Why we are where we are: Considering medicine's political history and theory

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Abstract

Medical advocacy is a core component of undergraduate medical education. The importance of advocacy has been highlighted by the SARS-CoV-2 pandemic, which made social determinants of health a core part of political discourse. The relevance of medical advocacy requires an understanding of the history and political theory of medicine. This can inform future advocates, ensuring that medicine's role in politics is effective. The goal of this commentary was to review research around medicine's political history and theory, and the current state of medical advocacy. A literature search was conducted on PubMed, using terms including "advocacy", "history", "politics", and "theory". 39 journal articles, position statements and letters to editors discussing medical advocacy, politics, and history were reviewed. Many were specific to sub-specialty advocacy or niche historical examples of medical advocacy. 22 articles contributed to a narrative understanding of medical advocacy by establishing a historical trajectory, describing a set of normative values, or contemplating the current state of advocacy. Tracing the historic trajectory for medical politics demonstrates that medicine has not always inhabited the political role it does today. Before the form of advocacy practiced currently, medicine was governed by a responsibility to the state, not a responsibility to patients. There is contention nowadays regarding the extent that advocacy should dictate medical practice and inform physician responsibilities. Further discussion and education around the profession on the physician's role as advocate is necessary for advocacy to be effective. This requires advocacy training with goals decided by various community members, along with an understanding of the boundaries of medial advocacy.

Keywords: advocacy; medical education; history; politics; social determinants of health

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Introduction

Medicine's role in politics, commonly manifesting as advocacy, is complex and ever-changing. Physicians and medical institutions wield influence and power. This is evident today as the SARS-CoV-2 pandemic has thrust physicians into the spotlight. They are in the headlines, advising policymakers, and communicating to the public. Some are now involved with partisan politics, public policy, and decision-making around conditions within communities. Many medical students are aware that medicine is political, but not why it is political or how this has changed. Students across Canada can recall the CanMEDS "Health Advocate" competency.[1] Some are given formal instruction on medicine's role in colonialism. Here in Manitoba, medical students even lobby members of the Legislative Assembly of Manitoba on an annual basis. However, the roots of medicine's role in politics should be elucidated to navigate its future. This commentary traces the development and philosophy of Western medicine's political history, and how its norms and goals have changed over time. It will also consider the current state of medical advocacy and politics in medical education, as well as the future of medical advocacy.

Medicine in political thought, politics in medical thought

The term "medicine" is used here to describe the institution of medicine, including physicians, medical schools, and regulatory bodies. "Medicine's role in politics" describes medicine's overarching goals within the state, such as alleviating physical and societal ills. An example of this is the CanMEDS "Health Advocate" competency, which asks physicians to "understand [patient and population] needs... and support the mobilization of resources to effect change."[1] "Medicine's role in politics" also describes how medical concepts influence political theory. This survey of medicine's role in

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politics will first focus on medicine's influence on political theory, and then medicine's institutional goals within the state. Later, the term "advocacy" will be interchanged with "medicine's role in politics."

Medical ideas have influenced political thought at a macro, theoretical level as far back as Plato's *The Republic* (375 BC). In *The Republic*, Plato seeks to describe the ideal political society and the individual's role in it. This society is a city-state called a "polis." [2] Plato compares stable and unstable states using the terms "healthy ... and [describing] the more complex polis as feverish." [3] At the theoretical level, a medical understanding of function and stability informed Plato's evaluation of the state. Foundational political thought "posited the nation as an object for medico-political mastery" even in the far reaches of Western political history. [3] Thomas Hobbes constructed another landmark in political thought with *Leviathan* in 1651. [4] *Leviathan* professes that when humans are ungoverned, they exist in a "state of nature" and that life is "nasty, brutish and short." [4] This state of nature can only be avoided with a strong government. Hobbes conceives of this state or "body politic" as "an artificial man, though of greater stature and strength than the naturall [*sic*] ... every joynt [*sic*] and member is moved to performe [*sic*] his duty." Magistrates are described as joints with reward and punishment as nerves. Riches are described as musculature and strength. [4] They are necessary for the "body politic ... itself an articifiall [*sic*] man ... [to] ... promote both political power and political health." [3] Medical thought has influenced some of the most important Western political texts. In turn, these texts have influenced the course of Western political thought.

This influence can be demonstrated throughout history. Many assessments of medicine's political history center on Rudolf Virchow, the father of germ theory. [5–7] He declared that "physicians are the natural attorneys of the poor, and social problems fall to a large extent within their jurisdiction." [7] Virchow's germ theory is influenced by politics. His description of "the body as a social organization ... of mutually dependent individual existences ... indicates that the organic view of the nation had by then become second nature." [3] The medico-political thoughts of Plato and Hobbes informed medical conceptions of the state, and Virchow's understanding of our own cellular composition.

The political responsibilities of doctors

Medicine and politics are historically intertwined. While medical concepts informed the growth of political theory, they did not always influence political decision-making. Instead of serving patients due to a purely moral obligation, physicians served as agents of the state, and were tasked with policing the health of the growing populace. As states grew and entered the Industrial Revolution, they asked more of the medical profession, including the development of "water purification, sewage disposal, sanitary food storage and handling, extermination of disease vectors, and the like". [3] Per Plato and Hobbes' sentiments, a state is as healthy as the sum of its parts.

Physicians were once more politically and ethically responsible to the state than the patient. An example of this can be found during the Black Death in Italy, which waxed and waned for 300 years after 1348. Doctors did not establish their own standards for treatment and care, but were dispatched by "health boards, comprised mainly of merchants ... including physicians as consultants" and "were regulated by contracts that differed in substance but not in form from the commercial instruments ... used to regulate ... the most affluent economies." [8] Medicine's ethical responsibility was a "less effective ... motive for action than economic interest, or more broadly, fear of loss of status." [8] This system was repeated in England, and later the United States. During an outbreak of Yellow Fever in Philadelphia in 1793, "civic authority and a negotiated contract with a physician who saw a personal opportunity in the epidemic determined the organization of medical care." [8] Physicians were not advocating for patients, or dictating social priorities. Instead, they were well-compensated agents of the state who addressed public health, as governments sought greater regulation and control.

The growth of advocacy

The foundations of Western political theory are informed by a "medical" understanding of the state. In turn, medicine was practiced for the good of the state because it was well remunerated and necessary. This is not mutually exclusive with advocacy, and an ethical responsibility to patients and their communities. It is necessary to consider when advocacy became a key part of medicine's role in politics.

Physicians today are held in high social esteem in return for their work. This is one end of a social contract: power and responsibility are given to physicians, and much is expected in return. Many schools of thought posit that "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 ... can include political advocacy." [5] Advocacy can be described as "action by a physician to promote those social, economic, educational, and political changes that ameliorate the suffering and threats to human health and well-being that he or she identifies." [9]

Physician advocacy inhabited various forms as it developed. Examples include blanket organizations like the American Medical Association or the Canadian Medical Association, or smaller sub-specialty groups. These groups have traditionally advocated for physician interest, more so than patient interests. When Medicare and Medicaid were introduced in the United States, they were "met with great resistance from the American Medical Association, which was one of the first examples of a large medical group getting involved in the political process through advocacy." [6] The focus

of physician involvement in politics has recently turned to more issue-specific advocacy. Larger organizations are taking notice of social issues that influence determinants of health. An example of this is the withdrawal of the United Kingdom from the European Union. Dr. Neena Modi, President of the Royal College of Pediatrics and Child Health at the time, stated, “Brexit is placing at risk [European Union] policies that focus on the wider determinants of health by giving us clean air, good food, and healthy living. . . with a damaging effect on health.”[10]

What drove this shift in medicine’s political role? Over the past decades, the ideological leaning of medicine has changed. Using political donations as an indicator of political beliefs, the “political alignment of physicians in the United States changed dramatically” between 1991 and 2012.[11] It is possible that the same changes occurred in Canada. Additionally, there is an increasingly progressive makeup of physicians in lower-earning specialties.[11] This political shift may be due to partisanship following economic interests, or “it is also possible that physicians in training have characteristics that result in their being both partisan ... and entering higher paying specialties.”[11]

As the physician population has changed, more physicians expect that they may be called to serve not just as professionals, but as private citizens. This is bolstered by the “overwhelming experience of those who engage in policy and advocacy ... [that] career satisfaction improves with involvement, the likelihood of burnout decreases, and it helps develop strong physician leadership skills.”[12] Physician advocates are exhorted “as private citizens, to work as agents of social change with the nongovernmental advocacy organizations of their choice ... [to] effectively overcome the profound effects of the social determinants of health.”[13]

Interpretations of advocacy

There are two key questions that frame the theoretical exploration of physician advocacy: (1) How far should advocacy be carried out beyond the immediate medical responsibilities of the physician? (2) Is advocacy a private or a professional matter? Some who are concerned about the boundaries of physician advocacy argue that “physicians must limit their advocacy to matters clearly related to promoting the health and well-being of their patients and communities.”[9] This is anchored in the concern that “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.”[14] A counterargument to this is that “medicine, inexorably linked as it is to money and power, is an inherently political vocation ... the choice to remain out of the political debate ... is still a choice.”[5] This argument relates to the professional–private citizen dilemma: “proponents of mandatory physician advocacy need to explain why physicians may not legitimately prefer whatever activities they please to politics.”[14] Conversely, some proponents of modern physician advocacy seek to fuse the private and the professional, and “reimagine virtuous professional behavior as an emergent property of care, faculty, and collective citizenship teams” rather than “individuals playing discrete roles entailing competing moral obligations.”[15]

Moving forward

It is evident that advocacy has deep roots in medicine, but its extent and essentiality are not agreed upon. Two principles need to be developed for advocacy to be effective for populations and physicians.

First, medical education specific to advocacy should be developed. Medical students need to understand the history of their profession, and how it came to inhabit its political niche. Medical students may also benefit from a practical education in advocacy. The Accreditation Council for Graduate Medical Education emphasizes advocacy education focused on the social determinants of health, which reflects changes in legislation and society that shape curriculums.[16] One review notes that “an interested minority of medical students develop advocacy skills either on an ad hoc basis or through optional training experiences”.[7] Barriers to advocacy education include a lack of detailed research on outcomes and implementation, scarce published criteria guiding educators on how students should apply advocacy concepts to individual patients, and conflicts with time demands for clinical responsibilities.[16,17,18]

Greater practice complexity and health system pressures have demonstrated a need and highlighted opportunities for broader advocacy training.[7] These opportunities are emerging primarily in pediatrics and family medicine residencies. They are accomplished by establishing partnerships with community organizations, engaging in community-partnered advocacy projects, and supporting legislative advocacy.[18] Successful training at a residency, clerkship, and pre-clerkship level will require implementation, measures of outcomes, and assessments of impact, as well as increased curricular flexibility and instructional capcity.[16] Longitudinal curricula and active learning appear to be superior for teaching medical advocacy compared to short, discrete units.[19]

A second principle that requires development is the establishment of boundaries for advocacy. Many societal issues can be addressed under the “Health Advocate” competency. It is rooted in beneficence, which can be exercised through engaging in legislation, effective administration, clerical best practices, and managing ethical conflicts.[16] Medicine risks losing public legitimacy if physicians “participate in partisan political activism unrelated to the practice of medicine; it is critical that the physician engage in such activity as ‘a concerned citizen’ only and not in their professional capacity clearly identified as physicians.”[20] A systematic review assessing advocacy instruction, grounded in the CanMEDS “Health Advocate” competency, identified ‘a number of publications willing to name the

elephant in the room – our collective discomfort with 'activism.'"[19] This is clearly a difficult boundary to prescribe. It needs to be effectively developed through consultation with physicians, healthcare team members, community stakeholders, and those most affected by medical decisions and resource distribution, such as Indigenous peoples in Canada. This boundary may also be established as a result of training program effectiveness: "frameworks that prioritize reliability, defensibility and standardization may be incompatible with the intended goals of meso and macro-level advocacy."[19] The Canadian Medical Protective Association has established guidelines for advocacy, which are situationally dependent: physicians should "consider the appropriateness of the campaign ... [and] whether it is necessary or appropriate to discuss the planned activity with parties who may be affected." This appears to acknowledge that what constitutes "appropriate" advocacy may be ambiguous. The best way to navigate this is to "act professionally, provide an informed perspective, and offer constructive input", while operating within the provincial regulatory frameworks established by various colleges.[21]

Conclusion

Medicine is political insofar as it relates to life and death, and money and power. Medical activism cannot be understood without considering the society in which medicine is situated. Medicine's political role has changed over the centuries, as societies have developed. Currently, Canadian medicine is situated in a political order that favors austerity, with many provinces levying "cuts to families and individuals, a move away from government responsibility."[22] If physicians are "expanding conversations about wanting a better, healthier world" they need to understand the roots of their advocacy, the limits of their advocacy, and how to make it effectively interact with the political system that they operate in.[22]

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