

Virtual Mentor

Ethics Journal of the American Medical Association
December 2005, Volume 7, Number 12

Policy Forum

Physician-Advocate: Deciding What to Fight for and When

An interview with Philip A. Pizzo, MD,
Dean of the School of Medicine, Stanford University, Palo Alto, California.

Q. What led you to become active in advocacy for causes in medicine and pediatrics? You have had a complicated relationship with the federal government: you worked for the government at the National Institutes of Health, interacted with it both as the dean of a major medical school and in an advisory capacity in the Institute for Medicine, and now as director of the California Stem Cell Initiative. Can you tell me a little bit about these experiences and how they have shaped your thinking about your role as a physician and now a public figure?

A. I was influenced by the dramatic changes in social welfare as well as discord that characterized the 1960s. I became immersed in the great debates of those times—civil rights, health and welfare, peace versus war. My wife, who was an advocate for children, demonstrated the importance of taking a stand. For me, the opportunity to change the lives of individuals—or a society—was compelling and galvanizing. So too was the sense of idealism that one's efforts could transform our world.

The issues were directly related to the personal experiences I have had—as a student, trainee, physician, scientist, administrator, and leader. A common underlying theme for me has always been to put the importance of helping people or society first—even if that has personal costs. Patients have been the starting point for most of my advocacy—but I have tried to couple advocacy with scientific or at least evidence-based underpinnings.

My earliest public foray was in supporting children with cancer or bone marrow failure who needed advanced technologies or medications that may not have been readily available. This took on a larger context as HIV infection and AIDS became prevalent in children during the mid-1980s. The fact that drugs were not being developed—or were not even available—for children prompted me to take on drug companies and the FDA, as well as state and federal governments, to overcome these barriers. This required confronting the FDA's regulatory posture and mobilizing public attention in a manner that compelled that agency to change its decision and make a drug, AZT, more available to children with AIDS. Over time these activities have contributed not only to immediate changes in drugs for children but also to sweeping legislation that has resulted in new federal regulatory policies. More recently, these same issues have had to be addressed in a number of developing nations where access to AIDS drugs has been drastically limited and national infrastructure, drastically lacking. In these latter efforts I have worked with nonprofit organizations, like the Elizabeth Glaser Pediatric AIDS Foundation, to drive change.

I clearly recognize that over the years my responsibilities and activism have assumed greater magnitude. As this has happened, I have always tried to remember that my personal role needs to be sublimated to a higher cause and that neither the desire for personal credit nor the fear of discredit can play any role. I recognized that in taking on issues which confront the norm or which challenge organizations—especially organizations with financial resources or power— it is imperative to sustain one’s personal integrity and do everything possible to stand above reproach. That has meant making specific decisions that have personal costs.

Q. This issue of *Virtual Mentor* discusses where politics and medicine meet. Where have you noticed that intersection in your career? Could a physician ignore politics and be successful?

A. It is hard for me to separate the role of the physician from that of advocate— although I recognize that this relationship may be more seamless in pediatrics. As a physician it is important to advocate for one’s patients at a fundamental level—for their health and welfare and for their safety and well-being in a community. In some ways, the huge advantage and success that the US has had in biomedical research is a consequence of political and governmental decisions, especially in supporting the National Institutes of Health. Conversely, the dysfunctional health care system in the US (which is not really a system) is also the consequence of political decisions or indecisions. Many of these extend back decades, in the case of health care to President Woodrow Wilson’s inability to launch an organized health care system—a failure that was replicated during the Truman, Johnson, Nixon, and Clinton administrations. The policies of local, state, and federal government on decisions of health care (eg, state support for Medicaid and medical education) or national policies on research (eg, stem cell or contraceptive research), and matters of public safety and the public good (state or federal policies on science, gender, marriage, abortion) all have tremendous consequences on individuals. While a physician can stay focused on simply delivering medical care, it is hard for me to imagine that our rapidly changing economic environment and evolving global community will leave anyone immune to involvement in societal or political problems.

Q. In your opinion, how should the federal and state governments and medicine interact?

A. The dynamic interaction between the state and federal governments has been both positive and negative. For example, when a positive social care program—like Medicaid—was passed on the federal level, states had the right to determine their level of funding, and some choose to do so quite minimally, perhaps driven by social and even racial perspectives. More recently, when the federal government decided to block stem cell research, certain states— California most notably—challenged that decision and established separate state funding mechanisms to support it through Proposition 71, the 2004 ballot initiative that established the California Institute for Regenerative Medicine. In contrast, other states (eg, Kansas, Missouri) are moving to ban such research with all the consequences therein. On another level, some states (Oregon, Vermont) have introduced novel initiatives in health care whereas others have made health care a lower priority.

I believe there is a benefit to having areas of state and federal separation as well as unison. It depends on the issue and the availability of resources. For example, we need a health care revolution in this nation, but I am not sure that it can occur at a national level first, given past history. It may require state development and experimentation to create opportunities for success.

Q. Do you find that serving on a committee of medical experts appointed to advise the federal government is useful, and how do you think those experts should be chosen?

A. A committee's usefulness clearly depends on its purpose, on how it is chosen and appointed, what authority it is given, and whether it is advisory or driven by political agendas. In recent years a number of national advisory committees have been contaminated by ideology, religion, and politics. Individuals have been appointed to committees at the FDA and in HHS, for example, because they had a certain point of view (eg, regarding abortion or faith). When the committees in question are medical and scientific, appointments on such grounds make a mockery of the scientific advisory process. Most recently, this circumstance has been evident in the President's Council on Bioethics as well as committees on reproductive health at the FDA. It is notable that the appointment of leaders to major federal institutions has been politically motivated or influenced by "litmus tests" of alignment with the administration. Again, this is a most unfortunate development and impacts negatively on the success and credibility of the committee. Further, committees can be negatively affected when members have conflicts of interest that are either unexpressed or that influence their decisions—as may have recently happened in some FDA advisory committees. In my opinion, each of these is an example of the function or integrity of a committee being negated or compromised.

Q. When did you decide that seeing patients or doing research was not enough and that it was necessary for you to take on some sort of public role? I'd be especially interested in your decision process regarding the California Stem Cell Initiative.

A. My more public roles have never been replacements for patient care or research—they have been extensions of those activities. Before I came to Stanford 4 years ago, I spent the prior 3 decades in patient care, research, and education. As for the stem cell research initiatives, the major motivation on my part was to do everything I could to not have ideological points of view impede vital research that could improve the lives of adults and children. While I am respectful of individuals who have moral or religious objections to stem cell research, I do not agree that such a point of view should negate the ability of individuals who don't share those objections to carry out this type of research; nor should it prohibit our nation from supporting it.

I have long believed that it was important for me to help remove whatever impediments stood in the way of patients' benefiting from new discoveries or receiving access to health care or programs that promote social justice. Accordingly, some of the problems I have confronted include funding for research, such as the stem cell research we are discussing, support for training future pediatric investigators,

the responsible conduct of clinical trials including the role of the pharmaceutical industry and National Institutes of Health in conflicts of interest, and, even more broadly, the emerging antiscience mood in the US and the future of health care.

One must be judicious in taking on campaigns that can challenge one's own institution, and there are times when one must make clear that he or she is speaking personally and not on behalf of an organization. Taking public stands on stem cell research or the need for fundamental change in our health care system can be tightropes to walk along. Finally, as one gets more publicly active, it is not beyond possibility that one's own career opportunities—or even employment—can be put at risk. But, if at the center of one's motivations is improving the lives of patients and people, such risks seem worthwhile—at least they have to me to date.

Q. Do you think physicians ought to be more in the public eye? How do you think medicine as a profession is doing with its public relations? Any personal insights from positive or negative public relations experiences?

A. Physicians are in the public eye—and, sadly, I think the public perception about profession of medicine has suffered during the past few decades. A number of factors contribute to this—including the avarice of some physicians about their own financial gain, the negative impact of managed care and its conversion of medicine from a service to a business, the role of big pharma in driving up drug costs or in eroding public confidence in the way drug companies conduct clinical trials and assure public safety, and the negative effects of the activities of some physicians with conflicts of interest. So, while members of the public usually feel positive about their own doctors, they have less respect for the profession of medicine. I believe this is a situation we all need to deal with; we need to win the public trust. We do not have viable, trustworthy organizations to speak on our behalf. I do not believe that the AMA has succeeded in that regard, and others have not stepped into the fray in a meaningful way. So we will need to create and develop other vehicles and mechanisms to do this. And the heart of this will be the role of physicians, one by one or in their communities, interacting more successfully and honestly with the public and regaining trust and respect for medicine as a caring profession.

Q. What would you say to an individual physician who wants to get involved in public advocacy but does not know how?

A. First that this is a serious decision that should be guided by motivations to help others and not oneself. Second, the issues should be those that the individual cares deeply about and for which she or he is willing to accept the responsibility and accountability that come from being engaged.

In medical schools and residency training programs there are organizations, individuals, or groups that are involved in advocacy. It could be worth beginning there, if possible. At Stanford there are a number of student groups, possibilities through scholarly concentrations, and specific programs (eg, in pediatrics) that create avenues for engagement.

If conditions don't exist for one's own issue, I think it might be best to find a mentor or guide and then develop one's own path—with the hope that others will follow.

Q. Regarding your role as dean, do you think medicine should be educating doctors to be effective public advocates?

A. I take my role as a leader in academic medicine very seriously. I have believed it imperative that I set an agenda and blueprint for Stanford—which I have tried to do since my arrival here. I have also believed that I need to address public policy questions that are important to me and to the future of medicine and science. By doing so, in the most honest and forthright way that I can, I hope that I am modeling and educating students and others to take an active interest in these matters.

This interview was conducted by Robert E. Burke, theme issue editor for December.

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