cures rather than on the social, behavioural and environmental forces that maintain health or produce disease. Unlike efforts to change social conditions, which were seen to be tainted by politics, advocacy and social diversity, the reductionism, objectivity and certainty of the biomedical model had great appeal. By the 1950s, the income, professional status and authority of doctors far exceeded that of public health professionals, and deep antipathies had evolved between them.

In the most recent 50 years, this relationship has become less polarised, due especially to three scientific and sociological developments. The first was the birth of modern epidemiology and multivariate analysis. They demonstrated that most major illnesses were not random occurrences and that peoples' overall health status was not only a consequence of the care they received. We now know that they are influenced by a range of social factors, including income and social status, social support networks, education and literacy, employment and working conditions, and social and physical environments.[6,7] Second, business and government replaced the individual as the principal purchasers of health care, and have been increasingly interested in research that reveals disparities in health status, unequal access to treatment and variable quality of care. Managers and policymakers have challenged the view that entrenched health problems can be solved simply by more doctors, more medicines or faster discharge times. Third, fuelled by the repercussions of high-profile cases such as the Bristol Royal Infirmary[8] and Bundaberg Hospital[9] cases, cynicism grew about the medical profession's ability to put aside its own interests and to self-regulate standards of performance.

In light of such developments, it is no accident that doctors have been concerned with issues of professionalism. In February 2002, a transatlantic team of physicians published a Charter of Medical Professionalism, which was a bold restatement of the responsibilities of doctors as professionals — a sort of modern Hippocratic Oath.[10,11] From July 2003, the American Council of Graduate Medical Education and the American Board of Medical Specialties required that all American medical and specialist training programs teach and assess "professionalism" as a core competency. The concept of professionalism rapidly gained traction, and the Charter provided a road map. It offered three fundamental principles: primacy of patient welfare, patient autonomy and social justice. The first two were uncontroversial. Social justice, however, with its implied responsibilities for public roles that redress social inequalities, was greeted with some ambivalence and much confusion, and needed clarification.

With colleagues at Harvard I developed a conceptual and operational model based on our qualitative research with a range of professionals, academics, consumers and social commentators.[12] Finding the label "social justice" generally unhelpful, we preferred the term "public roles", which we defined as advocacy for and participation in improving the aspects of communities that affect the health of individual patients. We justified doctors' public roles on the premise that doctors and the public expect discipline-based expertise to encompass all aspects of diagnosis, prevention

and treatment; patients expect the medical profession to do what it can to promote their health; and doctors can be effective advocates for societal change through changes in legislation, advertising, public awareness and so on. We set reasonable limits on these obligations, based on the strength of evidence and the feasibility of doctor-promoted change. We identified three strategies for action by busy clinicians: community participation, individual political involvement, and collective advocacy through professional organisations. We made the case that individuals could choose activities — small or large — that suit their own situation and disposition.

In the US the model generated considerable debate, became required reading for many medical training programs, and has been used in a variety of policy documents. In a survey of 1662 American doctors in six specialties, over 90% rated each of community participation, political involvement and collective advocacy as important roles, although fewer than half reported being involved in such activities in the previous 3 years.[13]

Dr John Furler and his team from the University of Melbourne Department of General Practice then explored the usefulness of the model for the Royal Australian College of General Practitioners' policy on health inequalities. They conducted 80 interviews and two focus groups with a range of internal and external stakeholders.[14] To some degree, Australian responses echoed the ambivalence to the concept of social justice observed in the US — public roles were supported when expressed within a familiar framework centred on care and compassion, but contested when expressed as matters of justice and fairness, particularly if any personal sacrifice was perceived. Their findings highlighted the tensions between the dual responsibilities of professional bodies to the public and to their members, and the importance of leadership from professional organisations in promoting public engagement.

So what can we conclude? First, that both scientific evidence and the relationship between the medical profession, politics and the public are dynamic and inter-related. Second, most doctors now seem to accept that their expertise should include knowledge about social determinants of illness and access to care and that, even when they are not personally involved, it is important that the profession provides a responsible expert voice on such determinants in public debate. Third, public roles are most likely to gain traction among doctors when conceptualised as issues of care and compassion rather than as actions of justice and redistribution. Clinicians want their expertise put to good use in the public sphere in a way that complements rather than detracts from their core responsibility of being expert in the traditional doctor–patient relationship, and the rewards reaped from it. Fourth, a double challenge lies ahead because, while contemporary professional standing may partly depend on public engagement, the effectiveness of such engagement depends, in turn, on how convinced the public is that the profession has its own house in order.[15] And finally, conceptual clarity, realistic expectations and good role models are needed if clinicians are to engage effectively with important public concerns. Teaching about social determinants of health alone is insufficient. To use this information and be effective political agents, future health care professionals will need skills in advocacy and public participation.

Virchow led an extraordinarily civic-oriented life, as a participant in the 1848 Berlin uprisings and later as a Berlin city counsellor, cofounder of the German Progressive Radical Party, and member of parliament. With public-spiritedness and the right tools, modern health care professionals could be both active clinicians and evidence-based advocates on important health-related matters in their communities. Virchow would be pleased — medicine would once again be a social science.

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References

1 Ackerknecht EA. Rudolph Virchow: doctor, statesman, anthropologist. Madison: University of Wisconsin Press, 1953.
2 September 11, 2001 [editorial]. *N Engl J Med* 2001; 345: 1126.
3 Horton R. Violence and medicine: the necessary politics of public health. *Lancet* 2001; 358: 1472-1473.
4 Brandt AM, Gardner M. Antagonism and accommodation: interpreting the relationship between public health and medicine in the United States during the 20th century. *Am J Public Health* 2000; 90: 707-715.
5 Starr P. The social transformation of American medicine. New York: Basic Books, 1984.
6 Anderson MR, Smith L, Sidel VW. What is social medicine? *Monthly Review* [online] 2005; 56 (8). http://www.monthlyreview.org/0105anderson.htm (accessed May 2008).
7 Berkman L, Kawachi I, editors. Social epidemiology. New York: Oxford University Press, 2000.
8 Dyer C. British doctors found guilty of serious professional misconduct. *BMJ* 1998; 316: 1924.
9 Van Der Weyden MB. The Bundaberg Hospital scandal: the need for reform in Queensland and beyond [editorial]. *Med J Aust* 2005; 183: 284-285.
10 Medical Professionalism Project. Medical professionalism in the new millennium: a physicians' charter. *Lancet* 2002; 359: 520-522.
11 American Board of Internal Medicine; American College of Physicians–American Society of Internal Medicine; European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med* 2002; 136: 243-246.
12 Gruen RL, Pearson SD, Brennan TA. Physician-citizens — public roles and professional obligations. *JAMA* 2004; 291: 94-98.
13 Gruen RL, Campbell EG, Blumenthal D. Public roles of US physicians: community participation, political involvement, and collective advocacy. *JAMA* 2006; 296: 2467-2475.
14 Furler J, Harris E, Harris M, et al. Health inequalities, physician citizens and professional medical associations: an Australian case study. *BMC Med* 2007; 5: 23.
15 Irvine DH. Everyone is entitled to a good doctor. *Med J Aust* 2007; 186: 256-261. ❑