

Letters to the Editor

Do Medical Professionalism and Medical Education Involve Commitments to Political Advocacy?

To the Editor: As pediatric residents, we take issue with Dr. Huddle's argument against training physicians in the techniques of advocacy.¹ His thesis is flawed for numerous reasons, three of which we highlight below.

First, Dr. Huddle notes that advocacy should be a civic duty rather than a professional obligation. However, it was not through our civic roles that we learned about the health impacts of childhood obesity. It was not through citizenship that we grasped the difficulties of navigating the health care system for children with disabilities. Rather, it was our profession and our patients that granted us privileged insight into these conditions. Accordingly, it must remain our professional mandate to use advocacy to address these challenging situations.

Second, Dr. Huddle draws arbitrary distinctions between permissible advocacy activities and those he deems more contentious. He notes that "advocacy for individual patients ... is unproblematic" but goes on to state that advocacy for a collective is unacceptable because "it is detached from the doctor–patient relationship." Such a view is perplexing. Why must we wait for injured infants involved in motor vehicle accidents to enter our emergency rooms before advocacy can begin? Why must we be prohibited from promoting more effective car-seat safety legislation instead? By forbidding us from being advocates for upstream solutions to avoid downstream problems, Dr. Huddle inappropriately eliminates preventive medicine from our scope-of-practice.

Third, Dr. Huddle highlights the fact that physicians currently "engage in community and political activities less often than do [their socioeconomic peers]" as a reason for continuing to refrain from advocacy. Although the reasons behind this less frequent engagement have not been fully elucidated, inadequate training in

advocacy skills may certainly be a contributing factor. If anything, abundant physician interest in advocacy, which Huddle openly acknowledges, and a concurrent lack of engagement argue in favor of universal training so that all physicians may become competent in advocacy and feel comfortable initiating and promoting positive community-based changes.

We applaud the efforts of the pediatric residency review committee to incorporate advocacy into our training. Although the thoughts we express here represent our pediatrics perspective, we suspect that doctors caring for other segments of the patient population share similar ideals. As a collective, we physicians are a powerful voice of the disabled and the sick, and as such, it is incumbent upon us to use any available tool to identify and halt all etiologies of disease, be they individual, institutional, or systemic.

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Reference

- 1 Huddle TS. Perspective: Medical professionalism and medical education should not involve commitments to political advocacy. *Acad Med.* 2011;86:378–383. http://journals.lww.com/academicmedicine/Fulltext/2011/03000/Perspective__Medical_Professionalism_and_Medical.29.aspx. Accessed April 25, 2011.

To the Editor: We wish to present a different perspective of advocacy education from that in Dr. Huddle's¹ article. To medical educators, *advocacy*

is not equal to political action or involvement in politics. Instead, advocacy education seeks to foster an awareness of the world around a patient beyond the four walls of the clinic. At the crux of this debate is the need to recognize the *social determinants of health*—the economic and social conditions that shape the health of individuals and communities. This means acknowledging the new understanding of health in which environmental, social, behavioral, physical, and economic factors contribute significantly to the health and well-being of patients. Physicians must address the problems facing adults and children in the 21st century by influencing these critical determinants of health and well-being. To do so, physicians must successfully merge their traditional clinical skills with public health, population-based approaches to practice and advocacy.

Current trainees are too familiar with scenarios in which a simple prescription is not sufficient to treat a patient's problems. Not only does an obese 12-year-old girl need antihypertensives to treat high blood pressure, but she will also need dietary and lifestyle modifications that could potentially save her life. Therefore, for trainees it is a natural extension of this broader approach to recognize the lack of safe places for children to play and exercise, the lack of quality choices of food in school cafeterias, and the challenges for lower-income children to access quality health care. Thus, it is vital that trainees learn that intervening at the population level to support local initiatives or to advocate the passage of legislative bills to improve these and related conditions is an appropriate function of a physician on behalf of his or her patients.

Here at UCLA, we have had a Community Health and Advocacy Training program for over 10 years. Our curriculum includes 12 weeks of specialized rotations, a community-based continuity clinic, longitudinal community projects, and a dinner seminar series featuring guest speakers from the community. We have also participated in a statewide coalition of 13 pediatric residency programs

focused on developing and sharing curricula for community pediatrics and child advocacy. Since 2003, we have had a one-month legislative and media advocacy rotation for third-year pediatric and med-peds residents in this program. During this month, residents are empowered to use their roles as physicians in society to improve the social and environmental conditions in which their patients live, with the goal of ultimately improving patient health and quality of life. Not only do these educational experiences fulfill “requirements” by the Accreditation Council for Graduate Medical Education, but we believe that this training also produces better doctors who are able to care for populations of patients and address the health needs of Americans in the 21st century.

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Reference

- 1 Huddle TS. Perspective: Medical professionalism and medical education should not involve commitments to political advocacy. *Acad Med.* 2011;86:378–383. http://journals.lww.com/academicmedicine/Fulltext/2011/03000/Perspective__Medical_Professionalism_and_Medical.29.aspx. Accessed May 2, 2011.

To the Editor: As young physicians, we read Dr. Huddle’s¹ article with disappointment. He not only fails to recognize public advocacy for patients as a vital professional responsibility of physicians but also ignores the achievements of generations of physician–advocates, whose voices we need now more than ever.

Advocacy is an essential physician skill, as it has been for ages. In 1849, Rudolf Virchow, a physician and the father of modern cell theory, wrote, “If medicine is to really accomplish its great task, it must intervene in political

and social life.”^{2(p323)} He would later become an advocate for better sewer systems and standardized food safety and inspection to protect his fellow citizens. More recently, physicians have led the fight to control tobacco and make motor vehicles and highways safer through seatbelt, airbag, and drunk driving laws. These achievements through advocacy complement our clinical efforts and have spared countless lives.

Becoming advocates may not interest all physicians, but those who wish to be advocates for population health should have ample opportunity. Just as all trainees are introduced to the principles of medical ethics or biostatistics to enrich their clinical careers, early medical training should cultivate advocacy skills as well. We should not fear that giving medical trainees the skills to advocate will turn them into politicians or lobbyists.

We can all agree we do not want the medical profession to be politicized. But like it or not, health care has already become entangled with politics, as recent election cycles have clearly shown. This existing politicization of medicine demands *more* effective physician advocates, not fewer. The solution: Train young physicians to represent the higher purposes of the profession in public discourse and to educate political decision makers with the best evidence. In this way advocacy provides a remedy to overpoliticization of the profession, not the slippery slope toward it.

We and many other physicians will continue to engage in public advocacy on behalf of the patients and communities we serve, without fear that this will somehow harm our professional virtue. Indeed, we harm our virtue and our patients so much more by refusing to stand up for them on public matters of health.

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References

- 1 Huddle TS. Perspective: Medical professionalism and medical education should not involve commitments to political advocacy. *Acad Med.* 2011;86:378–383. http://journals.lww.com/academicmedicine/Fulltext/2011/03000/Perspective__Medical_Professionalism_and_Medical.29.aspx. Accessed April 25, 2011.
- 2 Farmer P, Sen AK. *Pathologies of Power: Health, Human Rights, and the New War on the Poor.* Los Angeles, Calif: University of California Press; 2005.

To the Editor: As pediatricians and medical educators, we were taken aback by Huddle’s¹ recent perspective entitled “Medical professionalism and medical education should not involve commitments to political advocacy.” We strongly disagree.

Clinical advocacy in medicine is a direct response to the needs of patients. On a daily basis, the 21st-century doctor confronts illness caused by social determinants: poor nutrition (both under- and overnutrition), substandard housing, interpersonal violence, stress, commercial pressures, media influences, and poverty. To care for our individual patients, we need to be well versed in knowing how to be advocates for a wide range of resources that improve health and ensure life chances.

Group advocacy has been used successfully by doctors to bear witness to specific hazards affecting the health of populations and to create solutions. Doctors have been in the forefront of advocacy for safety caps on medication, car seats, bike helmets, HIV treatment, and on and on. Without the voices of physicians, these lifesaving interventions would not be available to patients. In fact, vigilance is needed to ensure continued funding and availability of even the most effective interventions, such as immunizations.

It is valuable for physicians to engage in legislative advocacy for improved services and access to care. A good example is early childhood intervention

programs. They are evidence based and confer protection against threats to healthy development. At birth, at least 5% of children have discernible biological limitations; by school age, more than 25% are behind where they should be, in a socioeconomically graded manner. We physicians have joined our voices with those of parents and educators and have begun to garner federal support for programs like Early Head Start and Home Visiting.

Dr. Huddle warns against professional advocacy, and we agree that some professional advocacy can be overly self-serving. On the other hand, in pediatrics, the recent threat to our children's hospitals and their training programs (by the zeroing out of funding in the president's 2012 budget) places access to specialty care for our sickest patients at serious risk. As such, pediatricians recently mobilized to protect access to care; they were driven by medical necessity, not financial contracts. When someone or something gets in the way of our doing our job for our patients, professional advocacy is justified and necessary.

Physicians inherit the results of failed public policy.² The time is *now* to bear witness to that reality.

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References

- 1 Huddle TS. Perspective: Medical professionalism and medical education should not involve commitments to political advocacy. *Acad Med.* 2011;86:378–383. http://journals.lww.com/academicmedicine/Fulltext/2011/03000/Perspective_Medical_Professionalism_and_Medical.29.aspx. Accessed May 2, 2011.
- 2 Wise PH. Children of the recession. *Arch Pediatr Adolesc Med.* 2009;163:1063–1064.

To the Editor: As a group of resident and faculty scholars in advocacy, we appreciate Dr. Huddle's thoughtful reflections on advocacy and advocacy education.¹ However, we have several serious concerns with his stance. His argument that political

advocacy is a civic virtue and not a professional one does not take into account the significant influence of the U.S. government on the current practice of medicine. While we agree that education in advocacy should not dictate particular political views, this position does not negate the need to train medical scholars in advocacy and promote political involvement for the sake of patients.

It is impractical to believe that a physician can competently perform clinical work in the U.S. system without political advocacy. Particularly as emergency physicians, daily we are faced with patients' most desperate health needs and barriers to health care. While Dr. Huddle points out that physicians may advocate and effect change for individual patients, this approach is not economically sustainable to meet the needs of every patient with barriers to care. All physicians should use research and contacts with patients to identify community-wide challenges in health care and advocate well-considered, systems-based change. Only through this approach can physicians accomplish their most fundamental duty demanded by medical ethics, thus benefiting entire communities rather than just individual patients.

While Dr. Huddle expressed his concern that advocacy education would displace clinical work and the basic duties of physicians, this is simply not true. Time and effort allotted to political advocacy may be the only way to protect the doctor-patient relationship. In the current medical climate, we physicians are often bound by preexisting mandates and laws set by individuals unfamiliar with our work. We desire to give the best care to each of our patients, but the environment in which we practice limits our ability to do so. This is why advocacy must be a part of university and medical school education. Without it, as Dr. Huddle says, advocacy "would thrust academicians into activities for which their careers have offered no preparation."

We do not argue for advocacy forced on the uninterested; however, we do propose that advocacy is necessary to facilitate the care our patients need.

There has been a paucity of advocacy education historically, but our current system requires more active participation than the "occasional and optional avocation" Dr. Huddle suggests. Through scholarly advocacy, based on objectivity and truth, we are able to provide better care to our patients. Recognizing societal challenges and advocating a system that removes barriers to health care for our patients is our responsibility as medical professionals.

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Reference

- 1 Huddle TS. Perspective: Medical professionalism and medical education should not involve commitments to political advocacy. *Acad Med.* 2011;86:378–383. http://journals.lww.com/academicmedicine/Fulltext/2011/03000/Perspective_Medical_Professionalism_and_Medical.29.aspx. Accessed June 13, 2011.

To the Editor: We read with great interest Dr. Huddle's¹ article on advocacy in medical education and practice. Most strikingly absent from his argument is the scientific research demonstrating the powerful roles social and environmental conditions play in shaping both health trajectories and health disparities. This emerging research throws an important wrench in the applicability of "traditional ethics." The ethics Huddle identifies—from Hippocrates to Percival to the American Medical Association's 1847 statement—were formulated in eras when disease was more strongly considered the direct result of health care access and quality, both of which are now known to contribute significantly less to medical outcomes than previously attributed. Based on more recent research, we know that what physicians do in clinical venues affects only 10% to, at most, 50% of health outcomes.² In light of these findings, which fundamentally change our understanding of the origins and trajectories of disease, the traditional roles of health care professionals prove inadequate. Instead, as we translate this research to practice, our roles necessarily will be directed, at least in part, outside of clinics, where powerful

social and political impacts on health can be demonstrated. This new science suggests that advocacy is, in fact, a professional virtue, not a purely civic one.

Second, Dr. Huddle suggests that advocacy education involves a mandate for partisan politicking, apparently based on the assumption that there is only one avenue through which to pursue a healthier society. Yet advocacy education and promotion do not direct the advocate toward any particular political position. There are advocates on all sides of health and social reform, representing various perspectives and approaches to social change. No calls for training in physician advocacy have recommended the partisanship that Dr. Huddle decries.

Our third critical response is nearly a cliché but bears repeating: Not acting can be interpreted as yet another political position. In fact, it may be among the most powerful of advocacy tools, as Martin Niemöller reminded us so vividly in his poem, “First they came for . . .”³ Medicine, inexorably linked as it is to money and power, is an inherently political vocation. Its stakes are literally life and death, power and powerlessness. So the choice to remain out of the political debate, however *political* may be defined, is still a choice. Educating both new and wizened health care professionals in the comprehensive armamentarium of advocacy tools available may, in fact, be a *less* partisan approach than Huddle’s absolute anti-advocacy education stance.

Finally, even Dr. Huddle’s traditional ethics include a professional responsibility to respond to society’s requests for help. Some might argue that a societal plea has been made and the medical profession has been decidedly silent.

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References

- 1 Huddle TS. Perspective: Medical professionalism and medical education should not involve commitments to political advocacy. *Acad Med.* 2011;86:378–383. http://journals.lww.com/academicmedicine/Fulltext/2011/03000/Perspective_Medical_Professionalism_and_Medical.29.aspx. Accessed April 25, 2011.
- 2 McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. *Health Aff (Millwood).* 2007;21:78–93.
- 3 Marcuse H. “Martin Niemöller’s famous quotation: ‘First they came for the Communists . . .’” <http://www.history.ucsb.edu/faculty/marcuse/niem.htm>. Accessed April 18, 2011.

To the Editor: With great interest, we read Dr. Huddle’s¹ perspective on the exclusion of advocacy as a professional responsibility, but we must respectfully disagree with his dissection of this valuable aspect of a physician’s identity. While we agree that partisan politics in medical education may not be appropriate, Huddle’s discussion blurs the line between partisanship and advocacy. Conceptualizing the role of the physician to assess, treat, and even be an advocate for individual patients without acknowledging the role physicians inevitably play to improve the systems in which they work too narrowly restricts professional responsibility. Dr. Huddle seems to suggest that a physician could be obligated to engage in advocacy on behalf of individual patients, but dismisses working toward systemic remedies. By this logic, a physician may be compelled to fight for coverage of a study for an individual patient, but is powerless to advocate systems-level redress.

Few professionals are poised to make such an impact on both individuals and society as are physicians. Medical education must embrace the full value and power of the tools at physicians’ disposal to ensure improved health and social welfare. From the development of Medicare to the Patient Protection and Affordable Care Act, physicians have played a vital role in telling their patients’ stories and advocating a more just and inclusive system. While the debate about these landmark pieces of legislation may have been politicized, the role of the physician should not be likened to that of a politician. Thus, the teaching and practice of advocacy need not be partisan.

We believe all physicians should have at least some competence in advocacy. There is a spectrum of physician advocacy activities that most, if not all, physicians engage in every day.² Given the current dysfunctional state of the U.S. health care system, it would be a tremendous disservice not to ensure that we, the next generation of physicians, are prepared to advocate in every sense of the word. Few can speak to and influence the processes that govern the factors and systems that affect individuals’ and populations’ health as well as physicians.

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References

- 1 Huddle TS. Perspective: Medical professionalism and medical education should not involve commitments to political advocacy. *Acad Med.* 2011;86:378–383. http://journals.lww.com/academicmedicine/Fulltext/2011/03000/Perspective_Medical_Professionalism_and_Medical.29.aspx. Accessed April 25, 2011.
- 2 Earnest MA, Wong SL, Federico SG. Physician advocacy: What is it and how do we do it? *Acad Med.* 2010;85:63–67. http://journals.lww.com/academicmedicine/Fulltext/2010/01000/Perspective_Physician_Advocacy_What_Is_It_and.22.aspx. Accessed April 25, 2011.

To the Editor: We respectfully disagree with Dr. Huddle’s opinion, expressed in his March article,¹ that political advocacy should not be a physician’s responsibility. From the time of Hippocrates, advocacy and service to society have been duties of physicians. Although Dr. Huddle accepts that he has an obligation to advocate on behalf of specific patients, he limits himself to this narrow commitment. What he does not acknowledge is the social contract between society and the medical profession, which gives the latter autonomy and self-regulation in return for fostering the health of society—an

activity that, at times, can include political advocacy.

Advocacy by physicians does not mean that physicians become politicians. It means that they are sufficiently aware of the determinants of health, as well as problems and resources in the specific communities where their practices are located, to know when a situation requires them to become advocates for the individual or collective well-being of their patients. Physicians are ideally placed to observe the health impacts of socioeconomic factors, which puts them in an advantageous position to promote the health of patients and communities as a professional responsibility. To go farther in political advocacy than is warranted by that professional responsibility is the physician's individual choice, which we maintain should be respected.

The kind of behavior that Dr. Huddle proposes, in which physicians turn their backs on their professional responsibilities to the health of their communities, will continue to undermine public trust in doctors and the health care system.

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Reference

- Huddle TS. Perspective: Medical professionalism and medical education should not involve commitments to political advocacy. *Acad Med.* 2011;86:378–383. http://journals.lww.com/academicmedicine/Fulltext/2011/03000/Perspective_Medical_Professionalism_and_Medical.29.aspx. Accessed April 25, 2011.

In Reply: I am happy that my article has provoked a spirited response among readers of *Academic Medicine*. Several correspondents (Banack; Stull; Sud) mistakenly suggest that I oppose society-level advocacy by physicians. I question

not the legitimacy of such advocacy but whether it is a necessary aspect of professional identity. Halliday et al. seek a middle ground on the necessity of physician advocacy: the exigencies of social need make such advocacy not entirely optional; at the same time, not all physicians need engage in it. I agree with Halliday that some (not all) physicians with the requisite aptitudes and inclination would do well to take on advocacy roles. I fear, however, that a middle ground between “optional” and “required” may prove illusory. A more peremptory stance on advocacy for social change, requiring it of all physicians, emerges from several other letters.

The argument for this stance goes: Patient health is a norm that should govern physician action (Gottlieb). Social factors loom larger than medical interventions in determining population health (Gottlieb; Kuo; Palfrey). Physicians, to be true to their identity, must, therefore, be advocates for social changes that would further health (Gottlieb; Kuo). Such advocacy ought not to be regarded as political (Kuo) or partisan (Gottlieb; Stull). Or if it is political, that is OK because medicine is “inherently political” (Gottlieb) or has become politicized (Schickedanz), and, anyway, not advocating is a political stance (Gottlieb).

The difficulty with this argument is not in the premises, but in the inference from the causes of ill health to a physician's *obligation* to advocate. There is no necessary connection between the underlying causes of problems addressed by an occupation and the accepted scope of that occupation's work. While physicians are necessarily committed to the health of their patients, there are compelling reasons why physicians ought not to regard the achievement of societal health through the political process as a similarly necessary part of their mission. The determination of measures that will achieve given societal health benefits may be a matter of medical expertise; weighing those benefits against their costs in

other goods foregone is not. Such weighing involves normative judgments that physicians make with no more authority than do other citizens. That being the case, professional morality does not (and must not) demand that physicians always favor spending more resources on health and less on, say, pensions or police.

For some physicians, professional and political identities join together. For others, politics remains separate from professional work. Citizens who happen to be physicians may or may not prefer additional increments of societal health to alternative goods when choosing among such goods in the political arena, and any such political preference is perfectly legitimate. That being so, it is a usurpation of our political prerogative as citizens to insist that we as physicians *must* be advocates for more resources aimed at health or health care rather than at competing goods in any given political context.

Contra Kuo, Gottlieb, and Stull, advocacy aimed at increasing health at the societal level inevitably involves contestable political stances and will, in the absence of societal consensus, inevitably be “political” and partisan. Our profession is, of course, politically situated. It does not follow that we should politicize it (or politicize it further) by instituting mandatory physician advocacy. Many physicians who engage in health-related political advocacy are doing the best they can for society and deserve nothing but praise for that work. Others do what they see as their best by conducting their clinical work according to professional norms and engaging in politics (or not) outside of medicine. That is also a legitimate choice. Let's allow those physicians who so choose to leave their politics at home when they don their white coats.

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