Global Essay Competition 2024

Title: “Natural Attorneys of the Poor”: How a New Social Contract Could Address the Scarcity of Physician Advocacy

Essay:

Introduction

It is time for society to make better use of physicians to address health inequalities. A physician, or medical doctor, is a “natural attorney of the poor” according to the 1800s German Pathologist Rudolf Virchow, who is known as the “Father of Social Medicine” (Arya, 2013). Virchow believed that it is the physician’s role to advocate for their patients beyond the consultation room to address the poor living conditions worsening their health, conditions which today are referred to as the social determinants of health (Lange, 2022). Sir Michael Marmot, Professor of Epidemiology and Public Health at University College London, has demonstrated through a lifetime of research that a social gradient of health outcomes exists, with one’s position on this gradient pre-determined by factors such as education, housing, income and employment (Marmot, 2005). Such social determinants create health inequalities between rich and poor, precisely along a gradient.

During each consultation, physicians observe the ‘symptoms’ of this social gradient. Through careful assessment, a physician can identify preventable social determinants that worsen the health of their patients and community. Physicians operate at the ‘coalface’ of the social determinants of health. It was this very proximity to patients that Rudolf Virchow saw as an opportunity for physicians to harness their civic reputation as knowledgeable and trustworthy to advocate for policies and resources needed to address the social determinants of health (Paul, 2019). Whilst Virchow saw advocacy in the 1800s as integral to a physician’s duty to society, sociocultural forces and healthcare fragmentation have since diminished its feasibility for physicians today. Consequently, a scarcity of ‘Physician Advocacy’ is limiting society’s ability to address health inequalities. This essay proposes that re-defining the role of physicians through a multisectoral driven ‘social contract’ will create the conditions needed to boost Physician Advocacy.

What is 'Physician Advocacy'?

Rudolf Virchow deeply embodied Physician Advocacy; in fact, he eventually became a parliamentarian to greater tackle policies affecting health outcomes (Lange, 2022). Whilst a life in politics is not on the agendas of many physicians, there is a broad spectrum of avenues in which physicians can advocate at a patient, community or structural level to improve health outcomes (Paul, 2019). At a patient level, a physician providing a medical certificate for their patient's employer is a simple means of advocating to protect that patient's employment while they are unwell, thereby recognising its importance as a social determinant of health. When a physician travels to isolated communities to undertake health checks, they are engaging in community-level advocacy to ensure the health of these patients is not neglected. For that same physician to lobby politicians and powerbrokers to better resource that isolated community typifies structural level advocacy (Paul, 2019). Some of this advocacy is "open" in the public domain, whereas other forms remain "closed" (Bagshaw & Barnett, 2017). The multi-levelled spectrum of Physician Advocacy is represented by Warwick et al (2022) as "action by a physician to promote social, economic, educational and political changes that ameliorate the suffering and threats to human health and well-being that he or she identifies through his or her professional work and expertise". With this clearly articulated definition, Physician Advocacy is a valuable resource which can be harnessed to tackle social disadvantage contributing to health outcomes.

The Power of Physician Advocacy in Tackling Social Disadvantage

"Medicine is a social science, and politics is nothing more than medicine on a larger scale" (Mackenbach, 2009). Rudolf Virchow's words establish the unique proximity of physicians to their patients and, hence, their ability to identify the 'symptoms' of resource allocation and policies affecting their patients' health (Fried et al., 2019). Whilst many occupations can aptly identify social disadvantage and its negative health implications, physicians have a unique civic reputation for being knowledgeable and trustworthy that can be utilised for advocacy purposes (Paul, 2009). There is an expectation by society that physicians will act in good faith, bound by an ethical code of duty to their patients (Levinsohn et al., 2017). The perceived authenticity of a physician's signed 'medical certificate' when a patient is unwell is testament to their civic reputation. In recent years, the COVID-19 pandemic highlighted the public's willingness to listen to the opinions of physicians in a time of crisis (DeGrazia et al., 2022). Through society's trusting perception of physicians, Physician Advocacy provides a potential conduit between patients' social determinants of health and the political decisions that shape them. Rudolf Virchow identified and harnessed this principle. Yet, despite Virchow's vision for advocacy to be the cornerstone of physician practice, evolving sociocultural forces have created a 'scarcity' of Physician Advocacy in the 21st century.

How did Physician Advocacy become a 'Scarcity'?

Rising individualism and healthcare fragmentation have created a challenging environment for Physician Advocacy, which as a resource for improving health outcomes, has become a scarcity. Bagshaw & Barnett (2017) argue that Physician Advocacy began declining from the 1950s as an increasingly consumer-oriented medical marketplace was partnered with a "proletarianized" employer-employee dynamic; consequently, healthcare infrastructure became more fragmented globally. Many physicians acquired several employment contracts with blurred boundaries of loyalty and the risk of professional consequences if lobbying against the interests of an employer (Bagshaw & Barnett, 2017). This dwindled the autonomy needed for 'open' Physician Advocacy. Concurrently, a cultural rise in neoliberalism and an emphasis on "individual responsibility" shifted the focus of physicians towards curative treatment, away from addressing the social determinants of health (Carpenter, 2000), a key precursor for Virchow's style of Physician Advocacy.

Despite these external forces, surveys conducted amongst the physician community suggest there is a motivation to engage in advocacy, particularly since the COVID-19 pandemic (DeGrazia et al., 2022). At the training level, medical schools are increasingly incorporating 'advocacy' into their selection criteria, curriculum, and assessment (Brender et al., 2021). Furthermore, the physician community is attempting to give graduates a toolbox of skills to best advocate for their patients in a multi-levelled way. A remaining challenge is to translate students' motivation and preparedness for advocacy into action following graduation from medical school. Self-reporting by American Physicians indicates a 75% decline in advocacy engagement of any kind from medical school to employment as a physician (Fried et al., 2019). Many physicians reported barriers to 'advocacy work', once employed, included limited professional time, conflict of opinion with employers regarding policy making, fear of losing objectivity and the most reported limitation, fear of damage to personal and professional reputation (Warwick et al., 2022). Clearly, a dichotomy exists between the ideals of medical school graduates and their reality.

Through sociocultural forces of rising individualism and healthcare fragmentation, physicians of today have extensive barriers to engaging in advocacy. Admittedly, 'Physician Advocacy' is not a simple solution to ameliorate the conditions which are worsening their patients' health and widening the gap in health outcomes between the rich and poor: however, its scarcity is limiting society's true potential to tackle these problems. The professional community of physicians today widely aspires to Rudolf Virchow's ideal that they be "natural attorneys of the poor" (Arya, 2013); how can we as a society create the conditions needed to support them in this quest?

A Social Contract to Re-define the Role of a Physician

To confront today's scarcity of Physician Advocacy, it is proposed that a redefinition of the perceived role of a physician is needed to reduce the existing barriers they face in advocating for their patients. The non-clinical forces responsible for these barriers necessitate multisectoral, non-health dialogue, across business, government, education and technology industries. A prerequisite for this dialogue would be an understanding of the potential utility in Physician Advocacy to identify the social determinants that worsen health outcomes. This, too, requires an acceptance of the contribution these determinants have on health inequalities along a social gradient. Within this context, diverse cross-sectoral approaches to incentivising Physician Advocacy could be brainstormed, with the hope of creating a "culture of advocacy" amongst physicians, as proposed by Fried et al (2019). For instance, how might an economist better incentivise structural-level Physician Advocacy in a busy fragmented healthcare landscape? What are the views of policymakers on increasing dialogue with physicians? A culmination of such discussions could inspire a 'social contract' or commitment to the betterment of society, across non-health industry experts, to position 'Advocacy' at the centre of society's expectations of physicians.

Ultimately, Virchow himself recognised that, whilst physicians may be able to identify the causes of social disadvantage through their patients' symptoms and narrative, it was those in politics and other sectors of society who are best placed to rectify these problems (Loh & Rajaram, 2020). This same logic can be applied to crafting a social contract across non-health sectors to facilitate a culture of Physician Advocacy. Through boosting Physician Advocacy, this social contract is likely to better maintain a free-flowing channel of intelligence from the patient consultation, social determinant identification by physicians and political action to address social inequalities. Even with the best multisectoral intentions of such a social contract, it is inevitable that physicians will identify hurdles associated with its implementation.

Limitations of Trying to Boost Physician Advocacy

Fried et al (2019) acknowledged that "all clinicians confront patient needs they cannot meet within the confines of the clinical encounter". As well as physicians feeling time-pressured in the existing healthcare system, the extensive stratification of medical specialities has created a dynamic whereby many physicians do not venture across their scope of practice (Loh & Rajaram, 2020). For some physicians, 'advocacy work' may be left to 'public health doctors'. Other physicians may prefer to 'just treat' patients (Bagshaw & Barnett, 2017). In an environment of individualism and healthcare fragmentation, with the existing barriers in place, advocacy has not played a central role in the working life of many physicians, an anathema to the working life of Virchow. The physician community, albeit

motivated to ‘advocate’ for patients, may be divided in re-defining society’s expectations of them. This highlights the need not only for a multisectoral dialogue, but also intergenerational engagement across industries to match profound experience with youthful optimism and enthusiasm about the utility of boosting Physician Advocacy to address social disadvantage. For instance, how do younger generations perceive physicians? Do older generations see advocacy as beyond the scope of physicians? A shared understanding across generations about the benefits of Physician Advocacy would strengthen any potential social contract that re-defines society’s expectations of physicians into the future.

Conclusion

Re-defining the role of a physician to boost Physician Advocacy would be a significant challenge. However, the scarcity of Physician Advocacy today, a product of sociocultural forces and healthcare restructuring despite the physician community’s best intentions, necessitates a multisectoral, intergenerational dialogue to remedy this imbalance. Physicians are at the coalface of the symptoms of social disadvantage and operate within a civic expectation of trustworthiness and knowledge which often precedes them. As such, they are well placed to not only identify the causes of social disadvantage contributing to health inequalities, but to take these causes and advocate to address them. At an educational, healthcare and governmental level, an advocacy culture can be fostered. But it is re-defining the role of a physician, through the ideas and values of various sectors of society, that will best facilitate boosting Physician Advocacy into the future. A ‘social contract’ or commitment amongst non-health sectors and across generations will provide the conditions needed to make advocacy central to the role of a physician, rather than cast aside for those ‘in public health’. Whilst Physician Advocacy is certainly not a simple solution, our society, particularly the most vulnerable, will be best served when their ‘natural attorneys’ are advocating for them.

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