Advocating for Advocacy in Pulmonary and Critical Care Medicine

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A school nurse in Maryland was called on to help a student with severe respiratory distress consistent with prior asthma. The student's albuterol inhaler was locked in her gym locker and inaccessible. The nurse gave her another student's albuterol inhaler; she took two puffs, and her symptoms started to subside. Subsequently, the nurse was fired for giving one student's inhaler to another.

The concept of moral distress was invoked during the coronavirus disease (COVID-19) pandemic to explain the difficulty providers experience when the care that is medically indicated cannot be performed (1). More broadly, as pulmonary and critical care providers, moral distress impacts us frequently when we see patients being harmed by structural barriers to care, neglected needs, or careless policies. In the example above, the student may have experienced a potentially fatal outcome had the school nurse refused to treat her out of fear of punishment. When Dr. Christy Sadreameli, a pediatric pulmonologist at Johns Hopkins Hospital, heard the above story firsthand, she was inspired to connect with others in the American Academy of Pediatrics and ATS (American Thoracic Society) to advocate for stock albuterol legislation, which allows schools to stock albuterol inhalers and indemnifies personnel who use them (2).

Healthcare providers may use advocacy to bring attention to these injustices and to effect change in policies. After all, our voices are strong! During a Center for Career Development session at the ATS 2021 virtual meeting, the ATS Health Policy Committee spoke with Drs. Sharron Crowder of Indiana University School of Nursing, Naftali Kaminski of Yale University School of Medicine, Mary Rice of Harvard Medical School, and Christy Sadreameli of Johns Hopkins University School of Medicine about being healthcare providers who practice advocacy.

What Is Healthcare Advocacy?

Advocacy in health care refers to the efforts undertaken by individuals or groups to bring about change in some aspect of health care, such as the protection of patients' rights, increased research funding, expanded insurance coverage, or remediation of public health issues. The motivation to pursue advocacy usually stems from bearing witness to the suffering of a patient or the community because of a deficiency in the healthcare system or possibly even within a broader society. Advocacy may involve raising awareness by writing an opinion piece or editorial, testifying before state legislatures or Congress, or meeting with elected officials. Advocacy allows providers to have a broader impact than could be achieved in caring for individual patients. In response to disturbing trends in ongoing tobacco use in the United States, for example, groups such as ATS and the ALA (American Lung Association) advocated for an increase in the legal purchase age of tobacco products, resulting in the passage of federal Tobacco 21 legislation by Congress in 2019 (3, 4).

Bodies such as the American Board of Internal Medicine and AMA (American Medical Association) have endorsed advocacy as a component of medical professionalism (5), although the parameters of this role have yet to be well defined. The concept of advocacy overlaps with that of activism, but Dr. Kaminski makes an important distinction that advocacy is organized and may promote the agenda of a committee or professional society. As such, a healthcare provider's participation is grounded in their professional expertise. Activism, in contrast, involves activities centered on personal passions, though, of course, there is often overlap between the two.

Institutions or universities may have explicit rules regarding employees' participation in advocacy or activism in the role of healthcare professional, in which they may be perceived as representing the views of the institution. Checking whether one's institution imposes limitations on advocacy ahead of time will avoid future conflicts, as will being explicit in one's intentions and role. In a piece published in the AMA Journal of Ethics, Dr. Matthew Wynia, Director of the Center for Bioethics and Humanities at the University of Colorado, describes the importance of identifying whether our medical expertise is related to the cause we are working for before invoking our medical background in discourse. Otherwise, he states, we may be "simply cloaking one's personal views in the mantle of respectability that being a doctor provides" (6). Similarly, when tweeting about a particular topic, Dr. Kaminski is explicit

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about whether he is tweeting as a physician, researcher, or citizen.

How Can One Get Involved in Healthcare Advocacy?

Providers get involved in advocacy in a variety of ways. Some stumble into it by accident. Dr. Sadreameli explained that she first testified in front of the Maryland legislature to discuss a policy to regulate smoking in vehicles. Others are more intentional in their path to advocacy. Dr. Crowder recommends finding an alignment between one's clinical or research work and a specific advocacy need. She began by working as a nurse specialist with children with asthma and, recognizing the needs of this population, advocated for federal and state programs to improve the health outcomes of children with asthma in Georgia. Dr. Kaminski's team started a support group for patients with idiopathic pulmonary fibrosis and raised awareness for the disease, which at that time had no treatment.

A common recommendation is to get involved with a local chapter of a national organization. Dr. Rice, for example, did research on air pollution during her fellowship, which inspired her to participate in local advocacy activities in Boston through the ALA. Then, with support from the ALA and ATS, she began meeting with congressional staffers and legislators, speaking at congressional hearings, submitting policy recommendations to the Environmental Protection Agency, and publishing opinion pieces.

Given the importance of relationships in advocacy, Dr. Crowder recommends identifying policymakers you can support to create better policies by supplying professional guidance. For example, call state representatives when they are not in session to introduce yourself. During her 2019–2020 Robert Wood Johnson Foundation Health Policy Fellowship placement on Capitol Hill, she also saw how influential healthcare providers could be at the Congressional level. As Dr. Rice explains, our unique advantage as physicians is that we have access to patient stories, and sharing them can be a way to get others interested in the causes we advocate for.

In addition to participating in civil discourse, we can be subtle advocates, activists, or agitators in our daily life. For example, Dr. Kaminski will not participate in panels unless at least one of the other panelists is a woman. When the media asked for interviews during the COVID-19 pandemic, he directed them to Yale's female faculty members, who historically were less likely to be asked to give expert commentary. Similarly, the Association of American Medical Colleges, in a strategic framework (7), calls on healthcare professionals to be constantly striving to recognize and eradicate racism in medicine and to promote diversity, equity, and inclusion, a goal that can be practiced in daily life as well as professionally.

What About My Career?

It can be challenging to fit advocacy into a busy academic career. We are all familiar with the career paths for clinician educators, physician–scientists, and clinician administrators. But what about for a provider–advocate? The skills that benefit this role are similar in many ways to those that make a successful clinician, such as thoughtful listening and effective communication, as the root of advocacy is the formation and fostering of relationships between healthcare providers and policymakers. As noted by proponents of Tulane University's Internal Medicine Advocacy and Leadership Track, however, "most physicians received no formal training in the analytical and practical skills necessary to become physician–advocates" (8).

This lack of training and experience may be a barrier to practicing advocacy as a healthcare provider. Medical schools, however, are increasingly teaching social justice issues like the intersection of climate change and public health, together with advocacy skills such as how to write and submit an opinion piece to a newspaper (9). Some residency programs are creating specific curricula as well, such as the Advocacy and Leadership Track at Tulane, which aims broadly to "train a select group of internal medicine residents in the skills needed to become physician–advocates and to provide them with experiences that would help them maintain their advocacy activities beyond residency" (8). Rheumatology fellowships now offer Advocacy 101, a program to educate fellows on legislative and regulatory healthcare policies (10). Other healthcare professions advocate for advocacy as well, with the American Nurses Association providing an extensive framework for advocating for the profession and patients in multiple settings (11). Presumably, the rise of such trainees will formalize and normalize the role of the provider–advocate.

Currently, however, as Dr. Kaminski describes, we do not have the tools to describe or measure the impact of advocacy the same way we do with other scholarly activities. He suggests involving an administrator, such as the dean of faculty affairs, to help quantify the scholarly contribution of advocacy efforts, and notes that many advocacy activities can generate publications or contribute to an institution's success in other intangible ways. Getting involved in advocacy activities can also lead to committee membership and leadership roles, often at the state or national level. The ATS Advocacy page at thoracic.org/advocacy is a great place to start! ■

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