Commentary

Civic Engagement: A Physician's Perspective

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Abstract Deep currents of cultural change are having an effect on the medical profession, beginning with gradual decreases in membership numbers in county, state, and national organizations that influence education, training, policy making in the health care sector, and political lobbying, and with gradual increases in membership numbers in specialty organizations that provide educational materials and meeting venues for physicians to remain current in their specialties and to develop and maintain professional relationships. Concurrent with the demographic changes, medical professionalism has become a growing movement to organize accepted professional behaviors into ten commitments, two of which, improving access to care and just distribution of finite resources, are consistent with Russell L. Gruen's concept of civic mindedness. There are also increasing numbers of physician-activists who are emphasizing the need for greater civic engagement. Medical institutions have the opportunity to build on these commitments to inculcate strong social skills and civic attitudes and behaviors at all levels of education, training, and medical practice for the betterment of patients and for the greater public health of the community and the country.

Keywords civic engagement, medical education, medical training, organized medicine, public health

> *Knowing is not enough; we must apply. Willing is not enough; we must do.*
> —Goethe

Physicians have a long tradition of civic engagement, providing thoughtful opinion and leadership to the community. Yet, surprisingly little is actually known about the process by which this develops, thus this special issue, edited by my Tufts colleague political scientist Eitan Hersh.

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The deep currents of cultural change are beginning to leave their mark on the medical profession. For centuries, physicians have been relatively homogeneous in makeup: white, male, favored economically, and privileged, both professionally and socially. More recently, while the economics continue to favor the profession, the demographics have been shifting, and privilege is yielding to lessened paternalistic and more egalitarian pressures. Of particular interest, however, are the political lines that are brightening and the civility that is fraying. In this essay, I offer a highly personal view of the forces at play and thoughts about expected future directions.

Background

The modern era of medical education and training can be traced to the Flexner Report of 1910 that firmly placed the American and Canadian systems on a solid biomedical footing (Duffy 2011). It soon led to standardized curricula and more gradually to a collection of shared beliefs and practices among physicians. It also shifted the focus of clinical training from the community of private practitioners to the university (Starr 1982: 123).

Three distinct sets of professional activities have evolved over the twentieth century that concern the medical profession, beginning with medical education, proceeding through training and into professional life:

License to practice: Medical students and physicians in training must pass multistep exams administered by the Federation of State Medical Boards that they may use to apply for a license to practice medicine in each state of interest. Physicians must maintain each separate state license by complying with requirements for continuing medical education and by paying periodic fees.

Organized medicine: County, state, and national medical organizations that cut across medical specialties have grown into highly functional organizations that have supported and influenced the course of medical education and training, policy making in the health care sector, and political lobbying.

Specialty activities: A complex system of specialized, multiyear residency training programs has gradually evolved, conducted primarily at academic medical centers, comprising 24 specialties and 119 subspecialties (American Board of Medical Specialties n.d.). The practitioner who completes the requisite training and passes the exam for a specialty is recognized as a diplomate certified in the examined

specialty (or subspecialty). Hospitals, clinics, and other business entities that provide patient care often require diplomate status to practice a specialty in their facilities. Many specialty boards require periodic reexamination. Specialists usually maintain membership in separate specialty organizations (usually identified as colleges, academies, or societies), publish in their specialty journals, and attend local, regional, and national meetings to remain current in the knowledge base and to develop and maintain professional relationships.

Although the practice of medicine is expressly focused on the individual patient, as practiced since ancient times and codified in ethical codes, it is at the specialty level that more long-term, population-level, strategic goals are advocated, sought, undertaken, and lobbied. It is at this level that stress lines become especially evident.

Over the past several decades, vast changes have occurred in membership numbers, demographics, and interests that largely reflect societal changes and that have been facilitated by the dramatic acceleration of technological developments. Traditional memberships in county (41 percent), state (61 percent), and national (American Medical Association [AMA]: 26.4 percent) components of organized medicine have been gradually decreasing while memberships in specialty organizations (colleges, academies, and societies) have been gradually increasing (78.5 percent) (Physicians Foundation 2016). Key changes have also occurred in the nature of physician engagement.

Engagement

All practicing physicians spend the greatest proportion of their time in the clinical sphere, with little to no time available to spend in public and non-health-care business sectors. Instead, there is participation in specialty organizations that can range from simple membership to roles in leadership within the organization and representation to many different outside stakeholder organizations. These enhanced levels of participation (engagement) all require skills that are learned almost entirely on the job.

Against this backdrop of extensive, inwardly focused organizational activity, there has been a growing movement to organize accepted professional behaviors systematically under the rubric of medical professionalism. Based on three fundamental bioethical principles (primacy of patient welfare, patient autonomy, and social justice) and structured under four core physician values (patient-centered care, integrity and accountability, pursuit

of excellence, and fair and ethical stewardship of health care resources), Wendy Levinson and colleagues (2014) describe ten physician commitments: competence, honesty with patients, patient confidentiality, appropriate relations with patients, improving quality of care, improving access to care, just distribution of finite resources, scientific knowledge, maintaining trust by managing conflicts of interest, and professional responsibilities.

Two of these commitments, improving access to care and just distribution of finite resources, lend themselves well to what Russell L. Gruen, Eric G. Campbell, and David Blumenthal (2006) have identified as having civic mindedness, including community participation, political involvement, and collective advocacy. The field of public health has the most extensive experience in providing deeply researched issues that have been subsequently played out in all three aspects of Gruen's civic mindedness, often described as social determinants of disease, including poverty, racism, illiteracy, environmental pollution, tobacco use, alcohol, opioid and other substance abuse, domestic violence, depression, and suicide.

Political involvement by physicians has recently been brought into focus. Margot Sanger-Katz (2016), working with data from two large public data sets (analyzed by Eitan Hersh and Matthew Goldenberg 2016), has taken a close look at how party affiliation correlates with physician age, physician specialty, and specialty compensation. She shows that younger physicians tend to lean Democratic and older physicians tend to lean Republican, that specialties sort out across the spectrum from surgery (67 percent Republican) to psychiatry (24 percent Republican), and that higher-compensated specialties lean Republican.

The gradually increasing heterogeneity of the physician community is evident in the active, if small, number of physicians who engage in one or more of the three aspects of Gruen's civic orientation, including the well-recognized clinical physician-activists H. Jack Geiger (*Tufts Now* n.d.), Ellen Bassuk (1996), and James O'Connell (2015) and the Nobel Peace Prize recipient organizations Physicians for Social Responsibility (2018) and Médecins Sans Frontières (2018). There is also a growing rank of physicians who emphasize the need for active civic engagement, for example, Richard Pan (2014: n.p.), who discusses why it is important for physicians to learn "to step out of the hospital and clinic to support communities in making positive change"; Karen Rhea (2014: n.p.), who identifies civic participation as "the new frontier for physicians to combat the effects of poverty and inequality on health in enduring ways"; and Donald M. Berwick (2017: 2081), who expresses his concerns in moral

terms: "To try to avoid the political fray through silence is impossible. Because silence is now political. Either engage or assist the harm. There is no third choice."

Considering a related trend, books (e.g., Urman and Ehrenfeld 2012), blogs (e.g., Page 2018), and conferences (SEAK 2018) attest to the growing numbers of physicians at all stages of their careers who are dissatisfied with the present clinical environment of medicine and are seeking fulfillment in nonclinical careers in medicine. Such careers include health care consulting, entrepreneurship, the pharmaceutical and medical device industries, medical education, public policy and public administration, public and global health, journalism, and publishing and writing. Several of these are civic engagements or nonprofit-based endeavors (Urman and Ehrenfeld 2012).

And there have always been other, "hyphenated" physicians who have worked beyond the clinical sphere, for example, physician-writers/novelists (William Carlos Williams, Michael Crichton, Abraham Verghese, Atul Gawande), physician-journalists/popularizers (Lewis Thomas, Lawrence Altman, Nancy Snyderman, Elizabeth Rosenthal), and physician-politicians of all political stripes (Paul Rand, Howard Dean, Donna Christian-Christensen). These have been the exceptions—physicians who have found ways to express themselves beyond their patients, beyond clinical medicine.

Themes

The articles in this special issue delve into several distinct themes that cover a range of considerations in studying political beliefs and civic engagement of physicians.

Medical Education and Training

The road to becoming a practicing physician is an intensive process, spanning seven to ten or more years, that systematically teaches and evaluates basic sciences, medical sciences, and highly technical operative and procedural skill sets. However, institutions have spent far less time systematically teaching, developing, and inculcating both the social skills that are needed in today's health care environment and the civic attitudes and behaviors that are increasingly necessary for physicians to engage successfully with a broader and growing range of stakeholders. Social skills include collaboration and teamwork, conflict resolution and negotiation, management, and leadership. Civic attitudes and behaviors

extend beyond Gruen's civic mindedness and include community participation, political awareness and involvement, respect for differences, thoughtful expression, concern for and care of the disenfranchised and marginalized, and advocacy.

There are opportunities for making curricular changes in the direction of these needs. These are best organized in a graduated fashion to coincide with the degree of education or training. For example, for social skills, medical school curricula can build social interactions with other professional groups into disease-oriented case studies; during medical school clerkships and residency training programs, seminars can be developed to discuss common issues among the different professional groups (in particular, medical, nursing, pharmacy, physical and occupational therapy, dietary, and allied health). For civic attitudes and behaviors, medical schools can invite community groups to speak about their suggestions to improve health care, and hospital faculty can build broader social topics into grand rounds with guest speakers that connect community and advocacy activities directly to hospital care. However, without deeper institutional buy-in and support, the prospects for enduring change are uncertain.

In this special issue, Diana J. Burgess and colleagues show how the political ideology of first-year medical students correlated with attitudes and beliefs related to the care of marginalized patients assessed during their fourth year. This suggests that short-term clinical experiences of medical students in caring for vulnerable populations may have limited impact on their attitudes and beliefs regarding these populations. Alternatively, political ideologies formed during their preprofessional lives may have a greater impact on their eventual choices of specialties, locations of residency training, and locales of professional practices.

Public Health

A public health perspective provides the social context to a patient's immediate presentation of a disease process to the physician, following a centuries-long path of efforts, first, to the control of infectious-disease-based epidemics and, more recently, to the recognition of the significant role of occupation, environment, and other social determinants in the origins and processes of disease, in particular, the disparate effects of race, gender, and socioeconomic class. Much work continues to be needed at this level, especially as widening gaps secondary to economic forces are leaving behind larger segments of the population, to the detriment of

substantial gains in public health over the past century (Centers for Disease Control and Prevention 1999).

In this special issue, Michael K. Gusmano documents the favorable public positions taken by two specialty organizations, the American College of Physicians and the American Academy of Pediatrics, and by the AMA regarding five sociopolitical issues with public health implications: access to care for undocumented patients, climate change, fracking, gun control, and same-sex marriage. Gusmano suggests that the supportive positions taken by these organizations can be explained in part by the increase in the number of women members and by the number of physician members identified with the Democratic Party. This latter point is consistent with Sanger-Katz's (2016) findings for American College of Physicians (41 percent Republican) and American Academy of Pediatrics (32 percent Republican), though the evidence for the AMA position may be less clear.

Organized Medicine

Organized medicine in the United States can trace a critical milestone in its history to the founding of the AMA in 1847 and its enduring organizational importance, as articulated in its earliest goals: scientific advancement, standards for medical education, a program of medical ethics, and improvement of public health (AMA History). In another article in this special issue, Miriam J. Laugesen reports that, despite a long gradual decline in membership that has affected physician participation in its programs, the AMA has been able to remain fiscally vigorous through its development and gatekeeper control of billing and coding mechanisms. This is likely to remain the status quo, as long as government payment programs require a single point of contact with the medical community.

In her article in this special issue, Sorcha A. Brophy shows that American Academy of Family Medicine members articulate strikingly different visions of policy, depending on whether they stand in favor of progressive social policies that support external legitimacy of their organization or stand against progressive social policies and instead support internal cohesion of their organization. For insight into reasons for the marked differences, it is helpful to recognize that family medicine practitioners as a specialty are particularly exposed to the Sturm und Drang of their patients and their families as they manage the daily stresses associated with diseases highly influenced by social determinants. In moving from the individual level to the organizational level, it is relatively easy to understand how the

American Academy of Family Medicine struggles with issues that carry high social and/or political charge. Further, the continuing national shift in membership from organized medicine to specialty organizations (colleges, academies, societies) has the potential for the physician community to increase its civic engagement and to address an even broader range of health care issues (Page 2017).

Letters to the Editor

The letter to the editor (LTE) is a time-honored format of writing and scholarship that has been an important means for providing readership perspectives on topical issues in both medical journals and the lay press. As a venue in the lay press, the LTE is underappreciated and underutilized. So, it is refreshing to see Phillip M. Singer use this form of public discourse in his article in this issue to understand how physicians and the lay public contribute to policy developments that favor the Medicaid population. By analyzing LTEs published in one hundred newspapers across the United States for language that describes stance, evidence, personal experience, and framing, Singer shows that physicians demonstrate similar support for expansion of Medicaid and are likely to frame their arguments in terms of improving quality of care and saving lives. With acceleration of the transition to digitally formatted news outlets, the LTE can be expected to lose its value as a marker of public opinion, especially for younger generations.

Conclusions

Physicians in the United States have had limited institutional exposure to engagement skill development, few opportunities to practice such skills outside of the clinical sphere, and even less experience with civic engagement. Cultural, professional, and technological pressures are continuing to reshape medical education and training. Institutions have the opportunity to develop structures that can systematically provide the needed perspectives for physicians to learn how to adapt to the rapidly changing landscape in all domains. So, while physicians have had a long tradition of civic engagement, as stated at the outset, the profession would benefit from a better understanding of the pedagogy for inculcating attitudes and behaviors of civic engagement for the betterment of their patients and for the greater public health of the community and the country.

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