

# Virtual Mentor

American Medical Association Journal of Ethics  
September 2014, Volume 16, Number 9: 699-707.

## ETHICS CASE

### **A Call to Service: Social Justice Is a Public Health Issue**

Commentary by Martin Donohoe, MD, and Gordon Schiff, MD

Dr. Gregory has been in family practice in Allentown, Pennsylvania, for more than 30 years, during which time he has cared for three generations of local residents and earned a place as a respected leader in the community.

Over the past couple of years, Dr. Gregory has grown increasingly concerned about the impact that human activity through the burning of fossil fuels has had on the climate and environment and, in turn, on the health of the public. After reading in the peer-reviewed literature and studying the science behind global climate change, Dr. Gregory decided to pen a letter to the local newspaper advocating for policies aimed at reducing greenhouse gas emissions, including the installation of carbon-capture technologies in coal-fired power plants.

Mr. Peterson, a longtime patient of Dr. Gregory, mentions this letter during a routine visit. After they have discussed how Mr. Peterson is doing—taking all of his medication as prescribed, but admitting that he could do better with what he eats—Mr. Peterson says, “I read the letter to the editor you wrote in the *Morning Call* last week, Doc.” Mr. Peterson is not employed in the mines, but he has several family members and friends who work in the coal industry. “I’m concerned that all this talk about global warming will result in less coal being used and that will mean fewer jobs for us,” Mr. Peterson says. “And letters like yours, especially from a doc, don’t help matters.”

Dr. Gregory replies, “I realize that there might be financial hardships for some, but it will cost all of us more, economically and healthwise, in the long run if we ignore the problem and do nothing.” But after Mr. Peterson leaves, Dr. Gregory wonders if he should have prioritized his patients’ livelihoods above more general public health concerns.

## Commentary

*“A physician is obligated to consider more than a diseased organ, more even than the whole man. He must view the man in his world.”*

*Harvey Cushing [1]*

*“Medical education does not exist to provide students with a way of making a living, but to ensure the health of the community.... If medicine is really to accomplish its great task, it must intervene in political and social life.”*

*Rudolph Virchow [2, 3]*

This case raises three important questions: When physicians and patients disagree about social issues, can the therapeutic alliance weather that disagreement? Can and should physicians, in addition to caring for their patients, be advocates for broader social change? If, as we argue, the answer is “yes,” how should we go about doing so in a way that does not have detrimental effects on patient care and the doctor-patient relationship?

### **Discussing Controversial Topics with Patients**

Inevitably, conversations and even conflicts about sensitive political and social issues will arise in the clinical setting, and it is likely and natural that there will be differences of opinion. Physicians must be mindful of power dynamics (which often are further compounded by class, race, gender, and other inequalities) and the need for nonjudgmental respect for patients and tolerance of alternate viewpoints. It would be wrong for a physician, no matter how passionately he or she felt about a particular issue or how just the cause, to disrespect patients and leverage or exploit the doctor-patient relationship, whether it is to win votes for a candidate or impose particular views on abortion.

Nevertheless, we disagree with the teaching that physicians must be “value-neutral” and feel that transparent, respectful conversations with patients can be more helpful than avoiding topics of disagreement. Physicians must not only express our own views; we must be open and receptive to our patients’ experiences and views, ever mindful that we also have a responsibility to grapple with the conditions they face. Such discussions may even conclude with a respectful, nonjudgmental “agreeing to disagree,” which can be useful in discussing other topics (from the appropriate prescribing of antibiotics or opioids to the necessity of an MRI for a back sprain or the doctor’s willingness to write a disability letter). If done sensitively, engagement on contentious topics can help, rather than hinder, the patient-physician relationship.

During Mr. Peterson’s office visit, Dr. Gregory should focus respectfully on health issues and address Mr. Peterson’s specific concerns and questions. He should listen and respond nonjudgmentally to Mr. Peterson’s concerns, recognizing the inherent power imbalance of their relationship and trying not to increase it. His response should be conversational, rather than proselytizing, based on sound science, and rooted in concern for his patient, his community, and future generations. He might possibly respond to Mr. Peterson by saying: I respect your views, and I hope you can respect mine. Scientific evidence indicates climate change is an urgent problem, and I feel strongly that our society must address it, but it’s tough when tackling it seems to be at odds with some people’s economic security. No matter what, whether we agree or not, I will still be your doctor and provide you, as I do for all my patients, with the best care I possibly can, while at the same time advocating for my patients and a better world for us all.

### **Why Activism?**

Physicians can learn much from their patients and patients’ struggles with illness, poverty, sexism, or racism. We have a responsibility to grapple with the conditions

our patients face. Caring deeply for and about our patients should naturally lead us to contemplate how we can help them in the broadest and most effective ways—ways that would entail ameliorating their problems through a public health approach to practicing medicine.

Many common health problems are rooted in public health, environmental, economic, and social policies. These include reactive airway disease (tobacco, ozone, air pollution); obesity (farm policy, school lunch quality, fast food advertising, food labeling); heart disease (pollution, smoking, obesity, unavailability of affordable healthy foods and safe places to exercise); depression (poverty); reproductive issues (abstinence-only sex education and lack of access to contraception and pregnancy termination); and injuries caused by violence (poverty, crime, criminal justice system policies, guns). Lower life expectancy, higher rates of infant and child mortality, poorer self-reported health, higher rates of AIDS, depression, obesity, and crime, and diminished trust in people and institutions are all associated with income inequality. Un- and underinsurance, militarism and war, climate change, lack of access to potable water and sanitation, unsustainable agricultural practices (use of water and soil, slash-and-burn agriculture, overuse of antibiotics, and governmental agriculture policies), corporate malfeasance, and international trade agreements also contribute greatly to morbidity and mortality and cost society trillions of dollars [4-12].

Classifying mortality by root social causes illustrates the importance of a public health approach to medical care. For instance, in 2000, there were 193,000 deaths attributed to acute myocardial infarction, 168,000 to cerebrovascular disease, and 156,000 to lung cancer. But when one group of researchers examined the actual contributing causes, they ended up with very different results: they found that 245,000 deaths were attributable to low education, 162,000 to racial segregation, 162,000 to low social support, 133,000 to individual-level poverty, and 119,000 to income inequality [13].

A few studies show how effective changes in social policy could lead to changes in health outcomes. One group calculated that equalizing the mortality rates of whites and African-Americans would have averted 686,202 deaths between 1991 and 2000, whereas medical advances over the same period averted only 176,633 deaths [14]. Another calculated that 880,000 deaths per year would be averted in the US if the country had a smaller income gap, like those of many Western European nations, and their stronger social safety nets [15].

It's preventive medicine writ large: injustice, oppression, war, environmental damage—all affect our patients. As professionals dedicated to healing and health, physicians should advocate on behalf of the vulnerable and disenfranchised (including the poor, racial and ethnic minorities, lesbian/gay/bisexual/transgender people, children, the disabled, HIV-infected patients, those with mental illness, undocumented immigrants, the homeless, victims of violence, and prisoners), whose voices are often unheard and whose oppression has medical consequences.

### **Activism in Action**

Often attributed to Nobel-Prize-winning author Gunter Grass is the saying, “The job of a citizen is to keep his mouth open” [16]. This applies more than ever to physicians, who, because of the MD after their names, are afforded a great deal of respect, warranted or not, in a time when public acceptance of scientific information is threatened by politically and ideologically motivated obfuscation. Public trust of physicians is high, and doctors are considered a credible source of information [17]. This can open doors for them to meet with elected representatives, influence policy through such means as letters to the editor, and act as spokespeople for important causes and media contacts for questions relevant to public health. Doctors need not be experts on every topic, but should take an active and informed interest in the issues, offer recommendations based on sound science, be honest when unable to answer a question, and offer to find information that is not at their fingertips. They should actively oppose government and religious mandates that limit the provision of scientifically supported advice and treatments to patients [18].

History provides us with many examples of health care professionals who were activists, including Rudolph Virchow, Thomas Hodgkin, Margaret Sanger, Albert Schweitzer, Florence Nightingale, and Salvadore Allende. Activism takes time and can be associated with consequences for one’s personal life [5]. For some, activism may on occasion involve breaking the law (as did famous activists such as Martin Luther King and Nelson Mandela), but only after a thorough consideration of alternatives and consequences. Activism could cause one to become the target of criticism (from colleagues, patients like Mr. Peterson, or other members of the community), and in some cases could even lead to threats of (or, rarely, actual) physical violence, and thus requires a degree of courage moderated by self-protection. Pastor Niemoller, who spoke out on behalf of victims of the Holocaust, was imprisoned by the Nazis at Sachsenhausen and Dachau concentration camps. Others who sought radical changes in health care, from Ignaz Semmelweis to John Snow to Virchow, were regarded as troublemakers in their lifetimes. Albert Schweitzer was ridiculed; Bernard Lown, cofounder (with Russian cardiologist Yevgeni Chazov) of the Nobel-Peace-Prize-winning organization International Physicians for the Prevention of Nuclear War, was labeled a Soviet sympathizer; and David Gunn, George Patterson, John Britton, George Tiller, and other physicians whose practices included pregnancy termination have been murdered [19, 20].

Today many physicians labor, often anonymously, in support of the disenfranchised and a better world for all. Others work through well-known physician-activist organizations (such as Physicians for Human Rights, Doctors without Borders, Physicians for a National Health Plan, Physicians for Social Responsibility, and the Doctors Reform Society) and nongovernmental organizations, which focus on environmental degradation (Union of Concerned Scientists), reproductive rights (Planned Parenthood), and myriad other issues [21].

## **Medical Education for Social Responsibility**

Despite the obvious relevance of social issues to patient health, physicians as a group are not particularly engaged in civic redress of injustice and oppression: more than half of physician organizations are doing little to ameliorate racial and ethnic health disparities [22], physicians tend to vote less than members of other social groups [23], and, when physicians lobby Congress, their efforts tend to focus on issues that affect them professionally and financially [24], rather than those that affect their patients' health [25]. One way to try to change this may be in changing the training physicians receive.

The schism between public health and medical education and training dates back to the early twentieth century—with medical schools becoming more focused on biochemical mechanisms of disease and drug therapies than on societal issues—and has yet to be healed. Social issues and public health are covered inadequately in US medical schools [4, 5]. Furthermore, ethics training inadequately addresses the psychological, cultural, socioeconomic, occupational, and environmental factors that have health consequences for individuals and populations. Despite the Institute of Medicine's recommendation that one-quarter to half of medical students earn the equivalent of a master's degree in public health, most do not; indeed, only 10 percent of students at US public health schools are physicians, down from 60 percent in the 1960s [26]. Most medical students and residents today do not engage in activism, despite having begun their medical school careers full of enthusiasm and with typically strong records of volunteer work or public service. This may be due to burnout and cynicism or to barriers such as insufficient time, stress, and the need for rest.

But professional societies have developed policies regarding education for advocacy and activism. In 2001, the American Medical Association adopted the “Declaration of Professional Responsibility: Medicine's Social Contract with Humanity” [27]. This encourages physicians to “educate the public and polity about present and future threats to the health of humanity and advocate for social, economic educational and political changes that ameliorate suffering and contribute to human well-being.” The Canadian Medical Education Directions for Specialists (CanMEDS framework) of essential physician competencies requires physicians to be trained to use their expertise and influence as advocates for advancing the well-being of individual patients, communities, and populations [28].

There are many pedagogical approaches to augmenting training that encourages physician activism [4, 5, 29]. These include more curricular time devoted to community health; elective rotations in nontraditional settings (jails and prisons, domestic violence shelters, homeless clinics) and overseas; improving ethics training to include a major focus on social justice; research-based health activism courses (like those pioneered by Public Citizen's Health Research Group); residency programs devoted to social medicine (e.g., Montefiore Hospital/Albert Einstein University, the University of California at San Francisco, and the University of Miami) and global health (e.g., Harvard and University of California, Los Angeles);

the use of the humanities and social sciences (including literature, photography, and history), and lobbying/media training [5, 30, 31].

Medical student and resident selection committees should place more emphasis on applicants' life experiences, breadth of courses taken and service activities pursued, and potential as future activists and leaders. Schools of medicine and residency training programs must recruit qualified faculty and augment their curricula to include a greater emphasis on activism. This will involve a closer association with adjunct faculty who are working in the community and with nongovernmental organizations and who should be compensated appropriately for their efforts.

### Conclusions

Unless we can overcome the daunting challenges of building bridges between our clinical work with patients and the preventive public health mission that Virchow prescribed for us, we are doomed to find irrelevance and futility in our efforts to help our patients. Fortunately, collective advocacy for societal change and personal advocacy on behalf of individual patients cross-fertilize and nourish each other. Advocacy takes time, courage, and patience; the slow process of societal change can be frustrating, but the long-term rewards are great. It behooves us to remember that “the arc of the moral universe is long, but it bends towards justice” [32] and to consider Margaret Mead's encouraging words: “Never doubt that a small group of thoughtful, committed people can change the world. Indeed, it is the only thing that ever has” [33]. As an African proverb reminds us: “If you think you are too small to have an impact, try going to bed with a mosquito in your tent.”

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(American College of Physicians, American Pediatrics Association, American Public Health Association), despite recent attempts by half a dozen states to prohibit such discussions (Butkus R, Doherty R, Downey H. Reducing firearm-related injuries and deaths in the United States: executive summary of a policy position paper from the American College of Physicians. *Ann Int Med.* 2014;160(12):858-860. <http://annals.org/article.aspx?articleid=1860325>. Accessed May 30, 2014.). Many oppose gag rules regarding discussion of the full range of reproductive health care options (American College of Obstetrics and Gynecology), which are mandated in many states and at Catholic hospitals (Mencimer S. Do bishops run your hospital? *Mother Jones*. November-December 2013. <http://www.motherjones.com/politics/2013/10/catholic-hospitals-bishops-contraception-abortion-health-care>. Accessed May 30, 2014). The Charter on Medical Professionalism (endorsed by the American Board of Internal Medicine, American College of Physicians, and European Federation of Internal Medicine) states that “physicians should work actively to eliminate discrimination in health care whether based on race, gender, socioeconomic status, ethnicity, religion or any other social category” (Project of the ABIM Foundation ACP-ASIM Foundation, American College of Physicians, et al. Medical professionalism in the new millennium: a physician charter. *Ann Int Med.* 2002;136(3):243-246).

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### **Acknowledgements**

The authors thank the following for helpful comments: Matthew Anderson, Walter Tsou, David Himmelstein, Steffie Woolhandler, Michael Lacombe, and Lanny Smith.

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