Perspective: **Medical Professionalism and Medical Education Should Not Involve Commitments to Political Advocacy**

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Abstract

It is increasingly suggested that political advocacy is a core professional responsibility for physicians. The author argues that this is an error. Advocacy on behalf of societal goals, even those goals as unexceptionable as the betterment of human health, is inevitably political. Claims that political advocacy are a professional responsibility are mistaken, the author argues, because (1) civic virtues are outside the professional realm, (2) even if civic virtues were professionally obligatory, it is unclear that civic participation is necessary for such virtue, and (3) the profession of medicine ought not to require any particular political stance of its members. Claims that academic health centers should systematically foster advocacy are also deeply problematic. Although advocacy may coexist alongside the core university activities of research and education, insofar as it infects those activities, advocacy is likely to subvert them, as advocacy seeks change rather than knowledge. And official efforts on behalf of advocacy will undermine university aspirations to objectivity and neutrality. American society has conferred remarkable success and prosperity on its medical profession. Physicians are deserving of such success only insofar as they succeed in offering society excellence and dedication in professional work. Mandatory professional advocacy must displace such work but cannot substitute for it. The medical profession should steadfastly resist attempts to add advocacy to its essential professional commitments.

Physician responsibility for advocacy has had a prominent place in recent discussions of medical professionalism. Professional codes and professional organizations are increasingly including advocacy among core professional responsibilities. The American Medical Association (AMA) requires that physicians participate in activities contributing to community betterment and "support access to medical care for all people."[1] The Physician's Charter requires physicians to support universal access to health care and to advocate it.[2]

Advocacy is also finding its way into discussions of medical training and even into requirements of the Accreditation Council for Graduate Medical Education (ACGME). The pediatrics residency review committee now requires pediatrics training programs to provide "structured educational experiences … which prepare them [residents] for the role of advocate for the health of children within the community."[3] Recently, Earnest et al[4] suggested that the Liaison Committee on Medical Education and the ACGME should specify advocacy competencies that academic medical centers would be responsible for conveying to medical trainees.

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Calls for Mandatory Political Advocacy Are Novel and Have Been, So Far, Unheeded

Those who seek to make advocacy a compulsory aspect of professional life are seeking clarity as to what exactly counts as fulfilling this requirement. They are asking for more than advocacy for individual patients, which physicians have long seen themselves as obliged to offer. And they are not merely seeking to require that physicians do some work, possibly uncompensated, on behalf of the medically underserved, which is also a traditional tenet of medical ethics. The ethical statements of the AMA and the Project on Medical Professionalism imply a requirement for a specifically political commitment from physicians and for political activity. This requirement is consistent with the definition of advocacy recently proffered by Earnest et al,[4] according to whom advocacy is "action taken by a physician to promote those social, economic, educational, and political changes that ameliorate the suffering and threats to human health and well-being." Furthermore, political advocacy is not to be in any way optional. "If advocacy is to be 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.'"[4]

The impetus behind the new push for advocacy is the perfectly legitimate desire to fulfill our profession's commitment to the society that protects and encourages our work. In what does that commitment consist? Traditional medical ethics would hold that it consists, first and most importantly, in the competent and ethical performance of clinical work in the systems and settings provided by society for such work. Secondly, traditional ethics would require the medical profession to provide advice when society acts collectively to improve public health or health care access. Proponents of what is effectively mandatory political advocacy are clearly asking for more than traditional ethics has required.

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This attempt at incorporating political responsibilities into professional norms is relatively recent. It has not so far been strikingly successful. Earnest et al[4] claimed that a physician's duty to advocate has been widely accepted. Although various professional organizations have recently declared a duty to advocate to be part of medical professionalism and physicians may acknowledge such a duty when responding to surveys,[5] most physicians do not engage in advocacy activities. And they engage in other community and political activities less often than do others with similar levels of income.[6,7] In a 2004 survey, just 25% of U.S. physicians claimed to engage in political activity on local health issues beyond voting.[5] Medical trainees may not even acknowledge social justice or advocacy to be among their professional responsibilities.[8]

The notion of ethical commitments being part of the physician's occupational role is, of course, as old as the Hippocratic writings. That those commitments included obligations to society was affirmed in 19th-century discussions of medical ethics, such as Percival's *Medical Ethics* (1803) and the AMA's *Code of Medical Ethics* (1847). For Percival, physicians owe society competent and ethical professional work.[9] The AMA code expands professional responsibility to society to include physician availability during epidemics.[10] As the AMA revised its Principles of Medical Ethics over the years, physician responsibilities to the public primarily continued to be competent work and giving advice as needed. In 1957, a charge to participate in activities tending to improve the health and well-being of the community was added to the AMA Principles of Medical Ethics.[11] To this charge was added, in 2001, an obligation to support "access to medical care for all people," a rather vague commitment elaborated further in the organization's *Declaration of Professional Responsibility*,[12] drafted the same year, as "an oath by which 21st century physicians can uphold … ideals that, throughout history, have inspired individuals to enter medicine." The *Declaration* enjoins physicians to "advocate for social, economic and political changes that ameliorate suffering and contribute to human well-being."

Formal claims that commitments to social justice and political advocacy are part of medical professionalism thus have been made only in the last 20 years. The medical profession has yet to accept and act on these claims. Ought it to do so? I suggest that those who favor mandatory physician advocacy have mistaken the scope of the profession's obligation to society, which includes advice when called on but not political action of any kind. If the medical profession becomes politicized, even on behalf of ends such as social justice or health care access for all, the world will not thereby be a better place—as the medical profession has no special authority or insight into what is demanded by justice or how far societal resources should support communal health rather than other priorities. It will be a worse place—as mandatory medical engagement with politics will displace real medical work, which is the only contribution of medical professionals, as such, to societal betterment.

Why Political Advocacy Is Not a Professional Norm

The professional norms that historically have governed us as physicians reflect on our professional work, more specifically, our conduct in the doctor–patient relationship. To society, we have offered our advice and a commitment to doing our work competently and ethically. The recent claim that political advocacy must also be a professional norm is a category mistake. Political advocacy, if it is a virtue, is a civic virtue rather than a professional one. If we owe society civic virtues, as perhaps we do, we owe them as citizens rather than as professionals. To those who propose extending professional norms into the realm of civic virtues, it may be asked, why stop there? Why not require of physicians the virtues of any social role that they might find themselves playing? The claim that being a good citizen is a professional imperative is no more or less cogent than claiming that physicians must also be good spouses, good parents, or good friends. But the point of professional ethics is to identify and enjoin specifically professional norms. It is enough for us to demand of ourselves that we be good physicians. We ought not to make these moral virtues a specifically professional burden. To the extent that we diffuse our moral energy across the span of social life, we make it less likely that we will succeed even at being good professionals.

Physicians ought not to mistake norms of civic behavior for professional imperatives. Having done so, those who favor mandatory physician advocacy have mistaken what norms of civic behavior can rightly demand. Political participation is a virtue for those political theorists who favor deliberative democracy or civic republicanism. There are plenty of opponents of both of these positions in contemporary discussion. It is by no means obvious that participation in public affairs is necessary for the good or virtuous life. And many contemporary political theorists see no gain for the polity in demanding universal political participation.[13–15] Many citizens are uninterested in politics and ignorant about public policy; it is unclear, then, what is to be gained by chivvying them into political activity, and there are no adequate grounds for concluding that their choice of work, family, or other activities in preference to public affairs is mistaken. Likewise for physicians. Proponents of mandatory physician advocacy need to explain why physicians may not legitimately prefer whatever activities they please to politics. Those physicians who are moved by egalitarian strains of social justice theory or who are inclined toward public affairs ought, of course, to follow their inclinations and agitate for their view of the public good. The case has not been made, however, as to why all physicians must do so.

So far I have suggested that physicians are not subject to the norms of civic behavior by virtue of their occupation and that, even if they were, those norms would not necessarily demand political participation. But there is yet more fault to find with demands for mandatory physician advocacy. Most theorists of deliberative democracy or civic republicanism favor political involvement but do not specify the political ends that politically active (and hence virtuous) members of society should seek. They, in fact, go out of their way to avoid suggesting that political commitment must be to particular political ends (so long, perhaps, as political activity avoids the unacceptable extremes of the political spectrum). Those who favor mandatory physician advocacy have specified the ends physicians are to pursue: "health care

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access for all" or an end to "threats to human health." As political ends, these sound uncontroversial. But any such advocacy, when it is actually performed, must be not for states of affairs in an ideal world, but for particular measures seeking to direct scarce collective resources in one direction and not in another. No such advocacy can be politically innocent; that is, it must necessarily involve privileging one among many defensible ways of ordering our collective life together. Insofar as physician advocacy amounts to a demand for the diversion of resources toward public health or health care and away from other legitimate societal ends, it cannot be an unmixed expression of professional virtue. It must instead be an eminently contestable political stance. And it cannot be proper that the profession of medicine demand a particular political stance of its members (i.e., any one stance in the universe of acceptable political stances).

It is worth noting that our traditional undertaking to help the medically indigent does not require a problematic political commitment. Physicians have traditionally committed themselves to providing some uncompensated care to those who cannot pay. Such care is a straightforward act of charity on the physician's part, an undiluted doing of good. Its benefits are unequivocal, and it imposes costs only on the individual physician actor who fulfills this commitment.

Another traditional commitment, to advocacy for individual patients, can, perhaps, have political implications at the institutional level. Such advocacy is unproblematic, however, because a physician's obligation to an individual patient is not limited by collective welfare considerations. Obtaining a service or a study that would not otherwise have been available imposes costs and inconvenience on physicians themselves or on the institutions in which they work, perhaps even on other patients cared for in those institutions. Advocacy at the local level will lead to difficult decisions and trade-offs but, presuming that such trade-offs are carefully and voluntarily achieved, will enhance the welfare of individual patients at an acceptable cost to those immediately involved. Physicians engage in such advocacy as a natural extension of their obligation to help and heal their patients.

Political advocacy, on the other hand, generally has as its target not local resources already devoted to health care, but those of the larger polity devoted to other societal goods. As such, political advocacy is detached from the doctor–patient relationship and the individual patient advocacy that accompanies that relationship. At the societal level, it may responsibly be argued that health care deserves more collective resources—or that health care deserves fewer. That the garnering of such resources for health care might lead to better health or improved patient care is, of course, a defensible reason for physicians (or anyone else) to advocate their capture on behalf of health care. But such resources might alternatively be applied to other purposes that provide equally cogent reasons for advocacy. Physicians' special knowledge of health care needs cannot privilege their assessment of those needs in relation to other societal needs—as physicians are both relatively ignorant of other societal needs and lacking in special authority to determine that health care needs must prevail over non-health-care needs. For that reason, political debate over the use of societal resources must transcend a professional perspective; such debate ought to engage physicians fundamentally as citizens rather than merely as professionals. That physicians use societal resources for good ends cannot warrant a physician obligation to seek such resources on behalf of those ends any more than the prospect of more effective national defense could obligate soldiers to seek higher defense appropriations through political means or farmers to seek increased crop price supports. The ethics of a particular profession should enjoin caution rather than zeal among professionals advocating the professional use of collective resources. Physicians seeking the diversion of collective resources away from non-health-related social goals in favor of health care thus do not exhibit professional virtue; they are simply one more political constituency engaging in politics. That they may be doing so from the highest of motives does not alter this truth.

Those who favor mandatory physician advocacy might counter that some concrete political measures are not simply part of a family of legitimate political options. They likely hold that measures such as ensuring universal access to health care are demanded by morality and justice and, hence, must be favored and furthered. Unfortunately, even universal access to health care is not beyond political challenge. "Positive rights" to economic goods or services are much more contentious than rights to freedom from interference, such as those rights enshrined in our founding documents. Demanding that physicians advocate particular positive rights, such as a societal right to universal health care, is demanding allegiance not simply to justice but to a particular, contestable account of justice. It is to demand a politically partisan stance.

As a practical matter, despite divergent views about rights to health care, the American people have, by and large, stipulated that in our society there will indeed be such a right. This has been true throughout our history[16] and is no less true today, despite our failure to enact that right in a readily enforceable way. It would, I believe, be difficult to find any substantial body of opinion on either side of the political spectrum in the United States that would not favor that our society provide all citizens with some level of access to health care. Our collective difficulty in attaining this end is not disagreement about its desirability but over the proper means of bringing it about. That we mostly agree on the desirability of universal health care does not, however, make it acceptable to mandate its political advocacy by physicians any more than widespread sentiment against socialism among American physicians would make it acceptable for the profession to mandate political action opposing socialism as a condition of professional membership, that is if we are to be a profession—an occupation involving a particular kind of work carried out with particular normative commitments—rather than a political interest group.

Why Advocacy Is Not a University or Medical School Function

Universities, in our society, are about research and education. Their traditional tripartite mission also includes "service," but the unspoken presumption behind the inclusion of service in the university's mission is that service in the university

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will be instrumental to (or, perhaps, occur as a side effect of) research and education. Service without reference to research and education is not a university function. It is true that universities have taken on a myriad of tasks in the past 50 years that have no (or very little) clear connection to their primary mission. These tasks include achieving social change, fostering diversity, improving student morals, and preparing students for citizenship.[17] Medical school mission statements generally have been more circumspect, usually asserting the importance of research, education, and service without explicit attention to broader social ends.[18]

It is not necessarily a bad thing for some universities to assume a diversity of institutional functions in addition to their traditional ones. Research and education are not necessarily impeded by other activities going on alongside them. Nor, for that matter, are research and education immune from mutual interference if relations between them are not kept in order. Nevertheless, the activity of learning, whether in the form of extension or transmission, is what universities are about. The claim that some other task, or societal priority, is essential not for a given university but for any university, expresses a misunderstanding. Such misunderstanding is evident in the contemporary movement to task universities with "community engagement." Part of that movement has involved an attempt to modify traditional conceptions of scholarship to fit community engagement into the usual university structure of incentives and rewards.[19,20] This is an error. Some universities in specific circumstances may wish to reward certain forms of community engagement that involve neither research nor education. Such rewards will properly be offered outside of the structure of reward for scholarship. And those universities that eschew community engagement, except insofar as it furthers scholarship, will be making the eminently defensible choice to stick to the task that society has given them and that only they can accomplish.

Given academic health centers have taken on various forms of community engagement with some success, including efforts in aid of public health and of expanding access to health care. The latter end, in particular, is one that schools of medicine have limited means of achieving. Medical academicians involved in these efforts have often very naturally engaged in political advocacy, and they have inspired medical trainees to join with them. That is as it should be. But while it is one thing for individual academic centers to offer a place for health-related advocacy, it is quite another to insist that all must do so, that the advocacy must be for given ends, and that all physicians must participate. Even those most active in the movement for broader university–community engagement have not sought to make advocacy a part of that movement. Many have, in fact, made a point of stating that they seek that university–community engagement be pursued in a spirit of "academic neutrality."[21]

Such caution is a natural consequence of the need for universities to avoid entanglement in political activity. That need is self-evident to anyone sensitive to the traditional norms of scholarship: accuracy, objectivity, and truth. Medical educators have embraced these norms, as well they should; for it is commitments to objectivity and truth that justify the place of medical education in the university. The difficulty of combining such commitments with advocacy is that advocacy is often, if not always, incompatible with them. For the advocate, truth is instrumental to changing the world. Whereas the scholar seeks truth, the purpose of advocacy is persuasion with a view to action. Objectivity and truth are often sacrificed by advocates, as is all too clear in our political discourse. As Anthony Kronman[22] has observed, becoming an advocate can induce cynicism about truth seeking, and education in advocacy may convey such cynicism. The best advocates are seldom the best scholars, and vice versa. Advocacy, if made a condition of membership in the academic health center, will not simply coexist alongside scholarship; it will predictably subvert it.

The case for academic advocacy is, of course, familiar—scholarship cannot avoid political implications, and it certainly has political effects. As the university subsists on societal resources, it owes society the fruits of its endeavors, and, as political implications are implicit in any university work, there ought to be no bar to bringing such work to bear on public affairs through explicit political advocacy. As academics cannot escape politics, they may as well embrace it. The difficulty with this case is its presumption that the existence of connections between politics and scholarship warrants consciously mingling the two. That scholarship may have implications for politics does not lessen the differences between the two activities. Although advocates properly make use of scholarship, insofar as scholarship itself is infected with advocacy, it ceases to be scholarship, because "all scholarship endeavors to state something true"[22] and not to achieve social change.

The academic health center of today is a massive, unwieldy, and balkanized collection of institutions and departments; it is tenuously held together by its academic commitments—to the production and transmission of knowledge for use in clinical practice. Although service in the form of clinical practice is essential for medical research and education, the recent tendency has been for clinical enterprises in the academic health center to grow so much as to threaten the educational mission. Those who would saddle academic medicine with an advocacy mission in addition to education and research not only seek to thrust the university into the political realm, where it has no business being, but would thrust academicians into activities for which their careers have offered no preparation, distracting them from playing the roles they can and should play well—being scholars and educators.

Academic medicine will never lack for physicians interested in the bearings of health care on public affairs, and such physicians will naturally engage in advocacy. The modern discipline of public health draws on a tradition of "social medicine"—medical concern with the social causes of diseases and their amelioration—that can be traced to Virchow.[23] That tradition has always had a presence in American academic medicine, even if its influence has been limited. Those medical trainees with an interest in public affairs and public health will continue to be drawn to politically committed academic mentors, as they have been in the past. And such trainees will, perhaps, find their way into careers combining scholarship with advocacy. But advocacy must remain an occasional and optional avocation in academic

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medicine, not a universal and mandatory commitment.

Medical Community: Political or Professional?

The medical profession is a community united by explicit moral commitments and common experiences in training and in medical practice. Historically, our common commitments have shared a reference to the work that we do. We have not specified any shared political commitments, allowing these to reflect the pluralism of American society. While we have sought unity in the morality of our medical practice, we have not, at least until now, attempted to achieve such unity in our approaches to other social relationships. Although our profession is no less implicated in historical injustices than other occupational groups, we have in the past 40 years sought to include in our membership persons across the spectrum of politics, religion, and social class. As our society has become less homogenous and our moral disagreements more prevalent, we have sought to remain a "big tent," even to the extent of attenuating the morality of medicine, to which we publicly assent at the time of medical school graduation, by removing proscriptions on abortion and suicide from the oaths that physicians take.

Those seeking mandatory physician advocacy of health-related political measures wish to add a new dimension to our shared community as physicians. If they succeed, physicians will share certain commitments that are now foreign to our sense of vocation: commitments to a vision of the good life as involving political participation and to particular political goals, involving communal health, achieved through a higher level of collective effort than our society so far exhibits. Proponents of physician advocacy have not told us just what political commitments to health they regard as necessary; they have implied that physicians must actively seek more common resources devoted to health than our society has so far provided. This audacious attempt at enlarging the common commitments of the medical profession raises several questions. What kind of a community will our profession be? Will it continue to define itself primarily through adherence to the norms of medical practice? Or will it successfully transform itself into a political community, united by a common determination to achieve health at the population level through collective action?

The medical profession cannot, of course, be completely detached from politics. Its place in the larger polity must always be politically negotiated, and some physicians must represent the profession and engage with society in determining societal support of medical licensure, medical training, specialty distribution, and payment for publicly reimbursed medical work. Such engagement will inevitably reflect the multifarious character of any political activity, blending, as it must, physician self-interest and devotion to the public interest. Such inevitable medical politics should be the limit of explicitly political advocacy claiming to speak with the profession's voice (as opposed to that of individual physicians or physician groups).*

Insofar as the profession of medicine becomes a political community in the larger sense favored by proponents of mandatory physician advocacy, we will be less a profession and more a political interest group. Society will then receive from us, less clinical work and disinterested advice and more political pressure. Society will rightly be skeptical of our political agenda; it will take note of the substantial conflict of interest that will accompany any advocacy on our part for more resources directed to health care, as it should. And, insofar as advocacy infects academic medicine, society will reasonably question why public funds ostensibly devoted to education and research are now being expended in support of political causes.

Rather than embracing mandatory political advocacy, the medical profession would do better to invigorate its commitments to competent and ethical professional work and to providing society with the information and advice it needs to accomplish public purposes. These are the historic commitments of medical professionalism to society, and they remain the most certain guarantee of professional integrity in our relations with society and of societal benefit from professional activity.

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* That is, in normal circumstances. The medical profession would, of course, need to respond politically if society were to confront physicians with demands incompatible with professional identity, such as faced the German medical profession during the Third Reich, or the psychiatric profession in the Soviet Union.

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Teaching and Learning Moments

Complicated

"If people knew about the risks of all these tests, they would think twice before pressuring their doctors into ordering them."

I nodded my head in firm agreement and commiseration; now here was a patient whom I could really talk to. I was seeing Jessica for a routine annual exam in the resident clinic, and, in more ways than one, she stood out right away.

Most clinic patients spoke little English; their grasp of the nuances of modern medicine, let alone the perils of false-positive screen results and needless diagnostic interventions, was typically not very sophisticated, to say the least.

Jessica didn't quite fit the "clinic" mold in other ways either. A thin woman in her 50s, she was dressed, coiffed, and made-up immaculately; she carried a lavish designer handbag that looked a lot more expensive than the usual knock-offs I was accustomed to seeing. Suddenly I was acutely aware of the coffee stain on my white coat.

I took a complete medical history; Jessica seemed to be in excellent health. Next I rattled off the questions I routinely ask at an annual physical: Do you exercise regularly? Religiously, she answered. Do you wear seatbelts? Always. Do you feel safe in your home environment? Yes, absolutely. Do you perform a monthly breast self-examination? Every month, especially because I don't get mammograms. Do you have any concerns about …. Excuse me? No mammograms?

Jessica calmly explained that she felt mammograms were more dangerous than they were helpful; a mammogram killed her mother, she said, and she wasn't about to let one kill her too. I quickly scanned through the records of previous visits in her chart: "Mammo declined …." "Refuses mammogram today; plan to readdress next visit …." Apparently, this was not a new issue.

She went on to tell me that her mother died several years prior from complications of breast surgery for what was ultimately found to be a benign tumor, and, since that time, she had become a nationally recognized patient advocate working to reduce unnecessary medical interventions. I expressed my sincere admiration for her work and made a mental note to later Google the name of the organization she founded.

We then moved on to the physical exam.

Somehow I was not surprised when I found the mass. Hard. Fixed. Irregular. How could this intelligent and educated woman not have noticed it before? She told me she was sure it was nothing. I said I wasn't so sure.

Arranging an appointment for a biopsy with a breast surgeon was easy, but actually convincing Jessica to go was not. The more we spoke, the more suspicious I became that something wasn't quite right about the impressive stories she told about her activism and national recognition. Needless to say, even Google couldn't validate her reputation. Eventually, government conspiracy theories and other blatant paranoia crept into her diatribes. All of a sudden, Jessica's lavish grooming didn't seem stylish and elegant; it was flamboyant, bordering on flirtatious and inappropriate. Only weeks later did she finally agree to a formal psychiatric evaluation, and the depths of her psychiatric disorder were plumbed.

Ultimately, my pleading did prevail. Jessica had her tumor surgically removed. It was malignant, but fortunately, it hadn't yet spread.

As it turned out, Jessica was right after all; a mammogram was not really what she needed. She needed someone to listen, someone to understand who she was. Learning to be a good doctor can sometimes seem endlessly complicated; but every once in a while, it really isn't that complicated at all.

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Author's Note: The name in this essay has been changed to protect the identity of the patient.

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