Advocacy May Have a Place in Medical Curricula

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To the Editor—We read with great interest the recent issue on the changing face of North Carolina's health care workforce. There is certainly great need to recruit diverse talent into our field, and health care delivery would indeed benefit from improved partnerships with rural and grassroots organizations. One article that we found particularly interesting was Hodge and coauthors' piece on innovations in medical education in North Carolina [1]. Ongoing debate in health policy, alongside recent headlines of humanitarian crises, raises an inescapable question related to such curricular changes: should "advocacy" be taught to future physicians?

This question calls upon us to reevaluate what it means to be a physician. Traditionally, the moral center of medicine was understood to be at the patient's bedside. Scholars like the late Edmund Pellegrino wrote that the patient-physician relationship was a "covenant of trust, a special kind of promise to serve those who require her [the physician's] expertise" [2]. This notion of medical professionalism finds that a core responsibility of the physician is to serve their immediate patient and to recognize any potential conflicts of interest when carrying out that duty. But where are the lines of said responsibility demarcated? Surely, no one expects physicians to purchase medications for their patients who cannot afford them. But is it a professional obligation for physicians to advocate for affordable drug pricing?

Where macro-scale problems like drug pricing obviously harm patients, they can also impact physicians. In recent studies, physician burnout was found to be more closely linked to factors unrelated to direct patient care. Clerical obligations of electronic health records (EHR), "upcoding" for insurance, and reduced face-to-face time with individual patients are just some of the system-based factors that have simultaneously caused cognitive decline and mental exhaustion among physicians nationwide [3-4]. In such circumstances, perhaps physicians owe it to themselves to address these issues publicly.

For decades, public health experts have recognized that changes in policy are needed to improve macro-scale problems, and yet there is an absence of clinician preparedness to impact policy development and implementation [5]. As medical schools continue to innovate their curricula, they must clarify if and how our professional responsibilities extend beyond the bedside to the bigger issues that affect both patient and physician well-being. If we accept that advocacy and legislation have impact tomorrow, then we should consider teaching medical students how to leverage those tools starting today. NCMJ

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