

# Ethics of Advocacy

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## ABSTRACT

The physician duty to advocate for patients has evolved to address the need for high quality and sustainable care for all patients. As described in the CanMEDS Health Advocate role, health advocacy is about promoting health equity and engaging with partners across sectors to address the social determinants of health. Ethically, health advocacy is supported by beneficence (substantial medical benefit can be achieved by addressing the worst off) and justice (a commitment to sufficiency or equality in access to care and in health outcomes). Dilemmas or emerging challenges in health advocacy include distinguishing “special access” that is designed to address health inequities from preferential access for associates or “VIP”s, whether and when reciprocity or restorative justice should matter in healthcare, navigating the perception or reality of the politicization of medicine, and addressing responsibilities for non-maleficence (“do no harm”) by examining privilege, promoting cultural safety, and engaging in affirming and inclusive practice.

## DEFINITION: ADVOCACY AND THE HEALTH ADVOCATE ROLE

To advocate, by common dictionary definition, is to recommend or support a cause or policy publicly. In medical practice, advocacy has historically referred to advocating for a particular patient: to use influence to secure them the best possible medical care.<sup>1-3</sup>

The dictionary definition of advocacy has two key limitations. First, it describes a skill independent of ethical considerations about the content of the cause or policy for which one advocates. One could advocate for a harmful policy or a beneficial one, for personal interest or the public good. Second, it highlights a passive approach to advocacy – as though the responsibility to advocate could be fulfilled by clicking “like” or signing a petition. The traditional understanding of advocacy – for an individual patient – has its own key limitation: it is at odds with the ethical insight that the “best” care for one patient should not come at the cost of the best care for another.

Dodson et al. recommend separating the competency of promoting the individual patient’s benefit (which they call agency) from advocacy as policy engagement, or

“supraclinical” advocacy.<sup>4</sup> I argue that an ethical conception of health advocacy clarifies the relationship between advocacy at the clinical and the supraclinical levels.

## ADVOCACY FOR WHAT?

Developments in medical education since the turn of the millennium have answered the question “advocacy for what?” Physician advocacy is advocacy for health equity and for serving population health needs. This is not to deny that key advocacy skills, for example change management or knowledge translation, are also applicable to quality improvement in clinical practice in general or to promoting advances in medical technologies (for example). However, the advocate role is specific to the obligations of physicians that are grounded in justice and beneficence: to address health inequities and to take a population perspective on health needs.

The ABIM Charter on Professionalism<sup>5</sup> focused on advancing equity through non-discrimination in practice and removing barriers to access to care, while indicating that health equity also requires “the promotion of public health and preventive medicine, as well as public advocacy on the part of each physician...”. This ignited a debate about the scope of the physician responsibility to advocate for “improving aspects of communities that affect the health of individuals.”<sup>6</sup>

The CanMEDS competency profile formalized the role of Health Advocate in 1996<sup>7</sup> and gave the role specific content:

As Health Advocates, physicians contribute their expertise and influence as they work with communities or patient populations to improve health. They work with those they serve to determine and understand needs, speak on behalf of others when required, and support the mobilization of resources to effect change.<sup>8</sup>

The CanMEDS definition of health advocacy goes beyond passive support. It encompasses collaboration with communities and the active mobilization of resources, at both the clinical and the policy levels. Furthermore, it goes beyond achieving equity in *access*. It invokes the social accountability of the profession, which includes working in partnership across sectors (with community agencies, social services, education, and workplace health and safety, for example) to address the social determinants of health.<sup>9</sup>

The CanMEDS Health Advocate role does not distinguish working with individual patients and families and working with populations and communities. Helping patients and families navigate health care systems and connect with resources in the community is continuous with working with patients and communities to identify healthcare needs and secure the resources and policy changes necessary to meet those needs.<sup>10–13</sup> This should not be surprising: just as the practice of scientific medicine involves literacy in research, participation in research, and the application of the results of research in individual patient care, so health advocacy includes identifying and establishing resources in the community to help patients and families meet their healthcare needs, and connecting individual patients and families to those resources in clinical care.

### WHY ADVOCACY?

Health advocacy has two ethical sources. Some physicians engage in health advocacy because greater health gains can be achieved by addressing unmet needs than by focusing on marginal benefits for those already well off. The good that health care providers can do individual patients is sometimes dwarfed by the effects of social structures and systems on their health opportunities and outcomes. Professional responsibilities extend to addressing structural factors that influence patient access to health care and broader factors that influence patients' health status and outcomes. That is, a commitment to beneficence may lead a physician to health advocacy work.

Others engage in health advocacy because of justice-inspired commitments, whether to health equity in particular or to social justice more broadly. Within the CanMEDS framework, health equity is defined as “individuals and populations reach[ing] their full health potential without being disadvantaged by, for example, race, ethnicity, religion, gender, sexual orientation, age, social class, economic status, or level of education.”

The ethical obligation to advocacy is in this sense “over-determined”: it is supported by more than one core principle of health care ethics. This creates an ethically complex landscape: different grounding commitments can foster collaboration across political differences and can also raise ethical dilemmas when beneficence and justice would recommend different courses of action.

### ETHICAL CHALLENGES IN HEALTH ADVOCACY

Health advocacy involves a number of ethical challenges.

Within health care, a focus on disparities in access and outcomes is relatively quantifiable and (relatively) politically neutral. But addressing the structural determinants of access and outcomes outside of health care takes the profession quickly into matters of public policy that are politicized.<sup>14</sup> In the political domain, the nature of a just

society is contested: for example, protecting private property,<sup>15</sup> ensuring fair equality of opportunity,<sup>16</sup> and fostering relations of equals,<sup>17</sup> are different visions of social justice with their adherents. These differences will not be settled within health care. Ethical practice will involve being alert to the different considerations each conception of justice highlights.

In the following, I review four areas of ethical debate in health advocacy: balancing the value of treating like patients alike and differentiating treatment to address barriers to access and to good outcomes; questions about the range of conceptions of justice that should inform health care; concerns about politicization of the profession; and the considerations of non-maleficence in health advocacy.

### Old and new expectations of patient advocacy

In a well-organized healthcare system that meets patient needs, advocating for additional resources for a particular patient could be equivalent to seeking preferential access. It could be unfair to other patients and, depending on how a service is funded and the relationship of the physician to the patient, a misuse of public resources for the benefit of one's own associates.<sup>18</sup> Advocating for individual patients experiencing health disparities carries some of the same ethical risks as advocating for special treatment. These risks are mitigated when patient need, and not personal relationships, drive the advocacy, and when the lessons learned from individual advocacy are directed towards changes in policies and procedures to meet the needs of other patients in the same situation.

For example, to ask a patient to return on another day or attend another clinic for follow-up, instead of providing it immediately on site, may be a minor inconvenience for a patient. But a friend, a colleague, or a patient accustomed to deferential treatment due to their social status,<sup>19, 20</sup> may pressure the physician or their staff for such a favour. For another patient, such a requirement may be a barrier to care, and providing follow-up immediately on site may enable access. Providing this “special treatment” is qualitatively different in its ethical goals. Similarly, flexibility in appointment time for all patients would be unsustainable, waste resources, and inconvenience other patients; flexibility for a small number of patients who lack access to transportation and face many competing practical priorities in their day may enable access to care they would forego without that flexibility. Establishing policies to clarify when patients do or do not qualify for pathways that facilitate access, and shaping clinical services to meet the needs of patients with insecure lives, ensures that patients who are relevantly similar can access equivalent services.

### Should reciprocity or restorative justice play roles in health justice?

An open question in the ethics of health advocacy is whether compensation (in the form of reciprocity or restorative

justice) has a role in health care. Should we advocate to secure equitable access and/or outcomes, or should health care be an arena in which we compensate for inequities in other social dimensions that create or reinforce health inequities? An example is in triage of critical care resources in COVID: should we ensure that racialized minorities have the same access to critical care resources as others,<sup>21</sup> or should we prioritize access for patients whose COVID status is derived from their social determinants of health?<sup>22</sup> For example, consider that racialized minorities disproportionately work in the public-facing service economy, with precarious employment conditions and minimal provision for sick leave, while their families and communities take on their risk of exposure to COVID in turn due to high-occupancy housing and a lack of outdoor public spaces for safe recreation. In addition, they may serve a public that resists social distancing measures, placing them in unnecessary danger. Should they be prioritized alongside health care providers for reasons of reciprocity? Should they be prioritized for reasons of restitution, given the long-standing historical roots of oppression?

### Politicization of the profession

It has been argued that an advocacy obligation is inconsistent with the profession's political neutrality and with scientific objectivity.<sup>23</sup> This critique assumes that policy engagement and commitments of solidarity with patients are driven by pre-existing political commitments. They may be informed by causal relations in the world and by medical need. To refuse to act on causes of health detriments because addressing the causes in question (for example, work conditions, gun laws, pandemic control policy) has been adopted as a political cause by one party or another would be to bow to political pressure.

Furthermore, when mainstream political parties fail to challenge or even offer the appearance of supporting the resurgence of ideologies detrimental to human rights and health, such as Naziism, the profession cannot take the threat of "politicization" as an argument for silence. In such an era, it is important to revisit the medical profession's history of complicity with fascism on the left (with Soviet medicine) and on the right (with Naziism), and affirm the profession's commitment to human rights.<sup>24</sup>

Nonetheless, physicians in their policy engagement must work with governments across the political spectrum, often raising dilemmas between ideal ethics and realism. The tension between ideal and realistic courses of action is a source of ethical dilemmas and moral distress.<sup>25</sup>

### Non-maleficence in health advocacy

Many descriptions of the health advocate role highlight that physicians are uniquely situated to identify health inequities and to use their privilege to mobilize resources to address the social determinants of health.<sup>3, 26</sup> However,

while physicians may observe some of the effects of the social determinants of health in their clinical practice, they may not be well-situated to identify causes or interventions. Assumptions and biases that arise from their own socioeconomic status may interfere with understanding others' lives and communities.<sup>27</sup> In health advocacy, the principle of non-maleficence, which encompasses avoiding harm and minimizing or mitigating unavoidable harms, deserves more attention. Although the Health Advocate role arose from an imperative to look beyond medicine to the social determinants of health, the profession must also address harms that occur within medical practice and within the medical profession.

First, to address blind spots, biases, and limitations in training in population health and relevant social and environmental sciences, it is essential to collaborate with health care and social service providers with experiences in these areas, as well as with researchers with relevant expertise.

Second, it would usually be inappropriate for physicians to prioritize which inequities to address. Community engagement, grounded in trust-building and guided by ethical principles, is crucial.<sup>28</sup> Community engagement is also a matter of epistemic justice, or taking seriously the "lived experience" of disparities.<sup>29</sup>

Third, a number of frameworks and models are available to guide clinical work and community engagement with specific communities to avoid harm in biases, assumptions, and language. Examples include cultural safety and humility or decolonization as frameworks for working with Indigenous patients and communities,<sup>30</sup> affirming practice for diverse sexual orientations and gender identities,<sup>31</sup> inclusive practice for different forms of disability.<sup>32</sup> Anti-racist practice<sup>33</sup> and trauma-informed care<sup>34</sup> can address the needs of multiple communities.

Fourth, physicians must take responsibility for barriers to social justice within the profession,<sup>35</sup> including (for example) policies and cultures that keep minorities out of medicine and women out of particular specialties, educational materials in which clinical conditions are presented solely in patients with white skin,<sup>36</sup> and the "minority tax" imposed on members of the profession who are expected to educate their colleagues and do the advocacy work within the profession.<sup>37</sup>

### CONCLUSION

Health advocacy to advance health equity and serve the needs of the community has been defined and endorsed as a legitimate goal of medicine, grounded in beneficence and justice. We can distinguish old conceptions of advocacy for individual patients at the expense of the health care system from advocacy at the practice level for individual patients at risk of experiencing barriers in access to care or the detrimental effects of the social determinants of health.

Concepts of social justice are contested politically, but this need not prevent the profession from addressing structural influences on access and outcomes. As the health advocate role has largely been developed with the goal of encouraging physicians to engage in the public sphere on the social determinants of health, considerations of non-maleficence within the practice of medicine and within the profession have received relatively little attention within the literature on health advocacy, but are important areas for future development.

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