

# Physician-Citizens—Public Roles and Professional Obligations

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**L**EADERS AND OBSERVERS OF THE medical profession have recently urged greater engagement of physicians in the public arena.<sup>1-9</sup> Three compelling reasons have been given. First, community and socioeconomic characteristics affect many health problems and access to health care; second, physicians' expertise is essential for properly addressing major quality, access, public health, and policy concerns; and third, clear and visible leadership in the interests of the public's health is regarded by many as the best way for the medical profession to regain and retain the public trust that has diminished in recent decades.<sup>6,7,9,10</sup>

For centuries, physicians have been involved in solving health problems in the community.<sup>11</sup> Public roles, however, have become less familiar to physicians because the medical profession has forged its expertise, identity, and influence on remarkable advances in biotechnology.<sup>12</sup> Consequently, in answering calls for greater public engagement, physicians may face unfamiliar challenges, such as broadening their focus to include communities of patients, addressing illness prevention, as well as its treatment, and accepting responsibilities outside regular practice settings.

Practice changes, increasing demands, and declining reimbursements have affected physicians' morale and may have discouraged public-spiritedness.<sup>13</sup> If calls for public engagement are to be effective, there must be a clear and justifiable definition of public roles, reasonable limits

to what can be expected, and clearly outlined tasks that are compatible with busy medical practices. In this article, we provide a framework for addressing these issues. By doing so, we aim to stimulate dialogue about the appropriateness of such roles and, ultimately, to facilitate physician engagement with pressing health issues in the public arena.

**Although leaders and other commentators have called for the medical profession's greater engagement in improving systems of care and population health, neither medical education nor the practice environment has fostered such engagement. Missing have been a clear definition of physicians' public roles, reasonable limits to what can be expected, and familiarity with tasks that are compatible with busy medical practices. We address these issues by proposing a definition and a conceptual model of public roles that require evidence of disease causation and are guided by the feasibility and efficacy of physician involvement. We then frame a public agenda for individual physicians and physician organizations that focuses on advocacy and community participation. By doing so, we aim to stimulate dialogue about the appropriateness of such roles and promote physician engagement with pressing health issues in the public arena.**

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To that end, we define physicians' public roles as advocacy for and participation in improving the aspects of communities that affect the health of individuals. Our definition focuses on communities but does so by considering the attributes that affect the health of individual patients. Physicians are members of a variety of communities—professional, social, local, regional, national, and global—and each physician's involvement in and obligation to each community varies. But all physicians have a primary ethical and professional responsibility for the health of the community members they serve. Local, state, or national physician orga-

nizations that promote the ideals of professionalism have similar ethical obligations to their respective populations, and almost all physician organizations articulate that obligation in their mission statements.

This definition also appeals to the growing evidence base associating individuals' health outcomes with social, economic, and environmental characteristics. Examples of ways in which these socioeconomic factors are important include influences on access such as geographic locale, transport availability, and insurance status; behaviors such as smoking and needle sharing that correlate strongly with particular socioeco-

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conomic subgroups; risks in an individual's environment, such as polluted water and road hazards; and broader characteristics such as race, income, and unemployment. Many physicians have been active in defining these associations. Implicit in the definition is the need for physicians to be familiar with this evidence and to contribute to new knowledge through practice-based data collection and research.<sup>14</sup>

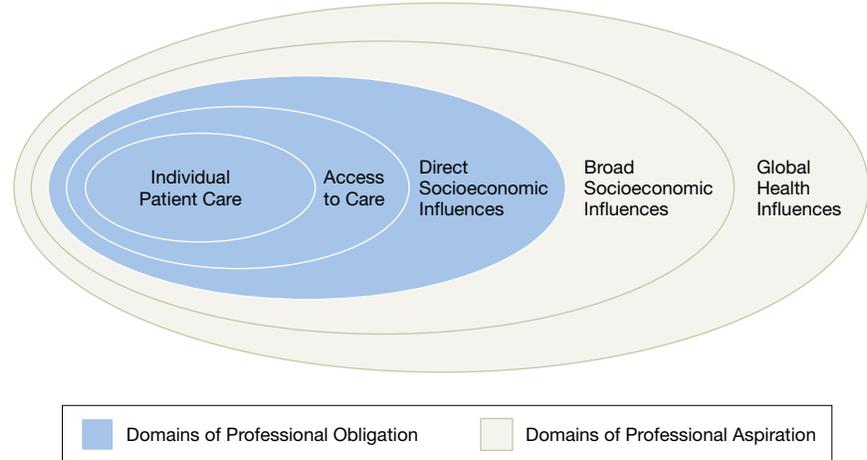
Furthermore, the definition reflects physicians' ability to be public "witnesses" to socioeconomic determinants of their own patients' health. Physicians are ideally placed, and perhaps uniquely so, to observe the health effects of socioeconomic factors or detect when such factors compromise their patients' care. Physicians can also provide the sort of information and professional authority that brings veracity and legitimacy to these concerns in public debate.

### Professional Obligations vs Aspirations

The notion of professional responsibility is derived from an understanding of professions in modern society. Most parties—including the professions and those who study them—agree that the relationship binding the professions and society is a type of social contract.<sup>15</sup> In this contract, society grants the medical professions—comprising individuals and their collective associations—special social status and certain privileges such as monopoly use of knowledge, practice autonomy, and the right to self-regulate. In return, the medical profession is expected to promote society's health.

Whether right or wrong, most members of western societies expect physicians to be the key to the health of individual patients and expect physicians to do everything within their means to reduce each patient's burden of illness. Physicians, for their part, usually regard discipline-based expertise as encompassing all aspects of illness and its treatment. Physicians and the public are likely to agree that physician expertise includes not only the biological aspects of disease but also its social, environmental, and economic relations.

**Figure.** Model of Physician Responsibility in Relation to Influences on Health



The ways in which socioeconomic factors influence individual patients' health are shown in expanding domains, depicting the proximity of each to physicians' core responsibility for patient care. Physicians have professional obligations to promote access to care and address socioeconomic factors that directly influence individuals' health (eg, smoking, road safety, interpersonal violence, housing conditions that cause disease), according to evidence of illness causation and feasibility of physician action. Aspirations for improving broader health determinants (eg, local or global disparities in income, education, or opportunity) are laudable, but physicians' responsibilities in these domains may not be sufficiently different from those of other citizens for them to be recognized as professional obligations. As evidence changes, however, issues may move from one domain to another.

However, myriad socioeconomic factors may affect health and health care outcomes, making any attempt to tackle these issues daunting. Ischemic heart disease serves as a good example. Differences in access to state-of-the-art treatment have been associated with insurance status, race, sex, income, and physical proximity to services.<sup>16</sup> Potentially modifiable behaviors associated with disease progression include smoking, nutrition, and exercise. Social characteristics associated with poorer outcomes include low educational attainment, poverty, and unemployment. Globally, the availability and affordability of cardiac services are affected by the overall distribution of resources. Although physicians should not be discouraged from addressing any public issues, it is reasonable to ask where a physician's responsibility ends. The challenge lies in distinguishing professional responsibilities from pursuits that, although laudable, are better considered aspirations.

We propose a model to encapsulate these issues and to conceptualize the possible boundaries between physi-

cians' professional obligations and aspirational goals (FIGURE). At the center of the model is physicians' undeniable core responsibility to provide high-quality care to individual patients in their regular practice. The socioeconomic influences that affect the health of each patient are organized in concentric domains, reflecting their relative relationships to the care of individual patients and physicians' spheres of influence. Immediately outside the core responsibility of individual patient care lies the obvious impact that access to care has on health. Systemic characteristics that influence access include, for example, insurance coverage and availability of care for uninsured patients, availability of after-hours care, geographic distribution of services, access for disabled patients, and appropriate signage and use of interpreters for non-English-speaking patients.

Beyond access to care exist further domains of socioeconomic influences on health. We separate them into 3 areas differentiated by how directly they relate to the health of individual pa-

tients and the feasibility and efficacy of physician involvement. The innermost of these domains includes socioeconomic issues relating most directly to health. Public policy about cigarette smoking is a typical example from this domain. Giving advice about smoking cessation within a clinical encounter is part of individual patient care and belongs in the center circle. Taking a public stand on smoking policy to reduce cigarette consumption in the community of patients belongs in the domain of direct social influences on health. Other similar public policies include the use of bicycle helmets to prevent head injuries and the availability of clean needles to prevent blood-borne diseases. They are policy areas in which the link between policy and health is well established and in which physicians' involvement is feasible and potentially effective.

Further outward in our model lies the domain in which socioeconomic factors are clearly associated with health status, but the evidence of causality of illness in individual patients is weaker, or the feasibility or efficacy of physician action is less clear. Here is located the effect of disparities of income, education, housing, and exposure to environmental pollutants on health. The outermost domain contains socioeconomic influences on health at a global level. Here the focus is on the health effects of the global distribution of resources, knowledge, and opportunity.

Although it can be argued that the broader social determinants of health in the outer domains of our model may have a greater overall impact on the health of communities than more narrow and targeted areas such as tobacco use, the evidence of direct causation is less clear, often making it impossible to determine the fraction of health problems or disparities that are attributable to these broader influences.<sup>17</sup>

By using this framework, it is possible to address where the boundary should exist between professional obligations and professional aspirations. The distinction is based on evidence of causation of illness in individual pa-

tients and the feasibility and efficacy of physician action.

Associations between socioeconomic factors and health that fall into the inner 2 domains—access and direct determinants—should be considered professional responsibilities of physicians. Given that the quality and outcomes of patients' care so directly depend on good access, promoting health system improvements that reduce barriers to access should be professional responsibilities of all physicians, individually and collectively. Direct social determinants, such as smoking or wearing bicycle helmets, have a good evidence base connecting them directly with health outcomes and operate clearly through individual patients. They are issues in which physician advocacy, directed toward potential patients and policy makers, is likely to have some impact. They are issues on which society expects physicians to hold and articulate a public position.<sup>18</sup>

Physicians may be effective working in the broader policy areas of the 2 outermost domains of our model.<sup>19</sup> Here, however, the evidence linking socioeconomic factors with individual patients' illness is less direct, and societal expectations of physician involvement may not be sufficiently different from that of regular citizens to warrant their inclusion as formal professional obligations.

In its delineation and separation of policy areas, our model is meant to be flexible, allowing for progress in scientific knowledge, changes in evidence of causation, and further deliberation by society and the profession on what should be expected of physicians. Some socioeconomic issues may seem at the current state of evidence and societal understanding to be neither directly related to health of individuals nor directly amenable to individual action. As we learn more, however, and as we engage in an ongoing dialogue with society, some socioeconomic issues may move from outer to inner circles, from aspiration to acknowledged obligation.

Two key points require reiteration. First, physicians have professional re-

sponsibilities that require them to engage in activities and processes beyond the office setting. Second, because these responsibilities are open ended and in many ways limitless, the role of each physician is to choose some activities that are consistent with his or her expertise, interests, and situation.

### **Advocating for and Framing a Public Agenda**

The model can help individual physicians and their professional organizations identify a public agenda that relates to their actual and potential patients. We encourage consideration of professional responsibilities in 2 main areas. The first is to promote systems of care that ensure that all patients in their community have access to needed care. The responsibility for improving health systems entails working with other physicians serving that particular population and addressing the root causes of poor access, which may include lack of health insurance, lack of interpreters, and poor transport services. It may also entail political or grassroots advocacy to bring about changes in the structure of the health care financing system.<sup>20</sup>

A corollary to this first obligation is the responsibility to address the rising costs of health care, which are a key threat to access. Physicians must review their own clinical practices and work with other physicians systematically to address discrete areas such as administrative costs, pharmacy use, or radiology costs and perhaps even engage in debates about pricing. To advocate access without reviewing the costs over which we have so much control would be hypocritical.

The second public obligation of physicians is involvement in addressing socioeconomic factors most directly associated with poor health outcomes. Physicians may be drawn most to action in their own fields. For example, cardiologists may be most interested in helping to reduce cigarette smoking or to improve education about exercise, pediatricians may be interested in supporting programs for immunization or preventing child abuse, trauma sur-

geons may be interested in bicycle helmet and seatbelt use, and oncologists or dermatologists may be interested in programs to prevent skin cancer. Some physicians may work in settings in which broader issues, such as housing quality, more directly affect their patients' health and therefore confer greater physician responsibility. An example is improving conditions in housing developments for low-income individuals, where there is a high prevalence of childhood asthma.

Physicians may find that multiple issues in the public arena fall within their professional responsibilities. The model will actually demand more of physicians working in lower-socioeconomic-status areas. Although this demand may be appropriate in terms of health priorities, it is unfair for such physicians to shoulder the burden alone. Physician organizations are also responsible for this agenda, and it is particularly through them that physicians in more affluent areas can support the work of their colleagues.

A clear conceptual understanding of professional responsibilities should increase physicians' willingness to be part of the solution to pressing health problems in society.<sup>21</sup> To be an effective part of the solution, however, physicians will have to become skilled at advocacy and public participation.

To advocate is to "publicly defend, maintain, recommend, stand up for, or raise one's voice on behalf of a proposal or tenet."<sup>22</sup> Physicians are natural advocates not only because of their special knowledge, perspective, and proximity to health issues but also because of their public influence.<sup>9,23</sup> However, most physicians are more familiar with advocating for the needs of individual patients and their own needs. In contrast, public-interest advocacy can be defined as "the pursuit of influencing public policy and resource allocation decisions within systems and institutions (health, social, political and economic) that directly affect people's health."<sup>24</sup>

Advocacy and participation represent a spectrum of activities within and outside a physician's regular practice

### **Box. Examples of Advocacy and Participation**

#### **In Regular Practice Settings**

- Raising awareness among patients and colleagues about a pressing issue through informal discussions, a seminar, or other forum
- Working informally with others to improve systems of care within an institution
- Supporting an institutional initiative or outreach directed at patients in their community setting
- Improving access for minorities by advocating appropriate signage and interpreters
- Volunteering and offering free care

#### **Outside Regular Practice Settings**

- Raising public awareness about a health or social issue by discussing it with family and friends or participating in a public forum
- Writing a letter, signing a petition, or participating in another form of public advocacy and lobbying
- Working informally with others to solve a health problem in the community
- Encouraging a medical society to act on an issue that concerns the public's health
- Organizing and forming a group for political advocacy
- Voting in a local or national election
- Serving in a local organization, political interest group, or political organization
- Attending a rally or protest or participating in a boycott
- Working on a campaign for a candidate or issue

(BOX). Within one's own practice setting, examples include involvement in improving immunization rates in a group practice, developing mechanisms to enhance care for individuals without insurance in the local catchment area, improving access through practice strategies such as the provision of free care to the poor, and enhancing cross-cultural communication with minority patients. Much of this advocacy and participation amounts to better patient care guided by evidence of the social context of disease.

Physicians may be just as effective in activities outside their normal practice environment. Advocacy may be as simple as writing a letter to a newspaper, posting a comment on a Web site, or asking a question at a meeting.<sup>5</sup> Alternatively, it may involve engagement with other health professionals, leaders, community groups, or the political process. Political activities, broadly speaking, are those that are intended to alter understanding, beliefs, practices, and policies in external institutions, communities, and government.<sup>25</sup> Even talking to patients, colleagues, or lay people about a pressing health issue when the intention is to modify opinions and facilitate

change is an inherently political activity. Physicians should be reassured that even small actions can be influential, that political involvement is more than just voting in elections, and that these activities are important and admirable aspects of citizenship. The practicing physician should be able to choose from a range of strategies, such as those listed in the Box, that suit his or her particular situation and take into account primary responsibilities of individual patient care.

Physicians must realize that they also share goals in common with other members of the profession and that, although individual action is laudable, collective action is a hallmark of professionalism. Physician groups have been particularly effective agents of change in institutional issues, local community matters, legislative action, and much broader issues, such as civil and human rights, prevention of nuclear war, and the banning of landmines. These larger movements have shown physician advocacy to be most effective when it has a specific goal, a clear message, good supporting evidence, collective action, and participation in the political process.

Established medical organizations have taken on the role of public-interest advocacy to various extents. Some have effectively influenced tobacco legislation and public safety concerns, for example. These organizations also have other important roles, however, such as promoting physicians' welfare, which may conflict with or be perceived as conflicting with genuine promotion of the public's health.<sup>10,26</sup> Collective advocacy is greatly supported by national organizations that help people articulate and work toward goals in all circles of our framework. Although existing organizations have important advocacy roles, other less formal collectives may be as effective, particularly for addressing local issues. Physicians must therefore be prepared to organize around a common issue if no other effective advocacy body exists.

Public-interest advocacy projects are often coordinated by other groups, and physicians can fulfill their public responsibilities by providing support. Successful collaborations with consumer groups and public organizations have resulted in improvement of coordination between agencies, provision of care for disadvantaged populations, attention given to public health issues, success of health promotion initiatives, and the political impact of community-voiced concerns.<sup>27</sup>

### Conclusion

In this article, we have attempted to bridge the gap between rhetoric and reality—the rhetoric of social responsibility espoused in aspirational statements of professionalism and the realities of medical practice and the mechanisms by which social factors affect the health and care of patients.

In busy practices, finding opportunities to exert public influence will always be challenging. The first step is ensuring that physicians are willing to act within their means. The second is fostering public-mindedness in institutions and among colleagues. Although most public roles are not reimbursed directly, they can and should be considered aspects of patients' care.

We have framed public roles as issues of evidence and professionalism, not as matters of individual political persuasion. Because patients and physicians are likely to benefit, public roles should not be considered as being antagonistic to individual patient care, and they do not mean acquiescing to the demands of managers and bureaucrats. Instead, public roles are an example of the profession taking charge of its domain—promoting the health of its patients despite the adverse effects that broader social forces, including health and social policy changes, may have on patient care.

Successful advocacy requires clarity of purpose, good data, and effective strategies. It relies on promotion of the skills and attitudes of good citizenship in medical education.<sup>25,28</sup> Even with the right tools, however, the expectations surrounding public roles must be reasonable, and we have offered a means of differentiating professional obligations from aspirational goals. We hope to stimulate discussion about public roles that are compatible with medical practice and that are ultimately in the interests of patients, physicians, and society as a whole.

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