

# The Physician as Health Advocate: Translating the Quest for Social Responsibility Into Medical Education and Practice

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## Abstract

There is a growing demand for educating future physicians to be socially responsible. It is not clear, however, how social responsibility is understood and acted on in medical education and practice, particularly within the context of a growing desire to improve health care through an equitable and sustainable delivery system. The authors conduct a concept analysis, exploring the practical philosophical understanding of social responsibility and its implications for medical education and practice. The aim is to inform curricular development,

professional practice, and further research on social responsibility. The particular ways in which social responsibility is interpreted can either enhance or establish limits on how it will appear across the continuum of medical education and practice. A physician's place in society is closely tied to a moral sense of responsibility related to the agreed-on professional characteristics of physicianhood in society, the capacity to carry out that role, and the circumstances under which such professionals are called to account for

failing to act appropriately according to that role. The requirement for social responsibility is a moral commitment and duty developed over centuries within societies that advanced the notion of a "profession" and the attendant social contract with society. A curriculum focused on developing social responsibility in future physicians will require pedagogical approaches that are innovative, collaborative, participatory, and transformative.

**T**he topics of social responsibility and social accountability are receiving increasing attention in medicine. There is a growing demand for educating future physicians to be socially responsible.<sup>1-9</sup> Medical schools worldwide are being told

that they can be "held to account by society" if they do not demonstrate that their education, research, and service activities are preparing future physicians with the capacity to respond to the "priority health concerns of the community, region, and/or nation they have a mandate to serve."<sup>10</sup>

to the social determinants of health and to the health care needs of people who are vulnerable and marginalized. This is not a new concept. Rudolph Virchow opined in the 19th century:

Medicine is a social science, and politics is nothing else but medicine on a large scale. Medicine, as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution: the politician, the practical anthropologist, must find the answers for their actual solution.... The physicians are the natural attorneys of the poor, and social problems fall to a large extent within their jurisdiction.<sup>21</sup>

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Acad Med. 2011;86:000-000.  
First published online  
doi: 10.1097/ACM.0b013e318226b43b

The quest for social responsibility and accountability is a long-standing attempt toward defining, vivifying, protecting, and upholding the social contract between medicine and society. It is an agreement that the medical profession will receive certain rights and privileges in exchange for service to society and the public good.<sup>11-16</sup> At the same time, there must be a realistic response to the pull toward the private interests of professionals.<sup>17,18</sup> Similar concerns have emerged in other health care disciplines.<sup>19</sup> A recent study on social responsibility in dentistry, for example, found that there is a belief among some dental educators, clinicians, and leaders in the profession that economic imperatives are dominant features affecting how dental education and practice are structured in society.<sup>20</sup>

Within the context of society's priority health needs, medical education and practice need to be particularly sensitive

Several collective authorities such as the World Health Organization, the Accreditation Council for Graduate Medical Education (ACGME), and the Royal College of Physicians and Surgeons of Canada (RCPSC) have issued guidelines and accreditation standards around social responsibility in medical education and practice. The World Health Organization has provided a social accountability framework for medical schools highlighting the importance of working collaboratively with governments, health care organizations, other health professionals, and the public to meet society's priority health needs.<sup>22</sup>

The ACGME in the United States followed by developing general competencies that address the “development of core professional attributes, such as altruism and social accountability, needed to provide effective care in a multidimensionally diverse society.” The identified aim is to prepare future physicians to be “responsive to the needs of patients and society that supersede self-interest.”<sup>23</sup>

Health Canada followed by establishing a Steering Committee on Social Accountability of Medical Schools,<sup>24</sup> and the RCPSC responded by developing a framework of essential physician competencies to demonstrate a commitment to meeting “societal needs” through “better standards, better physicians, better care.”<sup>25</sup>

These competencies provide a means through which to operationalize social responsibility in medicine. The competencies that deal with professionalism and health advocacy seem to align closely with social responsibility. They are intended to prepare future physicians across the broad range of specialties not just to respond to individual patient health needs as part of patient care but also to respond to the health needs of the communities they serve, to identify the determinants of health of the population, and to promote health at individual, community, and populations levels.<sup>26</sup> The American Medical Association adopted a declaration of professional responsibility that calls on all physicians to “advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.”<sup>27</sup>

It has been over a decade since the formal adoption of competencies around health advocacy. Yet, how best to integrate them into medical education remains unclear, and little is known about how to effectively teach and assess learning in this area.<sup>28–31</sup>

The purpose of this article is to examine the idea of “social responsibility” and its use in medicine. We believe that a practical philosophical understanding of the term would help to improve its integration into medical education and practice and provide a better understanding of how best to operationalize the physician’s role as health advocate. The particular ways in which a concept or phenomenon is interpreted can enhance or establish

limits on how the concept is conceived and acted on.<sup>32</sup> Our aim is thus to encourage critical reflection.<sup>33</sup>

We begin by exploring the practical philosophical understanding of social responsibility. We then explore the relationship between social responsibility and its implications for medicine’s contract with society. We end with suggestions on how to better operationalize the educational competencies designed to enable future physicians to meet their social responsibilities.

### **A Concept Analysis of Social Responsibility**

Concept interpretation inquiry<sup>34</sup> seeks to provide an account of reasonable and practical understanding of a concept in order to produce an unambiguous sense of its use or meaning. It is an attempt to move toward a less abstract use of terms. Informed by the Aristotelian idea of *phronesis*,<sup>35</sup> which is the notion of seeking understanding by applying critical, analytic reflection on everyday practices within a particular context, our concept analysis attempts to provide a thoughtful and practical account of social responsibility. Our aim is to enable concrete interpretations that can inform curricular development, professional practice, and further research. In the words of John Wilson,<sup>36</sup>

Concept analysis gives framework and purposiveness to thinking that might otherwise meander indefinitely and purposelessly among the vast marshes of intellect and culture.

We begin our concept analysis with a focus on the term “responsibility.” In medicine, this term has different meanings and moral implications than it does in more general use. Physicians have a responsibility to make decisions and to take subsequent actions that have a foreseeable impact on the health and well-being of patients. This notion of role responsibility refers to the performance or fulfillment of the duties or sets of expected behaviors attached to a physician’s function as a medical practitioner. A responsible physician is one who is competent and who properly fulfills accepted or recognized commitments attached to that role. As a result, the practitioner is held to account for enhancing health, causing harm, or failing to prevent harm.

Role responsibility has a moral connotation as well. In following the Aristotelian notion of a virtuous person, a responsible person is required to recognize and do what is appropriate according to accepted moral norms. The idea of role responsibility is central to the moral fabric of medicine. The Hippocratic Oath, for example, pronounces physicians’ obligation to provide optimal medical care competently and humanely, with honesty, compassion, fortitude, authenticity, and fairness. Physicians are expected to uphold the identity and integrity of their profession not only by avoiding harm to their patients and promoting good health but also by avoiding behaviors that may compromise their moral obligations as members of the medical profession. Although a responsible physician is accountable for his or her actions through regulatory and legal means, the notion of responsibility in medicine is not motivated by a fear of liability or the expectation of reward. It is motivated by an internal moral commitment to certain core values such as excellence, integrity, respect, confidentiality, competence, altruism, fairness, human dignity, and compassion. In the words of Albert Einstein<sup>37</sup>:

A man’s ethical behavior should be based effectually on sympathy, education, and social ties.... Man would indeed be in a poor way if he had to be restrained by fear and punishment and hope of reward after death.

The notion of social responsibility is integral to the physician’s role responsibility and corresponding relationship to society. It has been argued effectively elsewhere that in addition to patients who individually avail of the physician’s care and attention, the neighborhood, the community, and the nation are all, in essence, also the physician’s patients.<sup>38</sup> Hence, a physician’s professional and civic duties can be seen as complementary. The idea of social responsibility not only respects the important notion of individual rights but also concerns the fundamental point of how an individual, as part of the collective, can and ought to contribute toward the common good.

Many complex problems emerge within the various intertwined contexts of social, environmental, economic, and political settings and, thus, require not only individual responses but also collective reflections and coordinated responses. As individuals, we have various private and public interests, some of which conflict with each other. To be human, however, is to be social. We cannot define “the good life” separated from others; we can only live a good life in community. This is best captured by Arnold Toynbee,<sup>39</sup> a leading British historian of the last century:

Society is the total network of relations between human beings. The components of society are thus not human beings but the relations between them. In a social structure individuals are merely the foci in the network of relationships.... A visible and palpable collection of people is not a society; it is a crowd. A crowd, unlike a society, can be assembled, dispersed, photographed, or massacred.

The common good, then, is not just the common denominator. It is the recognition that the collective well-being is part of the individual good as well as individual responsibility. Social responsibility in this context emphasizes a social conscience and attention to systems of inequality, power, and privilege and working to eliminate social inequities and injustice in the interest of the common good. It connotes an ethic of care and trust beyond individualism, fear of liability, and private interests.

Social responsibility is about ensuring, protecting, and contributing to the collective welfare of society. It is also about choosing to contribute to the common good rather than being legislated to do it. It is unsettling and frequently unhelpful when principles, no matter how righteous they seem, are imposed as a matter of law. Social responsibility becomes meaningless when what is right and good ceases to be an ethical standard to be upheld but, rather, a matter of legal injunction to be enforced. A commitment to social responsibility is part and parcel of physicians' concerns and the core values of doctoring.

Nevertheless, the emergence of the idea of social accountability<sup>40</sup> in the medical literature indicates that medical schools should “expect to be held to account by society for what they do.”<sup>10</sup> The emphasis

on accountability in this case appears in the literature as a concerned response to the shortcomings in the ways doctors are educated with respect to the relationship between medicine and society.

Our concept analysis thus prepares us to look critically at how we might expect physicians to behave in providing health care and how we might prepare them to be effective in that role.

### **Implications for Medicine's Contract With Society**

There exists an implicit and yet undeniable relationship between the medical profession as such and the idea of social responsibility. The requirement for social responsibility in medicine is not a new idea. It is a moral commitment and duty developed over centuries within societies that advanced the notion of what constitutes a profession. Medicine, having accepted the status of profession in society, and the special social, moral, and political status that follows, has also accepted a fiduciary duty to behave altruistically—placing society's concerns before its own.<sup>41</sup> In addition to obligations toward individual patients, therefore, society expects that physicians, both as individual providers and as a collective, will fulfill their enduring social responsibility. This is so particularly when dealing with issues around resource allocation, the social determinants of health, and inequities in health that result in avoidable differences in the incidence, prevalence, morbidity, and mortality that persist in society.

Codes of ethics for various health care professions therefore clearly recognize the power and obligations of their members that accompany entry into the profession. Those who hold the power to decide how health care resources are allocated and how health care professionals practice play a significant role in influencing the enormous disparities in health in the world today. Some have argued, therefore, that “it is not inequalities that kill people ... it is those who are responsible for these inequalities that kill people.”<sup>42</sup>

Social problems that arise from issues such as unemployment, poor living conditions, crime, gender inequalities, discrimination, and social exclusion play a key role in shaping the health and well-

being of people.<sup>43</sup> The maintenance and restoration of health is therefore a collective societal concern. People who are rendered vulnerable because of a combination of social, economic, political, environmental, or biological problems find it increasingly difficult to protect their own needs and interests. Chronic vulnerability leads to worse health outcomes and higher rates of morbidity and mortality.<sup>44</sup> Medical systems that tend to focus largely on the individual relationship between the physician and the patient, with little attention to the doctor's role and responsibilities to society, will face difficulty serving vulnerable groups. For these reasons, the 1997 Jakarta Declaration on Health Promotion Into the 21st Century places a high priority on “social responsibility for health,” particularly within the context of equity-focused approaches to policy making.<sup>45</sup>

Removing barriers to health requires the physician's responsibility to extend beyond the series of individual physician/patient encounters to the collective population—in Toynbee's terms, the “society”—in which those patients are embedded.

### **Implications for Medical Education**

If physicians are thus called on to practice social responsibility throughout their careers, how are they to be assisted in developing the skills necessary to express that responsibility and the insights required to assess whether they are doing so? Although systems of peer review will be an ongoing requirement for professional behavior, a more fundamental commitment to critical self-assessment is the real foundation for effective practice and lifelong learning by an independent professional. However, the question of how to better prepare future practitioners for their roles other than clinical expert is regarded as one of the more pressing and challenging issues facing medical educators today.<sup>46</sup>

This question is further complicated by concerns that some of the next generation of physicians hold negative attitudes toward patients with a low socioeconomic status.<sup>47</sup> Reluctance to address the needs of vulnerable populations is thought to be influenced by the fact that ever more medical

students and physicians come from privileged backgrounds and are socially distant from socioeconomic vulnerabilities.<sup>48</sup> Economic imperatives<sup>49,50</sup> are believed to engender an increase in self-interest over social responsibility,<sup>51,52</sup> resulting in an erosion of medicine's social contract and the ability of medical education to address these issues.<sup>13</sup> Added to this are student concerns about debt load, its relationship to specialty choice, and the tensions between these forces and societal needs in the physician workforce.<sup>53</sup> Medical schools are also being asked to ensure that future students and faculty come from diverse cultural, socioeconomic, geographic, and academic backgrounds.

It is beyond the scope of this article to adequately address all of these issues. At the very least, the integration of health advocacy into medical curricula and accreditation standards provides a strong impetus for nurturing future physicians to be socially responsive.<sup>54</sup> Medical educators are recognizing that "if advocacy is to be a professional imperative, then medical schools and graduate education programs must deliberately train physicians as advocates."<sup>55</sup>

It is nonetheless a difficult role to teach and evaluate—"it can be hard to teach messy real-world issues, but practitioners need to understand how these issues affect their patients and how to interact with, and ultimately improve, an exceedingly complex and fragmented system to provide good patient care."<sup>56</sup> In other words, it is not enough to simply tell medical students that health care practices and policies that fail to consider social determinants and ways of addressing related health disparities are unlikely to have the desired impact on health outcomes.<sup>57,58</sup> Learning needs to take place within the context in which it will be applied. Topics such as professionalism, health advocacy, social determinants, and ethics must be taught in ways that help learners move from knowledge to practice, acquiring the necessary skills throughout their medical education. Just as in clinical learning, educators will have to provide students with opportunities to experience what this knowledge looks like in their hands. If medical students believe that what they

are learning will have little or no impact, they will quickly become disengaged.

Hence, medical students need to be part of a community of practice, working closely with their teachers and others in the health care system who share a common interest and desire to develop and advance an increasingly sophisticated and practical sense of social responsibility. In this way, students learn that they can indeed effect positive change in the lives of their patients, in the communities they serve, and at the level of health policy and health systems. The recent establishment of accreditation standards requiring service-learning opportunities in medical education enables pedagogical opportunities that can facilitate the kinds of community relationships that are required to promote innovative approaches to integrating health advocacy competencies into medical training.<sup>59</sup> Medical schools have yet to fully integrate service-learning as part of the training process and to fully espouse this aspect of social responsibility, particularly during residency training.<sup>60</sup>

The few studies that have examined medical residents' attitudes toward health advocacy<sup>28–31,61</sup> indicate that although it is generally acknowledged as part of the physician's social responsibility, residents find few meaningful opportunities to practice advocacy during training. Moreover, residency is experienced as a stressful time for trainees, with immense pressure to master clinical competencies, and few mentors available in the area of health advocacy to work with and to emulate. Trainees identify enthusiasm, compassion, openness, integrity, and good relationships with patients as attributes they seek in their role models.<sup>62,63</sup>

Preceptors must model the behaviors they wish to see in future physicians. This can be done in several ways: (1) identify and become involved in advocacy activities that relate to your discipline, (2) apply evidence-based prevention and health promotion initiatives at the patient, community, and population levels, (3) identify and respond to factors outside the clinical encounter that influence health, (4) examine and respond to factors that result in barriers to care, and (5) take a scholarly approach to advocacy by encouraging and/or participating in research that contributes to a better understanding of the issues at

stake. These are only a few examples. Educators will need to work closely with learners to demonstrate in concrete ways how physicians' expertise and influence can help advance social responsibility in training and practice. We know that providing direct patient care is a powerful stimulus for learning, bringing together both cognitive and procedural knowledge as learners move from novice to expert clinicians through study and practice. The development of knowledge, attitudes, and skills pertaining to social responsibility can capitalize on this stimulus by actively involving learners in doing health advocacy.

A curriculum focused on developing social responsibility in future physicians will require pedagogical approaches that are innovative, collaborative, participatory, and transformative.<sup>64</sup> In practical terms, this means that medical schools, future physicians, and the communities they have a mandate to serve will need to work together to identify appropriate advocacy opportunities, collaborating on what specifically should be learned in areas of advocacy and why, how it can be best taught, and how learning should be assessed. Medical schools can begin by convening town hall meetings in their communities that provide opportunities for dialogue and discussion. Initial discussions can focus on how the curriculum can best foster opportunities for social awareness and responsibility. This also fosters the creation of a culture of social engagement. Postgraduate and undergraduate medical students can work together and help to prepare for the town hall by conducting literature searches and environmental scans, consulting with communities to identify priorities, exploring opportunities for partnerships with community-based organizations, and consulting with health authorities. Future physicians who participate actively in this process are more likely than those who don't to gain an increasingly sophisticated understanding of the issues, the relevance of social responsibility in medicine, and the importance of social accountability.<sup>65–77</sup> This is also a worthy scholarly activity that has been well established.<sup>78–80</sup>

Indeed, the social responsibility of medical educators and their institutions calls on them to succeed in achieving this

outcome by their students. This perspective has been confirmed at the global scale by the recently released Global Consensus on Social Accountability for Medical Schools.<sup>81</sup>

## Concluding Remarks

Our concept inquiry into social responsibility opens various possibilities for further examination. We hope to have provided a point of departure for examining the different epistemological and ontological considerations for exploring how medicine might consider its social responsibility for addressing health determinants, health disparities, and the priority health needs of society. We have also aimed to provide practical direction for actions to animate an evolving consensus among medical schools and organizations that a different future must be crafted than that which currently appears to be unfolding. By so doing, we wish to advance the common good—a good to which all have equitable access.

*Funding/Support:* This article was made possible by grant support to Dr. Dharamsi from the Social Sciences and Humanities Research Council of Canada, and the Royal College of Physicians and Surgeons of Canada.

*Other disclosures:* None.

*Ethical approval:* Not applicable.

*Previous presentations:* This article is based on a presentation by Dr. Dharamsi made at the symposium entitled Social Responsibility in the Health Professions: A Critical Exploration, organized by Dr. Dharamsi and Professor Tara Fenwick at the University of British Columbia in February 2009, and funded by the Social Sciences and Humanities Research Council of Canada.

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