

# Virtual Mentor

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## Clinical Case

### Lead Paint Dangers and Physician Advocacy

Commentaries by Lisa J. Chamberlain, MD, MPH, and Timothy Hoff, PhD

Dr Tim Jones, a family medicine physician, practices in a community health clinic outside of Oakland, California, in a low-income neighborhood. Dr Jones works long days seeing patients from the community with illnesses prevalent in groups of low socioeconomic status: tuberculosis, HIV, and metabolic syndrome, among others. He has a wife and one child, both of whom are healthy. He spends part of every weekend making house calls, helping patients get prescription medications, assisting his elderly parents with their needs, and meeting with community and school leaders about health projects. Dr Jones has become something of an expert in diagnosing and treating lead exposure in children, since many of the housing options in his community are not adequate. Given early diagnosis and treatment, including counseling of the family to try to limit exposure, many children experience minimal symptoms. This week, Dr Jones saw another child who had symptoms of lead exposure. He would like to help his community correct the root causes of this threat to its children, but, after caring for his family and his individual patients, he is exhausted.

### Commentary 1

by Lisa J. Chamberlain, MD, MPH

The case of Dr Jones elicits feelings of both admiration and concern. While we admire his deeply felt commitment to his patients and their community, we are concurrently concerned that his mode of practice is unsustainable, that his present course will negatively impact his family, and that he will suffer from exhaustion, undermining his career. This case raises many questions: What is the physician's obligation to the patient? What is the difference between a physician's obligation and a physician's aspiration to improve health? And finally, how can one practice and not overextend?

Increasingly, medical professionals are engaging in community and health policy arenas [1-3]. This involvement is in direct response to a heightened awareness that many health issues, such as lead poisoning, have their roots in the community. Aspects of modern culture that give rise to these diseases, such as environmental contamination, represent the new vectors of disease [4]. To address them one must practice both inside and outside of the clinic walls, and physician advocacy is one approach. One definition from the *Lancet* states "Advocacy only means taking the problems that one faces day to day and pursuing their resolution outside their usual place of presentation" [5].

### **What Is the Physician's Obligation to the Patient?**

Physicians have an obligation to work within their own practices and communities to ensure that patients have access to high-quality preventive, urgent, and specialty care that is geographically, linguistically, culturally, and financially accessible [6]. These noble ambitions frequently clash with the financial realities of a growing uninsured and underinsured population [7]. Practicing physicians are caught in the debate between the utilitarian notion of distributive justice, which acknowledges finite resources, and the notion of justice as equity where all patients are guaranteed equitable access. This is a crucial debate, and one in which doctors must be heard.

The strength of the link between the policy and the health outcome can guide physicians in distinguishing their obligations from their aspirations when advocating for patients [6]. For instance, Gruen et al suggest that it is the physician's *obligation* to work with individual patients and in the larger realm to reduce tobacco use because the health implications of tobacco use are well established. They suggest that physicians may *aspire* to address factors such as poor educational opportunities and neighborhood safety, since the impact on health outcomes is suggestive but not conclusive. Determining the strength of the scientific evidence can help a physician prioritize his obligations over his aspirations.

### **How Can One Practice and Not Overextend?**

Where does this leave Dr Jones? He is exhausted—and who wouldn't be—after making house calls, helping his parents, and partnering with community leaders on health projects. He would appear to have 3 jobs and be doing them all in isolation. Let's examine each activity to ascertain where obligations end and aspirations begin and then consider where different advocacy approaches would strengthen his work but lighten his load.

Dr Jones is exceeding his obligation to see that his patients have access to high quality care. Instead of making house calls, might he look upstream to assess why patients can't get to the clinic? Maybe the clinic is too far away, and he could establish a satellite clinic in a location closer to the need. Alternatively, if the practice values house calls, perhaps he could be given time during the work week to make those visits.

Dr Jones spends time assisting his patients in filling their prescriptions, which is a perennial challenge for many Americans. Luckily Dr Jones practices in California where a new prescription drug recycling program has recently been signed into law. This surplus medication collection and distribution law approved by Governor Schwarzenegger on September 30, 2005, creates a "...program for purposes of distributing surplus unused medications, as defined, to persons in need of financial assistance to ensure access to necessary pharmaceutical therapies" [8]. It is possible that Dr Jones is unaware of such recent legislation with all that he is doing. One easy way to stay abreast of such important issues is participation in local organized medicine, where short frequent e-mails alert members to legislative activity. A compelling part of the story behind this legislation is that it was the direct result of medical students' advocacy for patients just like Dr Jones's. In 2004 a group of Stanford medical students approached one of California's elected officials with the

idea of introducing legislation allowing indigent seniors to obtain medications that would otherwise be thrown away. With this legislation now law, countless California seniors will receive medications where before they would not. Medical students can clearly be extremely effective and unique advocates.

Finally, Dr Jones aspires to improve the health of the community through various projects with local community groups and schools. Self-care is important, and it appears that he is overextended in his aspirations. One approach to focus his activities would be to examine where his passion and expertise intersect: childhood lead poisoning. This is an area where the scientific evidence for prevention is very strong, thus it is a health topic where a physician is all the more obligated to act.

Regarding his clinic patients, Dr Jones should recognize that he is one member of a public health team available to address lead poisoning. His role is to provide medical treatment where indicated and then to refer these patients to the Alameda County Public Health Department. He should advocate at the county or state level in favor of lead abatement programs or legislation. As a physician who witnesses the effects of lead, he has a unique and powerful voice to bring to this process. When the next new patient comes in with symptoms of lead exposure he will be heartened with the knowledge of all that he is doing to prevent future cases. By focusing on lead issues he limits his efforts to an area where his impact will be greatest. He must not attempt to solve all of his patients' problems. At some point in the future his advocacy endeavors may shift to address obesity, or any one of myriad topics, but at this point in his career he has one issue and should remain focused. This will prevent overextension and burnout.

No epidemic has ever been halted by focusing on the individual patient, and many of the health issues facing our nation and world today are the same sort of challenges. As physicians learn to advocate for individual patients and beyond, they will improve the lives of many while they improve the quality and enjoyment of their work.

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## **Commentary 2**

by Timothy Hoff, PhD

Physicians have fallen far short in terms of using their power and influence to advance the public's health in the United States. The balkanization of medicine through specialization [1], the inability of doctors to view themselves as a united group of workers as well as highly educated professionals [2], the narrowly focused training and economic agendas of professional associations [3], and the increasingly unappealing aspects of practicing medicine as both a job and profession [4], conspire to render medicine a weak force for change or improvement in relation to the social and economic conditions that bear directly on health care in this country. Ironically, juxtaposed to this reality is another in which individual doctors, armed with technological gadgets and sophisticated understanding of disease processes, grow more effective at keeping people alive longer—newborns and the elderly alike—and improving the quality of life for select groups, in particular the insured, middle-class citizens in our country.

### **Citizen Jones and the Power of a Profession**

Dr Tim Jones will probably end his medical career frustrated at his inability to do much more than his job as a competent clinician. He could be the best clinician in the world. Chances are, however, that the lead poisoning diagnoses, the poverty-induced chronic diseases, and the preventable, life-shortening afflictions will keep arriving at his doorstep until he takes down his shingle or restricts his practice to some affluent American suburb where those problems are less visible. Certainly, being a competent doctor is enough for any one individual in his or her lifetime. But is Dr Jones required to do any more than what he can as a clinician to improve health in his practice community?

I believe the answer to this question is yes, but it involves Dr Jones's becoming an active part of a larger and potentially imposing collective persona—one that is in the best position to realize fully the social contract between medicine and the general public. This persona exists in the organizations that represent doctors. Such organizations have long been successful in gaining economic autonomy and clinical decision-making discretion for their members. But they have been less effective in bringing down the full measure of their influence on solving the problems that undermine people's ability to be healthy.

As a sociologist who studies medicine, I see a profession that has difficulty assuming an identity with respect to the larger purposes it serves for assuring the health of populations. In studying why doctors belong to organizations like professional associations, for example, I found that economic and instrumental interests, ie, the self-interest motivation, far outweighed concerns about achieving social justice in health care or using the power of the collective to lobby for and shape the kinds of changes needed to improve people's lives enough to make them healthier [3].

There are so many professional organizations competing with each other now for the attention and business of individual physicians that these organizations must focus on bread-and-butter issues like income and reimbursement, continuing medical education, and the advancement of legislation that furthers the interests of medicine. Improving the health of disadvantaged populations is simply not important enough in the mind of the average doctor to succeed as a marketing pitch for membership. Just getting physicians to join more than their little specialty organization is a major task these days. The professional associations know this; they know that the world of managed care presents challenges that affect the individual doctor's work life, and they know that doctors want to see these challenges solved by their membership group.

### **An Inward-Looking Profession**

It seems that everyone, individual physician and collective organization alike, are fixated on the local, everyday economic and clinical worlds of medical practice settings. The problem is that this myopic focus results in an almost exclusively inward-looking group of professionals. This is a group whose major journals and mouthpieces can talk about issues of health care inequality, the uninsured, or health care access, but that has little collective will, experience, or perspective to actually do anything about those problems at a policy level. In an ironic way, the attention paid to protecting physician autonomy—economic and clinical—from the onslaughts of managed care, insurance, technology, lawyers, and the government, has forged a situation in which the medical profession has difficulty breaking away from its more parochial, grassroots interests to attend to the larger societal interests that shape health and illness in our country. Just look at what happened during this country's last foray into a universal health care debate in the early 1990s. Medical specialties lobbied against each other. All of them lobbied to protect physician interests first and foremost. And "health care coverage for everyone" remained a noble idea few disagreed about, but few could actually stand being implemented.

### **Medicine: a Tough Calling**

For many in the profession, being a doctor is a tough calling these days. Becoming a clinician creates massive personal debt. Most need intensive advance preparation even to qualify for entrance into medical school and residency. The unique challenges faced by an increasingly diverse profession (eg, female physicians) in the workplace, the likely reality of salaried worker status once practicing, and the dizzying pace of knowledge change within some areas of medicine conspire to make the modern-day physician more prone to career dissatisfaction. At the least, these challenges create a life where the everyday work of patient care drains the energy and enthusiasm needed to tackle bigger-picture issues [4]. We cannot expect, nor should we, that the Dr

Joneses of this world will become individual crusaders, spending 10-20 hours per week trying to help solve the health problems brought on by persistent poverty, substandard living and nutritional conditions, lack of health care insurance coverage, and inadequate access to care. It is unrealistic, given how demanding and personally testing the life of the average doctor is these days.

### **Join Professional Organizations**

What we should expect, and what Dr Jones is obligated to do, is to engage his professional organizations actively to serve as change agents and work to correct the adverse conditions within which many people toil and which contribute to poor health. This means Dr Jones has to take several simple but crucial actions. First, he needs to join professional organizations, not steer away from them like his colleagues have in droves over the past couple of decades. He should not simply pay dues for his specialty association but should join the local county medical society, the larger American Medical Association, and one or more of the myriad grassroots physician interest groups dedicated exclusively to the bigger-picture health care issues, like the uninsured problem.

Dr Jones must take a small chunk of his salary and invest financially in those particular groups that can advocate for solving the problems that produce many of the sick patients who come to see him on a daily basis. Once a member of these different organizations, Dr Jones must devote a small amount of time to them, not 10-20 hours per week but a few hours per week. This involvement does not mean simply going to the annual meeting to hear presentations but serving as an officer or delegate or grassroots promoter. Dr Jones can interact with other colleagues in these groups over time and build constituencies to raise issues and bring them to the forefront of his association's agenda. This kind of involvement, performed by thousands of doctors across the country simultaneously, would quickly turn organizations such as the American Medical Association, often criticized for being "out of touch" and narrowly focused on a small subset of the profession, into broadly representative bodies that must be responsive to their membership.

### **Work for Change**

Dr Jones does not have to think about his role in grandiose terms. That will only disappoint and paralyze him. Nor does he have to burn himself out pursuing causes in relative isolation from his colleagues. What he needs to do, however, is get with it, recognize that real improvements in our population's health are made at the level of social and economic policy, and at the very least align himself formally with the professional organizations which, for better or worse, still command some level of respect and power in the political and social arenas. Then he needs to work with his colleagues to make those professional organizations the change agents for societal problems that impact the public's health. As an individual physician acting alone, Dr Jones will likely have little impact on population health. As part of an active, aggressive professional association or organization, one that is not allowed simply to serve medicine's interests but is pushed by people like him to force policy change on a grander and less self-interested scale, he stands the best chance of making a difference.

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