Physician Advocacy for Public Health

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Abstract This article documents the public positions taken by the American Academy of Pediatrics, the American College of Physicians, and the American Medical Association on five topics with implications for public health: access to care for undocumented patients, fracking, gun control, climate change, and same-sex marriage. There are stark divisions on each of these issues between political parties, and taking a strong public position on them runs the risk of alienating some members of Congress, but each of these associations has done so. At the same time, there is a clear distinction between the public positions of these organizations and the priority given to them by their offices in Washington, DC. Drawing on an organizational maintenance framework, the author argues that taking these public positions is explained, in part, by a growth in the number of women and the number of physicians that affiliate with the Democratic Party in the United States.

Keywords physician associations, physician advocacy, organizational maintenance, interest groups, public health

There is a substantial literature in political science and health policy that explores the role of organized medicine in US politics. Much of this work focuses on efforts by the American Medical Association (AMA) and other professional associations to shape debates about health care reform and physician payments. A few studies have investigated efforts by physicians and other medical professionals to advocate on behalf of vulnerable groups, and a there is a large literature on physician advocacy for global health, but there has been less focus in the political science literature on the

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level and variety of political activism among physicians and their professional associations to promote public health issues in the United States.

This article draws on the literature on organizational maintenance to explain advocacy by physicians and major physician associations in the United States on five topics with implications for public health: access to care for undocumented patients, fracking, gun control, climate change, and same-sex marriage. All five issues are controversial and marked by partisan polarization (Roberts 2016). The differences between Democrats and Republicans on these issues are so stark that they reflect not only differences in values but also a different understanding of the facts; for example, Representative Joe Wilson (R-SC) shouted "you lie" to President Obama during an address to a joint session of Congress, after the president said, "There are also those who claim that our reform effort will insure illegal immigrants. This, too, is false—the reforms I'm proposing would not apply to those who are here illegally" (Obama 2009). The rise of the Tea Party and Republican victories in the 2010 midterm elections were attributed, in part, to the perception that the Affordable Care Act (ACA) offered care to "undeserving" poor, including undocumented patients (Gusmano 2015; Williams, Skocpol, and Coggin 2011), even though the ACA continues existing policy, which excludes this population from eligibility for public insurance.

Factual disputes about climate change are well documented. A 2016 Gallup Poll found that 84 percent of people who identify as Democrats believed that changes in the earth's temperature over the last century are due to human activities, but only 43 percent of those who identify as Republicans believed this is the case (Roberts 2016). The partisan gap appears to be even larger among members of Congress. In 1970, the average voting score by the League of Conservation Voters (LCV) was 58 among House Democrats and 51 among Senate Democrats, and the scores were 32 and 29 among House and Senate Republicans, respectively. By 2015 the gap between Democrats and Republicans grew enormously, with near unanimous opposition to environmental regulation among Republicans. In 2015 in the House the average LCV scores were 90 among Democrats and 3 among Republicans; in the Senate, 89 among Democrats and 4 among Republicans (Roberts 2016). During the past year, President Trump has called global warming a "hoax," and Republican leaders in Congress have claimed that climate change is "fake science" (Davenport and Lipton 2017). Support for hydraulic fracturing, more commonly known as fracking, is also divided along party lines, but the divisions are

less clear: Republicans are more likely to support fracking than Democrats, but some prominent Democrats have supported it.

Debates about gun control also invoke intense partisan debates. Most congressional Democrats support efforts to strengthen the background check system for those who purchase guns, favor reinstating the assault weapons ban, and want to close the so-called gun show loophole that makes it possible to sell guns at a gun show without a federal license. Republicans oppose these measures and argue that they would have no impact on gun deaths. Some even claim that the gun show loophole does not exist (Sherman 2016). In the view of most Republican leaders, restrictions on gun purchases would only keep guns out of the hands of law-abiding citizens and would not affect criminals. President Trump frequently cites high rates of gun deaths in Chicago as evidence that strict gun control laws do not work (Huppke 2017). Among members of the general public, there is some convergence between Democrats and Republicans about the extent to which unlawful acquisition of guns contributes to gun violence but radically different views about the consequences of legal gun ownership and the need to place restrictions on it (Oliphant 2017). According to a 2017 survey by the Pew Research Center, "A majority of Republicans (56%) say there would be *less* crime if more Americans owned guns; by contrast, 51% of Democrats say there would be *more* crime if more Americans had guns" (Oliphant 2017: n.p.). The same survey found that 64 percent of Democrats believe there would be fewer mass shootings if it were harder for people to legally obtain guns, but only 27 percent of Republicans agree with this statement; in fact, 18 percent of Republicans claimed that making it harder to purchase guns legally would lead to more mass shootings. Partisan divisions over same-sex marriage are equally severe. The party platforms in 2016 took opposite positions on the issue, with Democrats supporting same-sex marriage and the Republicans opposed.

Partisan political differences about these issues raise the stakes for physicians and physician organizations that take a position on them: for individual physicians there is a danger that they may alienate some of their patients; for physician organizations there is a danger that they may alienate the president or members of Congress who disagree with their position. At the same time, focusing on social issues may provide professional associations with an opportunity to appeal to a changing physician workforce by providing members with what are known as "purposive benefits."

While all five issues are similar because of their partisan nature, in the case of access to care for undocumented patients, some physicians and

many health care organizations have a clear financial stake in the outcome, whereas in the other cases the consequences for physicians are more indirect. Despite this, leading physician groups in the United States have arguably taken stronger and more consistent positions on climate change, gun control, fracking, and same-sex marriage than they have on access to care for undocumented patients.

In addition to comparing the responses of physicians and physician association to these issues, I discuss the consequences of physician political activism. Should physicians and their associations take policy positions on these issues? What are the benefits and harms of doing so? Answering these questions requires attention to several issues. To what extent do physicians and their associations have an ethical obligation to take positions on these issues? Are physician efforts likely to impact policy decisions? Will taking positions on these issues strengthen or undermine public trust in the profession? From the perspective of physician associations, could taking positions on these politically controversial issues undermine the capacity of physicians to influence policy on other issues, including health reform or physician payment issues?

After briefly reviewing the data and methods, in the next section I introduce the idea of organizational maintenance and why taking public positions on public health issues may help physician organizations retain a changing physician workforce. I then review the scholarship focused on efforts by organized medicine to prevent national health insurance (and, in more recent years, to advocate for expanded coverage) and to lobby against price controls. I introduce evidence that, in recent years, physicians and physician organizations have increased their focus on broader public health concerns, at least in terms of taking public positions. These recent efforts to address broader public health issues do not mean that economic interests are not central to physician organizations, but it does point to a broader physician association policy agenda. I then discuss cases in which at least some of the leading physician associations in the United States have taken public positions on controversial policy issues that are less directly related to physicians' economic interests.

Data and Methods

This article presents comparative case studies of physician advocacy efforts about access to care for undocumented patients, climate change, gun control, fracking, and same-sex marriage. The case studies are based on a review of relevant documents and telephone interviews with key

informants. I combined a review of the literature in health policy and bioethics with an analysis of public statements by physician associations since 1990 about access to care for undocumented patients, climate control, and gun safety. The physician associations included in the review were the three largest physician organizations in the United States: the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the AMA. To identify statements from these groups, I conducted a search of the associations' websites and reviewed the journals published by each (*Annals of Internal Medicine*, *Annals of Surgery*, *JAMA*, and *Pediatrics*). I also included a review of statements about access to care for undocumented patients from the three nephrologist associations in the United States—this specialty has been particularly involved with the issue of undocumented patients. To find additional statements by these associations and individual physicians, I conducted a review of news media accounts of physician and physician association advocacy on these issues.

Along with the document review, I conducted eight telephone interviews with physicians who have been involved with the governance of the ACP, the AMA, the AAP, and the Renal Physicians Association (RPA) and five telephone interviews with staff from their Washington, DC, offices. I asked each respondent to explain how their association made policy decisions, asked about the association's positions on the public health issues identified above, and asked, more generally, about the circumstances in which the association agrees to take on politically controversial issues, including negotiations that take place between the Washington, DC, office and the association governing bodies. Finally, I asked them to reflect on the benefits and burdens associated with taking these positions. The purpose of the interviews was not to provide a record of specific physician association decisions but to aid to understanding the issues that shape these decisions.

Physician Associations and Organizational Maintenance

For decades, social scientists have explored not only why people join groups but also the strategies used by organizations to maintain themselves. Some of the more recent literature emphasizes the need for groups to attract funding and external support (Teles 2016), but along with this, organizations must also work to keep their members. According to James Q. Wilson (2005: 13), a key function of organizational leaders is to supply "tangible and intangible incentives to individuals in order that they will become, or remain, members and will perform certain tasks." There is a large literature that explains why people join groups. Mancur Olson (1965), for example,

emphasizes the ability of organizations to overcome the free rider problem and bring about collective action by offering "selective benefits" to their members. Others argue that important reasons for joining groups include feelings of solidarity from belonging to a group, and purposive benefits, which are emotional and psychological benefits members of a group receive when the feel they have contributed to a cause they view as worthwhile (Clark and Wilson 1961; Moe 1980). If members believe that the group to which they belong is pursuing worthwhile causes, they are more likely to care about the group (Rothenberg 1988).

A hypothesis suggested by the case studies presented in this article is that physician associations have increased their focus on public health issues in recent years in order to provide purposive benefits to a changing physician workforce that includes more women and is more likely to affiliate with the Democratic Party and its policy positions. The demographic profile of physicians has changed radically during the past several decades. Although there is still a significant lack of racial and ethnic minorities among US physicians, the number of women in the medical profession has grown. Studies have documented the extent to which these demographic shifts have changed the delivery of medicine (Khullar 2017; Tsugawa et al. 2017), but in this article I argue that these changes may also have influenced the policy positions of the country's major physician associations.

Adam Bonica, Howard Rosenthal, and David J. Rothman (2015) have documented a steady political shift among rank-and-file physicians in the United States. Although there is variation among physicians by specialty (Sanger-Katz 2016), historically physicians have been more likely to identify with and support the Republican Party. As of 2016, however, the majority of physicians (54 percent) with a party registration were Democrats (Sanger-Katz 2016), and Bonica, Rosenthal, and Rothman (2015) found that since 1991 individual physicians have shifted their campaign contributions toward Democratic candidates—although the shift toward contributions to Democrats was mirrored in the public as a whole, the shift has been more pronounced among physicians. They speculated that this may be due to a demographic shift within the medical profession: as the number of women within the medical profession has grown and the number of physicians operating in solo practices has decreased, campaign contributions from physicians has shifted to Democrats. In the 1960s, women represented fewer than 10 percent of medical students. Today, about half of the students in medical school are women, and about one-third of practicing physicians are women (Khullar 2017). This is significant because women are much more likely to identify as Democrats (54 percent) than

Republicans (38 percent), and this gap has been growing during the past twenty years (Pew Research Center 2016).

As I discuss below, each of these organizations has democratic processes for bringing issues to consideration by the governing bodies. As attitudes among physicians evolve, it is reasonable to expect that some change may occur in the policies of these professional organizations. Furthermore, the leadership of these organizations has a stake in making sure that rank-and-file physicians view the organizations as representative of their views on major social issues. Although staff from these physician associations claim that some of their more controversial stances on the issues reviewed in this article have led to a loss of some members, they believe that overall the adoption of these positions reflects the preferences of their members.

At the same time, these organizations must remain focused on protecting their capacity to address the issues that are of highest priority to the membership and the organization. Namely, they continue to give priority to protecting physician practice autonomy and maintaining physician incomes. To do so, it is important for the organizations to have the capacity to work with representatives of both major political parties. To balance the desire of a growing segment of physicians to take public positions on politically controversial public health issues with the desire of physician organizations to maintain good relationships with members of Congress from both political parties, these associations have developed procedures for making public statements about a wide range of issues while setting priorities for lobbying on Capitol Hill that are more narrowly focused and give higher priority to the core issues of concern for physicians. As Steven Teles (2016: 456) explains, the "key question in studying interest groups . . . [is] not how they [induce] member contribution but rather how they [interact] with sources of support who [are] not 'members at all.'" A key source of support for these organizations is members of Congress. Although the AAP, ACP, and AMA have all adopted more liberal views of issues ranging from gun control to same-sex marriage, the Washington, DC, offices of these associations have rarely made these issues top priorities on Capitol Hill. Instead, the Washington staff of physician associations have focused primarily on issues on which the profession has a more direct stake and clearer expertise, even while the associations take public positions on a broader set of issues and work in collaboration with federal agencies and interest groups focused on other domains (Box-Steffensmeier and Christenson 2014; Heaney and Lorenz 2013; Phinney 2017). Having opportunities to take public positions on these issues while focusing lobbying efforts on insurance coverage and physician payment has allowed

these associations to maintain positive relationships with most conservative members of Congress.

The Physician Lobby and Health Policy: Protecting Physician Interests

Students of health policy in the United States are familiar with accounts of organized medicine as the powerful opponent of national health insurance (Blumenthal and Morone 20109; Marmor 2000; Quadagno 2005; Starr 1982). The first campaign to adopt national health insurance in the United States took place during the Progressive Era. Between 1910 and 1920, reformers attempted to pass legislation at the state level to establish programs of compulsory government health insurance. These efforts were damaged, however, by the US involvement in World War I and the subsequent burst of anti-German rhetoric throughout the country. Because the idea of compulsory health insurance was so closely linked to Germany, physicians were able to successfully link it to totalitarianism. Based on my own review of articles on compulsory health insurance published in *JAMA* between 1910 and 1920, beginning in 1917 articles started appearing denouncing compulsory health insurance as "un-American" and warning against allowing the "evils of foreign systems" to ruin the medical system in the United States. The AMA was also able to convince the federal government's Creel Committee on Public Information to attack German social insurance as a sham that had been used to placate German workers (Numbers 1978: 78). The federal government, consumed by its effort to discredit Germany, gladly complied with the request.

During the California campaign, launched on the eve of American involvement in the war, opponents often used anti-German rhetoric in their attacks on the bill. One pamphlet pictured a German soldier under the inscription "Compulsory health insurance made in Germany!" (Viseltear 1969: 177–78). Another, put out by the California League for the Conservation of Public Health, a group of paid lobbyists and physicians, stated: "*What is compulsory health insurance?* It is a dangerous device invented in Germany, announced by the German Emperor from the throne the same year he started plotting to conquer the world" (qtd. in Viseltear 1969: 178). Even Samuel Gompers, the president of the American Federation of Labor, adopted this language when he claimed that the concept was "at variance with our concepts of voluntary institutions and of freedom for individuals" (Mandel 1963: 184). Tapping into wartime hysteria regarding Germany and the Kaiser, such attacks were quite effective (Starr 1982: 253).

In every attempt to adopt national health insurance since the Progressive campaign, opponents have tried to characterize the idea as un-American, foreign, or socialist. During the Truman presidency, Republicans, working with the AMA, tried to claim that national health insurance was part of a larger socialist scheme. They accused the Truman administration of spending federal funds on behalf of "socialized medicine" and "in furtherance of the Moscow party line" (Starr 1982: 284). In 1948 Truman decided to counter this effort during the presidential campaign by arguing that national health insurance was "100 percent American" (Poen 1979: 130). Truman's surprise victory over Dewey gave reformers new hope, but it also mobilized the AMA like never before.

After Truman's victory, the AMA began a nearly $5 million campaign to defeat national health insurance (Kelly 1956: 106). The public relations firm of Whitaker and Baxter made effective use of the special social role played by doctors and the emotional ties that they had with their patients (Wehrle 1993). In their now famous poster, Baxter and Whitaker displayed a reproduction of Sir Luke Fildes's painting of a doctor at the bedside of a sick child. Underneath the picture the poster read "KEEP POLITICS OUT OF THIS PICTURE!" It claimed that "compulsory health insurance is political medicine. It will bring a third party—a politician—between you and your doctor. It would bind your family's health up in red tape. It would result in heavy payroll taxes—and inferior medical care for you and your family. Don't let this happen here!"

They also evoked the familiar theme of socialized medicine in their pamphlets, falsely claiming that Lenin had declared socialized medicine to be the keystone of the socialist state (Starr 1982: 285). This campaign was wildly successful—by the end of the year they had been able to get 1,829 organizations on record opposing compulsory health insurance (Kelly 1956: 81). Support in public opinion polls also evaporated, and the measure remained deadlocked in Congress (Starr 1982: 285). The Baxter and Whitaker campaign, in addition to being a great success, sounded several themes that continue to shape our debates about national health insurance. In addition to socialism, they evoked the specters of bureaucracy, red tape, high taxes, and a government-imposed restriction of choice. Many of the claims made against the Truman plan in 1949 were repeated by the opponents of subsequent efforts to pass national health insurance.

Presidents John F. Kennedy and Lyndon B. Johnson shifted the Democratic strategy to focus on Medicare, a proposal to provide limited hospital insurance for older people. The AMA and other opponents used the same arguments to attack the Medicare proposal that they had used to attack

national health insurance in previous decades. In 1961, the AMA launched "operation coffee cup," which involved enlisting doctors' wives to convince friends and neighbors to write letters to Congress opposing the King bill, a later version of which became Medicare. As part of this effort, the AMA hired Ronald Reagan to record an album that would be played during these coffee meetings. Reagan explained that the King bill was a call for socialized medicine and one part of a broader effort to create a system of socialism in America. Toward the end of the record, Reagan warns that, if the King bill is adopted, "you and I are going to spend our sunset years telling our children and our children's children what is was like in America when men were free" (Reagan 1961). Despite these efforts, the 1964 election resulted in a landslide victory for Johnson and large Democratic majorities in Congress. This in turn led to the adoption of a more expansive version of Medicare, which included hospital (part A) and physician (part B) insurance, as well as Medicaid, a federal-state health insurance plan for the very poor (Marmor 2000). Although proposals for national health insurance resurfaced briefly during the Nixon and Carter administrations, physicians—particularly the AMA—continued to oppose the expansion of public insurance.

By the time national health insurance reached the agenda during the Clinton administration in the early 1990s, however, uniform physician opposition to public insurance had softened. Reversing its earlier opposition to government insurance, the AMA called for universal coverage, but it continued to oppose any efforts to impose government cost controls (Quadangno 2005). Furthermore, many physicians had left the AMA and joined other associations, including the ACP and the AAP, which endorsed the Clinton health reform plan.

In 2009, when health reform made another comeback during President Obama's first term, the situation had changed radically. To gain the support of organized medicine, President Obama and congressional Democrats assured leaders of the AMA and other physician organizations that they would not attempt to reduce physician payments and would change Medicare payment policies in ways that would lead to an increase in payments to doctors (Laugesen 2011). Since the presidential election of 2016, these organizations have actively opposed Republican efforts to repeal and replace the ACA. In a letter to the chairs and ranking members of the House Energy and Commerce and Ways and Means committees, James L. Madara (2017: n.p.), the chief executive of the AMA, expressed the AMA's objection to the House health care reform bill: "We cannot support the AHCA as drafted because of the expected decline in health insurance coverage and the potential harm it would cause to vulnerable patient

populations." Madara wrote similar letters in opposition to the Senate health reform bills and the Graham-Cassidy proposal in September 2017.

The shift in the position of organized medicine, including the AMA, on the issue of public health insurance does not imply that physician associations have shifted away from protecting the economic and professional interests of doctors. The Democrats' victory in winning the endorsement of the AMA for health reform came at a steep price because they could not address the issue of medical prices without losing AMA support (Gusmano 2011; Laugesen 2011), and this made it far more difficult to address insurance affordability without increasing the federal deficit and/or raising taxes. Furthermore, as Miriam Laugesen documents in her book *Fixing Medical Prices: How Physicians Are Paid* (2016), the AMA and the Specialty Society Relative Value Scale Update Committee continue to exercise extraordinary influence over Medicare physician payments: "Across a range of policy areas from licensure to education, professional scope of practice, and reimbursement rules that limit other professions' payments, specialty organizations in particular remain powerful political actors . . . so too does the AMA" (204).

Physician Advocacy for Public Health

It is clear from the history of organized medicine's positions on national health insurance and physician payment that physician associations have not been hesitant to adopt politically controversial positions and risk the ire of one of the major parties on issues for which they have a material interest. Opposition to national health insurance between the administrations of Theodore Roosevelt and Bill Clinton clearly antagonized more liberal presidents and members of Congress, and their more recent support of the ACA has antagonized Republicans. Somewhat less attention has been given to efforts by physicians that are less directly related to their material interests and more focused on broad public health and public interest issues. In many ways this is understandable—along with the prominent role of the AMA as a key opponent of national health insurance and the continued efforts by the AMA and other physician organizations to resist price controls in medicine, most of the contacts between physicians and members of Congress involve Medicare payments and other issues that influence the economic and professional interests of physicians. A study published in 2000 estimated that there are about 29,000 meetings between physicians and members of Congress each year (Landers and Sehgal 2000). During these meetings, physicians focus on Medicare payments, managed care reforms, and funding for medical research. Broader public health

issues, including access to care for the uninsured and tobacco control, were rarely the focus of these discussions with members of Congress. The same study found that legislative aids on Capitol Hill argued that physicians would be more effective if they addressed a "broader range of health care issues" (Landers and Sehgal 2000).

Despite the narrow focus of many physician lobbying efforts on Capitol Hill, US physicians have a long history of advocating for public health and taking on issues that are not usually thought of as clinical issues. In 1961, for example, Physicians for Social Responsibility (PSR) was founded in the United States. PSR is an affiliate of International Physicians for the Prevention of Nuclear War, which won the 1985 Nobel Peace Prize. The early work of PSR focused on the public health dangers of atmospheric nuclear testing, and its work led to the Limited Nuclear Test Ban Treaty. By the 1990s, PSR turned its attention to the issues of pollution and climate change, and it works in partnership with a broad coalition of other organizations on these issues.

Since that time, physician involvement has expanded in a range of issues with public health implications. A search of *JAMA* between 1990 and 2017 using the key words *climate change, gun control, fracking, same-sex marriage*, and *undocumented immigrants* provides some evidence of the growing attention to these issues among the physician community. There was some attention to the issue of gun control among physicians in the early 1990s. It is likely that this was on the agenda of physicians and the AMA's signature journal, not only because of the increase in gun deaths in the United States but also because two important gun control laws were debated and enacted by Congress during this time period. The Brady Handgun Violence Prevention Act, named after James Brady, who was shot in an attempted assassination of President Reagan, imposed a five-day waiting period on the purchase of a handgun and required local law enforcement agencies to conduct background checks on purchasers of handguns. The Violent Crime Control and Law Enforcement Act of 1994 prohibited the sale, manufacture, importation, or possession of specific types of assault-type weapons for a ten-year period. In contrast, during this five-year period no articles were published in *JAMA* on the issues of climate change or undocumented immigrants (fig. 1).

After 1995, however, the number of articles on climate change and undocumented immigrants increased significantly, and the issue of gun control reemerged after 2009. All of the articles on these topics discussed their health complications. Most of these articles focused on the importance of discussing these topics with patients, but most also called on

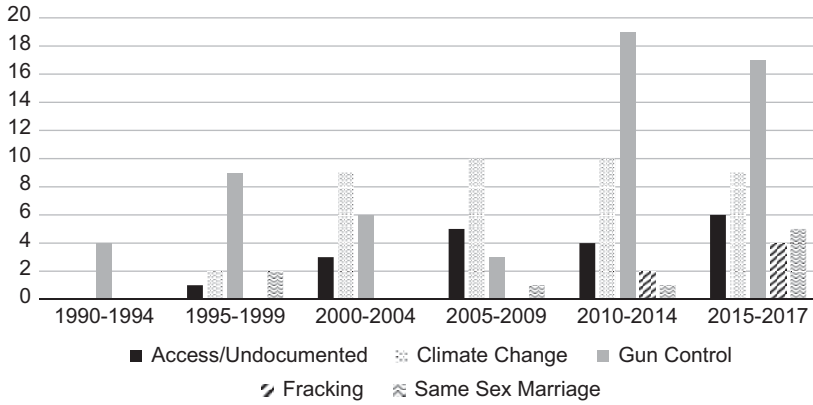

Figure 1 Number of Articles Published in *JAMA* on Access to Care for Undocumented Immigrants, Climate Change, Gun Control, Fracking, and Same-Sex Marriage, 1990–2017

Source: Author calculations based on a keyword search of *JAMA* issues published from January 1, 1990, through December 31, 2017.

physicians to take action, including collective action, to change relevant organizational and public policies.

As figure 2 suggests, the increased attention to these issues reflects their increased prominence on the broader societal agenda. As with the number of articles in *JAMA*, the number of articles in the *New York Times* increased for each of these topics during 1990–2017.

The Case of Access for Undocumented Patients

Undocumented immigrants in the United States face daunting barriers to obtaining health care. More than 11 million immigrants entered this country without valid visas or live here outside the terms of their original visas. Apart from their eligibility for emergency Medicaid, undocumented immigrants as a population are ineligible for public health insurance programs, including Medicare, Medicaid, the Child Health Insurance Program (CHIP), and subsidies available to purchase private health insurance under the ACA, because they are not "lawfully present" in the United States (US Department of Justice 1997).[1] These measures create a challenging

1. The public benefits category "Persons Residing under Color of Law" permits some undocumented patients, such as asylum seekers, to obtain Medicaid coverage if they meet exacting conditions.

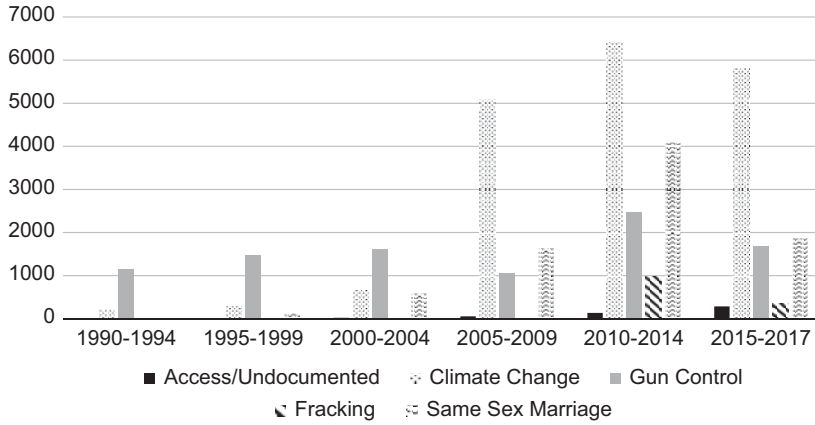

Figure 2 Number of Articles Published in the *New York Times* on Access to Care for Undocumented Immigrants, Climate Change, Gun Control, Fracking, and Same-Sex Marriage, 1990–2017

Source: Author calculations based on a keyword search of the *New York Times* issues published from January 1, 1990, through December 31, 2017.

environment for health professionals. Even before the election of President Trump in 2016, access to health care for undocumented patients was highly controversial.

Caring for undocumented immigrants often leads health professionals to consider what justice demands in an uncertain or even hostile policy environment. Increasingly, physicians and other health professionals have been asking how they should work to improve the health of undocumented immigrants (Marks 2012). Physicians often recognize that undocumented patients are members of a vulnerable population, whose vulnerability is often exacerbated by the legal and economic dimensions of their immigration status. These are also patients who experience injustice and may be reluctant to disclose information that reveals details of identity, residence, or immigration status. In addition to providing charity care and sharing information about the policies that support a patient's ability to get health care, individual physicians, health care organizations, and physician association have started calling policy makers' attention to the ethical challenges arising when regulations interfere with the professional duty of care or compel clinicians to manage undocumented patients' ongoing medical conditions as a series of emergent crises (Gruen and Pearson 2004; Rothman 2000; Wynia et al. 1999).

The three large physician associations I examined for this study have all taken positions on access to care for undocumented patients (table 1). Not

Table 1 Physician Association Positions on Access to Care for Undocumented Patients

Physician association	Public statement/policy on access to care for undocumented patients
American Academy of Pediatrics	*AAP Statement on Protecting Immigrant Children*, January 25, 2017: "The mission of the American Academy of Pediatrics is to protect the health and well-being of all children—no matter where they or their parents were born."
American College of Physicians	*National Immigration Policy and Access to Health Care, Summary of Position Paper Approved by the ACP Board of Regents*, 2011: "National immigration policy must balance several important factors. It should differentiate treatment of persons who fully comply with the law in establishing legal residency from that of persons who break the law in the determination of access to subsidized health coverage and treatment. At the same time, national immigration policies should ensure that all residents of the United States, without regard to their legal residency status, have access to medical care, especially for primary and preventive care and vaccinations against communicable diseases."
American Medical Association	*AMA Adopts New Policies to Improve Health of Immigrants and Refugees*, June 2017: "The AMA today called for deportation proceedings to consider and support the mental and physical health of children born in the United States to undocumented immigrant parents. These children are American citizens and the AMA believes their wellbeing should be taken into consideration when their undocumented parents may be detained or deported."

surprisingly, given the greater acceptance of providing health care to undocumented children, the AAP offered the strongest statement on this issue, arguing that children should receive medical care regardless of immigration status. The ACP board of regents adopted a policy in 2011 that was slightly more nuanced: it both acknowledged the possibility that citizens and legal immigrants may have greater claim on public insurance programs but still concluded that all residents, regardless of status, should have access to medical care. The AMA's position was more limited: it focuses on deportation policy and the potential harm to the health of children when parents are deported.

Along with efforts by larger physician associations to expand access to care for legal and undocumented patients and their children, physicians who treat undocumented immigrants with end-stage renal disease (ESRD) are particularly distressed at having to rely on emergency medicine to help manage this chronic condition because the patient is ineligible for the federal Medicare ESRD program and a state's emergency Medicaid program will not cover outpatient dialysis. Reliance on emergency treatment to manage this potentially life-threatening condition is problematic, as the patient's condition deteriorates rapidly without regular dialysis. Furthermore, emergent care, including dialysis, is more expensive than elective treatment, and the cost of an acutely ill patient's treatment and possible inpatient care is usually borne by the hospital (Raghavan and Nuila 2011). Similarly, some hospitalized undocumented patients no longer require acute care but cannot be safely discharged because, without insurance, they lack the means to pay for needed continuing care or no nursing home will accept them. This issue also has immense financial implications for health care organizations (Leland 2011; Roberts 2012). In one much-reported example, Atlanta's Grady Memorial Hospital, a safety-net institution that had started an outpatient dialysis program open to undocumented immigrants, closed this clinic in 2009, asserting that its $4 million annual subsidy had become unsustainable. In 2011, Grady and a private provider struck a deal to reopen the clinic, an arrangement that expired in 2014 (Sabin 2009; Williams 2011).

In 2010, the RPA revised its position statement on *Uncompensated Renal-Related Care for Noncitizens*. The association stated that:

> 1) all health care professionals and health care systems have an ethical obligation to treat the sick; 2) the federal government has the ethical and fiscal responsibility to provide care for patients within the US borders; 3) the financial burden of this care should fall not only on states that have the highest number of uninsured citizens or noncitizens, but also should be a national responsibility; 4) because of the unique nature of ESRD, all citizens and noncitizens with ESRD should be eligible for emergency federal funding if they do not have insurance or resources to pay for renal-related care; 5) nephrologists should not be expected to act as agents for the Immigration and Naturalization Service and should not be expected to report undocumented noncitizens because of patient confidentiality and the fiduciary nature of the patient-physician relationship. (Renal Physicians Association 2009)

This statement not only calls for public coverage of treatment for undocumented patients with ESRD but also argues that medical professionals treating these patients should not be asked to cooperate with federal government efforts to deport these patients as a result of their immigration status. In contrast, the other nephrology associations in the United States have remained largely silent on this issue, although they have joined other organizations raising concerns about the Trump administration's policies. For example, the American Society of Nephrology signed a letter that opposed the Trump administration's travel ban but has not issued a formal statement about access for undocumented patients. The American Society of Pediatric Nephrology was more indirect than the RPA but did produce a statement in which it argued that undocumented immigration status should not be used as a proxy for the likelihood of success associated with organ transfer, an intervention that is more relevant for children.

Taking these positions put the RPA in conflict with most Republican and many Democratic members of Congress. Although the RPA, along with most of the physicians who advocate for access to care for undocumented patients, is likely doing so because its members are distressed by the health implications of current law for these patients, the fact that physicians and hospitals have a financial stake in the policy debate raises questions about whether they would be willing to take on such a politically explosive issue if this were not the case. The next two cases—climate change and gun control—are useful comparisons because they are less likely to reflect these self-interested motives.

The Case of Climate Change

Scientists first took note of increases in global temperatures in the nineteenth century. In 1896, a Swedish chemist named Svante Arrhenius argued that a buildup of carbon dioxide in the atmosphere could lead to an increase in average global temperatures due to a "greenhouse effect" (Callahan 2016), but most scientists dismissed the claim. During the 1930s, scientist started documenting a clear trend in global warming, and Arrhenius was joined by Guy Stewart Callendar, who argued that warming due to the greenhouse effect was imminent (Weart 2012). In the 1950s, thanks to an increase in funding to study climate by the US military, scientists began to examine the buildup of carbon dioxide in the atmosphere and argued that this was likely to bring about global warming (Weart 2012). By the late 1970s there was a strong scientific consensus that human activity was

contributing to a change in climate and warmer temperatures. In 1979, the US National Academy of Science published a report in which it concluded that increases in carbon dioxide in the atmosphere would lead to rise in global warming (Callahan 2016). By 2007, the International Panel of Climate Change concluded that "warming of the climate system is unequivocal" (Callahan 2016) and reported that its members were confident that human activity was contributing to climate change (Weart 2012).

Although policy debates about climate change touch on a number of policy domains, including economic development, environmental policy, and energy policy, there is no question that climate change has implications for public health. The Greek physician Hippocrates (about 400 BC) related epidemics to seasonal weather changes, writing that physicians should have "due regard to the seasons of the year, and the diseases which they produce, and to the states of the wind peculiar to each country and the qualities of its waters" (Hippocrates 1978: 148). He exhorted them to take note of "the waters which people use, whether they be marshy and soft, or hard and running from elevated and rocky situations, and then if saltish and unfit for looking," and to observe "the localities of towns, and of the surrounding country, whether they are low or high, hot or cold, wet or dry . . . and of the diet and regimen of the inhabitants" (148).

There are a host of ways in which climate change may influence population health. Changing climates may limit the supply of affordable food and freshwater, two other global crises that threatened health (Callahan 2016). In addition, warming temperatures and rising sea levels may increase the risk of infectious diseases and heat stress (Cadot et al. 2007). Deterioration of air quality results in additional illness and death associated with respiratory and cardiovascular diseases. Children, older people, and other vulnerable groups, including people living with chronic illness and compromised immune systems, are particularly threatened by climate change.

All three of the physician associations examined for this study have issued policy statements in recent years (table 2). All three argue that climate change is real, is supported by valid scientific evidence, and has negative health consequences for the public. All three call on physicians and health care organizations to adopt environmentally friendly practices to reduce the contributions of the health care system to climate change. They also support policies and initiatives designed to combat climate change, but as in the case of undocumented patients, the AAP offers the boldest (and most specific) statement and calls for a "paradigm shift" with regard to energy production and consumption.

Table 2 Physician Association Positions on Climate Change

Physician association	Public statement/policy on climate change
American Academy of Pediatrics	*Global Climate Change and Children's Health* "Rising global temperatures are causing major physical, chemical, and ecological changes in the planet. There is wide consensus among scientific organizations and climatologists that these broad effects, known as "climate change," are the result of contemporary human activity. Climate change poses threats to human health, safety, and security, and children are uniquely vulnerable to these threats. The effects of climate change on child health include: physical and psychological sequelae of weather disasters; increased heat stress; decreased air quality; altered disease patterns of some climate-sensitive infections; and food, water, and nutrient insecurity in vulnerable regions. The social foundations of children's mental and physical health are threatened by the specter of far-reaching effects of unchecked climate change, including community and global instability, mass migrations, and increased conflict. Given this knowledge, failure to take prompt, substantive action would be an act of injustice to all children. A paradigm shift in production and consumption of energy is both a necessity and an opportunity for major innovation, job creation, and significant, immediate associated health benefits. Pediatricians have a uniquely valuable role to play in the societal response to this global challenge."
American College of Physicians	*Climate Change and Health: A Position Paper of the American College of Physicians (Crowley 2016)* "Climate change could have a devastating effect on human and environmental health. Potential effects of climate change on human health include higher rates of respiratory and heat-related illness, increased prevalence of vector-borne and waterborne diseases, food and water insecurity, and malnutrition. Persons who are elderly, sick, or poor are especially vulnerable to these potential consequences. Addressing climate change could have substantial benefits to human health. In this position paper, the American College of Physicians (ACP) recommends that physicians and the broader health care community throughout the world

(*continued*)

Table 2 Physician Association Positions on Climate Change (*continued*)

Physician association	Public statement/policy on climate change
	engage in environmentally sustainable practices that reduce carbon emissions; support efforts to mitigate and adapt to the effects of climate change; and educate the public, their colleagues, their community, and lawmakers about the health risks posed by climate change. Tackling climate change is an opportunity to dramatically improve human health and avert dire environmental outcomes, and ACP believes that physicians can play a role in achieving this goal."
American Medical Association	*Support for Efforts to Promote Environmental Sustainability and Halt Global Climate Change* "As climate change continues to affect public health across the world, the AMA adopted policy in support of initiatives that promote environmental sustainability and efforts to halt global climate change. The policy also calls for aiding physicians in adopting environmentally-sustainable programs in their practices and sharing these concepts with their patients and communities. Scientific surveys have shown clear evidence that our patients are facing adverse health effects associated with climate change. From heat-related injuries and forest fire air pollution, to worsening seasonal allergies and storm-related illness and injuries, it is important that we make every effort to put environmentally friendly practices in place to lessen the harmful impact that climate change is having on patient health across the globe."

The Case of Gun Control

According to the Centers for Disease Control and Prevention, more than thirty thousand people die in the United States every year from gun violence (Centers for Disease Control and Prevention 2017. Between January 1 and November 5, 2017, there were 307 shootings in which four or more people were injured or killed in the United States. Physicians have the potential to play an important role on this issue at the clinical level by speaking with patients about gun safety. Increasingly, individual physicians and physician organizations have decided that they should also take action against gun violence by advocating for gun control legislation and for federal research funding to better understand gun violence.

Support of legislation that would restrict access to handguns, for example, has always been high among pediatricians, and it has increased over time (Olson, Christoffel, and O'Connor 1997). Regardless, many physicians feel that asking about guns in the home and gun safety may cross a line between issues that are clinically relevant and those that are not. This issue forces physicians to consider how to balance the importance of encouraging gun safety and the capacity of physicians to do so with the concern that bringing this issue up in the context of a physician visit might anger some patients and undermine the doctor-patient relationship. One recent national survey found that 47 percent of physicians said that doctors should talk to patients about gun safety, 39 percent said no, and 4 percent were unsure. The push by many physicians and physician associations to encourage conversations about gun safety has led to a backlash in some states. Florida governor Rick Scott signed a 2011 law to restrict the ability of physicians to ask patients about firearms. The law made an exception for when questions about guns are "relevant to the patient's medical care or safety or the safety of others," but the law did not define what this means. Even though it seemed to leave an opening for physicians to discuss the issue with their patients, the law may have had chilling effect on physician behavior because the penalty for violating the law was loss of license. In February 2017, the Eleventh US Circuit Court of Appeals, in a 10–1 decision, struck down the portion of the law that restricted what physicians can say to patients about firearm ownership. The court found that the law violated the First Amendment rights of physicians (Hersher 2017).

Even in the face of political opposition to gun control and objections to physician efforts to promote it, all three physician associations have taken strong positions encouraging physicians to speak to their patients about gun safety. Furthermore, most of these organizations have also adopted positions encouraging Congress to adopt stronger gun control measures (table 3).

The Case of Fracking

Hydraulic fracturing, more commonly known as fracking, is a process for extracting oil and natural gas from shale rock. Developed in the 1940s, its use has increased substantially since the late 1980s. It involves drilling into shale, either vertically or horizontally, and injecting a mixture of water, sand, and chemicals at high pressure to release the gas trapped in the rock. Fracking makes it possible to tap into stores of gas that are otherwise difficult to reach. In the United States, the amount of natural gas that could be produced from fracking could increase the domestic supply of fuel

Table 3 Physician Association Positions on Gun Control

Physician association	Public statement/policy on gun control
American Academy of Pediatrics	*Firearm-Related Injuries Affecting the Pediatric Population (2012)* "The absence of guns from children's homes and communities is the most reliable and effective measure to prevent firearm-related injuries in children and adolescents. Adolescent suicide risk is strongly associated with firearm availability. Safe gun storage (guns unloaded and locked, ammunition locked separately) reduces children's risk of injury. Physician counseling of parents about firearm safety appears to be effective, but firearm safety education programs directed at children are ineffective. The American Academy of Pediatrics continues to support a number of specific measures to reduce the destructive effects of guns in the lives of children and adolescents, including the regulation of the manufacture, sale, purchase, ownership, and use of firearms; a ban on semiautomatic assault weapons; and the strongest possible regulations of handguns for civilian use."
American College of Physicians	*Reducing Firearm-Related Injuries and Deaths in the United States*, April 10, 2014 "A new policy paper from the American College of Physicians (ACP) offers nine strategies to address the societal, health care, and regulatory barriers to reducing firearms-related violence, injuries, and deaths in the United States. Reducing Firearm-Related Injuries and Deaths in the United States is published today in the peer-reviewed medical journal, *Annals of Internal Medicine*. Principal among ACP's nine strategic imperatives is the recommendation to approach firearm safety as a public health issue so that policy decisions are based on scientific evidence. As such, ACP strongly supports universal criminal background checks to keep guns out of the hands of felons, persons with mental illnesses that put them at greater risk of harming themselves or others, people with substance use disorders, and others who current regulations prohibit from owning guns."
American Medical Association	*AMA Calls Gun Violence "A Public Health Crisis"* "The AMA has adopted several policies that deal with multiple dimensions of gun safety. On June 14, 2016, the AMA issued a statement calling gun violence a public

Table 3 (*continued*)

Physician association	Public statement/policy on gun control
	health emergency in the U.S. In the wake of the worst mass shooting in American history and with more than 6,000 deaths already in 2016 from gun violence, the American Medical Association (AMA) today adopted policy calling gun violence in the United States "a public health crisis" requiring a comprehensive public health response and solution. Additionally, at the Annual Meeting of its House of Delegates, the AMA resolved to actively lobby Congress to overturn legislation that for 20 years has prohibited the Centers for Disease Control and Prevention from researching gun violence."

enormously, lead to new jobs in the energy sector, and reduce US reliance of foreign sources of fuel (BBC News 2015). Despite the promise of fracking, there are concerns about the potential environment and health implications of the practice. Studies have found that fracking has led to water and air pollution (Konkel 2016; Meng 2017) and that fracking creates public health hazards and leads to poor health outcomes (Hays and Shonkoff 2016).

As with the other issues discussed in this article, the public is deeply divided on the question of fracking, and party affiliation is highly correlated with these differences. According to a 2015 Gallup Poll, Republicans are much more likely to favor fracking (66 percent) than are Democrats (26 percent) (Swift 2015). Most Democrat officials in Congress and in the states either oppose the practice or call for stricter regulations, and most Republican officials support expanding the practice (Cama 2014), but the official party differences are arguably less stark than for most of the other issues examined in this article (Biello 2014). The complex partisan divide is illustrated by the disagreement between 2016 Democratic candidates Bernie Sanders and Hillary Clinton: Sanders expressed complete opposition to fracking, but Clinton had promoting fracking as US secretary of state (Evensen 2016; Leber 2016).

Fracking, because it has not been on the public agenda as many years as the issues discussed above, has not received as much attention from major physician associations. Nevertheless, in the past five years both the AAP and AMA have adopted positions on policies that would regulate fracking (table 4), but the ACP has not yet posted an official statement about fracking on its website. As with some Democratic elected officials, the AAP and AMA fall short of calling for a ban on this practice, but both organizations

Table 4 Physician Association Positions on Fracking

Physician association	Public statement/policy on fracking
American Academy of Pediatrics	*American Academy of Pediatrics Endorses Legislation to Protect Children from Unhealthy Chemical Exposures*, April 17, 2013 "As they grow and develop, children are especially vulnerable to the harmful effects of chemicals in the environment," said AAP President-Elect James Perrin, MD, FAAP. "Pediatricians commend Senators Lautenberg and Gillibrand for introducing the Safe Chemicals Act of 2013, which puts children's health first and foremost by making needed improvements to current law."
American Medical Association	*Calling for Disclosure of Chemicals Used during "Fracking,"* June 9, 2015 "Concerned about the inability to effectively monitor and track possible long term public health and environmental changes associated hydraulic fracturing, physicians today voted to adopt policy supporting the full disclosure of chemicals placed into the environment during the petroleum, oil and natural gas exploration and extraction process. . . . The new AMA policy also supports the requirement that government agencies record and monitor the chemicals placed into the environment for extracting petroleum, oil and natural gas. Monitoring for fracking chemicals should focus on human exposure in well water and surface water and government agencies should share this information with physicians and the public."

support enhanced monitoring and reporting of the environmental and health implications of fracking.

The Case of Same-Sex Marriage

On June 26, 2015, in *Obergefell v. Hodges* the US Supreme Court struck down bans on same-sex marriages as unconstitutional. State recognition of same-sex marriage has been an issue in the United States for more than forty years. In 1973 Maryland became the first state to pass a law banning same-sex marriages (Hagerty 2007). Twenty years later, the Hawaii Supreme Court ruled that denying marriage to same-sex couples is a violation of the Equal Protection Clause of the state constitution, but five

years later voters in Hawaii adopted a constitutional amendment to ban same-sex marriage (Lincoln 2013). At the federal level, President Clinton signed the Defense of Marriage Act 1996, which denied federal benefits to married same-sex couples (Adam 2003). Starting in 1999, several states, including California, Maine, Massachusetts, New Hampshire, and Vermont, adopted new laws to legalize same-sex marriage (Wolf 2015), culminating in the 2015 Supreme Court decision.

Support for same-sex marriage in the United States has been growing steadily since the early 2000s. Democrats and Republicans remain divided over this issue: 73 percent of Democrats and 70 percent of independents favor same-sex marriage, but only 40 percent of Republicans favor same-sex marriage, although Republican support has increased in recent years (Pew Research Center 2017). The differences between Democrats and Republicans are even more pronounced among elected officials than in the general public, as illustrated by the 2016 party platforms. The Democratic platform celebrated the Supreme Court's protection of same-sex marriage and called for expanding these protections. In contrast, the 2016 Republican Party platform read:

> Traditional marriage and family, based on marriage between one man and one woman, is the foundation for a free society and has for millennia been entrusted with rearing children and instilling cultural values. We condemn the Supreme Court's ruling in United States v. Windsor, which wrongly removed the ability of Congress to define marriage policy in federal law. We also condemn the Supreme Court's lawless ruling in *Obergefell v. Hodges*, which in the words of the late Justice Antonin Scalia, was a "judicial Putsch"—full of "silly extravagances"—that reduced "the disciplined legal reasoning of John Marshall and Joseph Storey to the mystical aphorisms of a fortune cookie" (Republican National Committee 2016).

The issue of same-sex marriage raises a number of public health issues. First, bans on same-sex marriage may contribute to broader environment of discrimination, which can lead to stress among individuals who are the targets of this discrimination (Buffie 2011). Second, bans are a threat to health because people may be denied access to health care if they are not protected by marriage benefits under federal or state laws (Buffie 2011; Schencker and Herman 2015).

All three physician associations have adopted strong statements in favor of same-sex marriages (table 5). The AMA has adopted a long list of policies to protect LGBTQ rights, including a 2011 policy articulating the group's support for same-sex marriage. The AAP adopted a statement in 2013 that

Table 5 Physician Association Positions on Same-Sex Marriage

Physician association	Public statement/policy on same-sex marriage
American Academy of Pediatrics	*Promoting the Well-Being of Children Whose Parents Are Gay or Lesbian*, April 2013 "The American Academy of Pediatrics (AAP) supports civil marriage for same-gender couples—as well as full adoption and foster care rights for all parents, regardless of sexual orientation—as the best way to guarantee benefits and security for their children."
American College of Physicians	*Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper From the American College of Physicians*, June 21, 2015 (Daniel et al. 2015) "In this position paper, the American College of Physicians examines the health disparities experienced by the lesbian, gay, bisexual, and transgender (LGBT) community and makes a series of recommendations to achieve equity for LGBT individuals in the health care system. . . . Various state or federal laws may affect the quality of life of LGBT persons and can affect their physical and mental health. Same-sex marriage bans may cause psychological distress (5), prohibitive hospital visitation policies may prevent a same-sex parent from seeing a minor while the child is ill or participating in medical decision making for the child, and exclusions on transgender health care in private and public health plans may cause a transgender patient to seek treatment options through illegal channels (6). These laws and policies, along with others that reinforce marginalization, discrimination, social stigma, or rejection of LGBT persons by their families or communities or that simply keep LGBT persons from accessing health care, have been associated with increased rates of anxiety, suicide, and substance or alcohol abuse (7)."
American Medical Association	*Health Care Disparities in Same-Sex Partner Households, H-65.973*, June 28, 2011 "Our American Medical Association: (1) recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households."

reaffirmed its position in favor of same-sex marriage first adopted in 2002 (American Academy of Pediatrics 2013). In 2015 the ACP also adopted a very similar position on this issue.

Conclusions: The Politics of Physician Advocacy and Organizational Maintenance

There is a long tradition of physicians playing an active role in promoting public health and addressing issues of public safety. During the past few decades, however, physicians appear to be paying increased attention to public health issues. In addition, physician associations have adopted clear public positions on issues that are both highly partisan and, at best, indirectly related to the economic interests of physicians or their professional autonomy. Organized medicine is still a potent force in American politics and has a profound effect on health policy (Laugesen 2016). Many physicians argue that this power brings with it responsibility (Physicians for Human Rights 2018). Although the AMA still tends to be more politically conservative than many other physician associations with regard to its policy positions, and more bipartisan in its campaign finance contributions, it too places an emphasis on physician social responsibility. In its 2001 Declaration of Professional Responsibility, the AMA House of Delegates declared, "Humanity is our patient," and stated they were "solemnly commit[ted]" to "[a]dvocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being" (Marks 2012: 240).

Should Physician Associations Address These Issues?

The AMA declaration suggests that physicians have an ethical obligation to speak out on the social and economic determinants of health, and many physicians and bioethicists agree with this position. Trust in physicians has declined over the decades, but they are still trusted more than most professionals and are a credible source of information on many topics (Donohoe and Schiff 2014; Patashnik, Gerber, and Dowling 2017). For example, one study suggested that physicians are a trusted source on the issue of climate change, even though most are neither trained in this field and do not conduct research on this topic. Public trust in physicians alone, however, may not be sufficient. The obligation of physicians and their associations to take public positions on issue has limits. When the issue in question depends on knowledge and expertise that physicians do not have,

it is not clear that they have an obligation to speak out. In fact, if being a physician does not provide special insights into an issue, it may be inappropriate to suggest that the public or policy makers should assume that the "doctor knows best." Do no harm is an important principle in medical ethics, and it applies to their participation in the political process as well. In the cases described in this article, however, physician associations have focused primarily on the health consequences of these issues. The positions they have adopted on the issues of climate change, fracking, and gun control have echoed the positions taken by groups with expertise in these areas.

It is easier to make a case for an obligation to advocate on an issue when physicians have knowledge that is relevant. In those cases, physicians may have an obligation not to remain silent (Dwyer 1994). Even though physician advocacy for social, economic, educational, and political change is still not widely accepted, the trust they enjoy, along with their understanding of the health consequences of many social issues, puts physicians in a unique position to address these topics. Indeed, due to their capacity to influence public opinion and their specialized knowledge, some argue that these professionals have a moral obligation to speak out (Ahn 2017). What explains the willingness of individual physicians and physician associations to adopt these positions?

Why Are Physician Associations Addressing These Issues?

The policy positions of the AMA and other leading physician associations seem to reflect a broadening of physician interest in public health and a willingness to break with Republicans on a number of key of issues. Representatives from these associations indicate that these policy position reflect the views of their membership but that the shift in the policy agenda of these organizations is often the result of highly motivated individuals who act as "policy entrepreneurs" within each organization. As one respondent explained, "I think we have definitely gotten involved in a broader set of public health issues. Sometimes we get push back from members about taking position on these issues. Climate change is a good example. A lot of members expressed concern and asked why we were putting ourselves out there on this? Our position on gun violence also got push back—but generally people have been supportive." Representatives from all of these associations described their policy making process as "democratic" and "bottom up."

Another factor that may have played an indirect role in bringing these issues to the agenda of physician associations is the role of coalitions,

which can draw organizations into new issues and strengthen their ability to influence policy in particular policy domains (Baumgartner et al. 2009; Phinney 2017). The AMA, ACP, and AAP all devote considerable energy to organizing, leading, and participating in coalitions on a routine basis (Heaney and Lorenz 2013). These associations often create or join coalitions, which then influence subsequent actions and priorities. For example, several physician organizations, including the AAP and AMA, partnered with the US Environmental Protection Agency to address the issue of environmental asthma (US Environmental Protection Agency 2016). The AMA, ACP and AAP all participate regularly in coalitions to influence health policy (Heaney 2006).

In the cases described in this article, however, the respondents I interviewed emphasized the role of individual members, rather than coalition partners, in bringing these issues up for debate at national meetings. It is possible that physician associations were encouraged to adopt positions on a broader set of issues in part to satisfy the political needs of the coalition leaders (Hula 1999), but the immediate source of these efforts appears to be from physician members. Nevertheless, it is clear from the statements adopted by each association that they have been influenced by other agencies, professional associations, and advocacy groups with which they have partnered on other issues.

Beyond the formal policy positions of the associations, one respondent emphasized that the associations offered a number of opportunities for members to shape the policy agenda without necessarily adopting formal policy resolutions. Each of the associations publishes professional journals, and according to this respondent, they offer opportunities for the association members to speak out on policy issues even when the national offices are not yet ready to take a formal position on an issue.

The AMA's House of Delegates and ACP's board of regents, in particular, tend to be more conservative than their members. In addition, the Washington, DC, offices of all the associations will sometimes push back against requests to emphasize particular issues. In some cases, they may interfere with other legislative priorities that directly impact physicians. For example, there were concerns about how much priority to give to the issue of undocumented patients because the lobbyists for each of these associations are placing greater emphasis on opposing the ACA "repeal-and-replace" efforts by Republicans and pushing to reauthorize the Child Health Insurance Program. The people with whom I spoke thought there was little chance they could get Congress to move on the issue of expanding access for undocumented patients but thought that they could preserve insurance coverage gains associated with the ACA.

This conservative tendency is also mirrored AMPAC, the AMA's political action committee (PAC). AMPAC was the first PAC established by a trade organization, and it is a large institutionalized PAC with a complex decision-making structure that is often slow to respond to changes in the political or social environment. Like most institutional PACs, AMPAC tends to be conservative and provides support for members of both political parties, but it provides the greatest support to incumbents in an effort to maintain access to decision makers. Historically, AMPAC has been more generous in its support of Republican candidates, and this did not change in 2016. More than half of AMPAC's contributions went to Republicans during the 2016 election cycle (Open Secrets 2016).

Among physician association policy staff working in Washington, DC, there is a clear focus on preserving access to members of Congress from both parties. Not surprisingly, the political feasibility of changing existing policy is a much greater concern among the staff working on Capitol Hill. According to one respondent, "It is important for us to have national policies, but the DC office does not have to be active on everything. We set priorities based on our assessment of what is feasible." A respondent from one of the other associations used almost exactly the same language:

> There are obviously things that get passed at [the national meeting] that never get implemented or are only implemented in a modest way. The Washington office may not make certain issues high priorities. If you are not going to be able to create any movement on an issue, it is a mistake to burn political capital on it. . . . We try to act strategically. After Newtown, there is a moment in which you may be able to act on gun control, so we try to take advantage of those windows of opportunity.

During the past two decades, professional physician associations have clearly broadened their focus to include a wide range of public health issues. The leading physician associations in the United States have adopted bold, politically controversial positions on issues that fall outside the usual scope of clinical medicine. These efforts appear to reflect the changing demographics of the physician population in the country and the democratic nature of the professional associations that represent them. To the extent that physicians continue to enjoy a position of trust among members of the public, these policy positions and public statement may be important to the broader public dialogue. Nevertheless, the desire to maintain support from a changing group of rank-and-file physicians has not distracted the leadership or the professional staffs of these associations from their primary focus in Washington, DC. With few

exceptions, the legislative agendas of these organizations remain focused on insurance coverage and physician payment.

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