Letters to the Editor

Regarding Physician Advocacy

To the Editor: I have struggled to accept the logic of Dr. Huddle,[1,2] and in the setting of a formal debating contest, I concede that he can hold his own. But we physicians are not debaters, lawyers, or sophists. A rising tide of poverty and misery sweeps over our country, leaving in its wake a permanent underclass. Our political leaders refuse to find common ground; their current policies are already harming many of our patients. If we leave our politics at home when we don our white coats, we are complicit—and our failure to stand taller as a profession is neither "a legitimate choice"[2] nor the correct one. We can hide behind "our political prerogative as citizens,"[2] or we can heed the words of Martin Luther King: "A time comes when silence is betrayal."[3] The question, really, is not whether physicians should be advocates but, rather, how can they be more effective advocates?

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References

1 Huddle TS. Perspective: Medical professionalism and medical education should not involve commitments to public advocacy. Acad Med. 2011;86:378–383.
2 Huddle TS. In reply. Acad Med. 2011;86:1065.
3 King ML. A time to break silence. Speech delivered April 4, 1967; New York, NY. www.informationclearinghouse.info/article2564.htm. Accessed October 5, 2011.

In Reply: Dr. Sandroni finds argument to be otiose in the face of a reality that demands action; poverty and misery in our surroundings cry out for the proper response from physicians. In his view, we who confront that reality are either with him and the forces of good or against him and them. If we are with him, we will be engaged in political advocacy on behalf of the poor and miserable; if we are not so engaged, we fall short of meeting our professional responsibilities.

Dr. Sandroni's willingness to condemn physician stances toward advocacy other than his own should, I think, give us pause. A take-no-prisoners approach to the politics of social welfare has, of course, plenty of precedent in our political tradition. Its appeal is likely to be a matter of temperament as much as of political conviction. While many things might be said in response to Dr. Sandroni, the most salient might be that however much he wishes all of us to join in a political crusade on behalf of the poor and miserable, it is not going to happen. Too many of us have no interest in politics, or no confidence in the efficacy of political action (or, at least, of the kinds of political action Dr. Sandroni would likely favor) for relieving poverty; some of us, doubtless, care less about poverty and misery than we should. Dr. Sandroni may succeed in inspiring some of those around him to follow in his activist footsteps through his own dedication to advocacy. But he is not going to convert all of us in the medical profession to political activism by presuming our moral inadequacy or by attempting to redefine medical professionalism to fit his own political preferences. Nor should he, or others who favor mandatory physician advocacy, try to do so.

He is, in any event, correct to suggest that what is at stake here has implications going far beyond academic debates. He and I could doubtless have an interesting discussion (or, failing that, perhaps, a debate) about policies likely to diminish poverty, our duties to the poor and miserable, or our civic responsibilities. And, at present, we could afterwards proceed to the wards or the clinic and conduct our professional practice in good fellowship, united in our professional commitments if not in our political views. However, if the movement for mandatory physician advocacy had its way, such unity amid diversity would no longer be possible, as physicians who made the political choice of noninvolvement in advocacy (or, perhaps, involvement in the wrong kind of advocacy) would be censured and ejected from the profession. Whether we choose to maintain our present catholicism of political outlook in a unity defined by our professional work—or insist that a given political stance is required for professional orthodoxy—is about as momentous a decision as our profession can possibly make.

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What Happened to the Concept of the Physician–Scientist?

To the Editor: There has been growing concern that the number of physician–scientists is decreasing.[1,2] While this problem is multifactorial, we are most troubled by the belief that it is too difficult to do both medicine and science. Young trainees are faced with a choice: either pursue research (and rarely see patients) or practice medicine (and have nominal research activity). The consequence is growing disillusionment with a career path that, in theory, unifies the two. In contrast, we believe in an integrated concept of the physician–scientist: actively practicing physicians who transform their *own* clinical observations into research hypotheses and who, in turn, use that research to drive improvement in patient care they themselves deliver.

We argue that the above concept of the physician–scientist needs to be reclaimed by the medical community: training programs, funding organizations, and academic centers should restore that ideal by developing infrastructure to train, support, and retain individuals committed to this path. The educational experience should be multidisciplinary, incorporating leadership training, contract negotiation, clinical trial design, and statistics in addition to the traditional medical and scientific education. This requires new educational pathways that incorporate coursework from schools of health research, policy, business, and law. Second, the educational career should