19-Apr-2024
How to maintain trustworthiness when doctors act as policy advocates
BMJ-2024-079929

Along with the revised text, please provide a point by point response to our comments and those of the reviewers. We also ask that you keep the revised manuscript within the word count of 1800-2000 words.

We would like to thank the editors and reviewers for taking the time to review our work and provide this constructive set of comments. We have responded to each point below and we think the resultant changes to have strengthened the piece.

The word count of the revision is 2035.

Editors' Comments:

1. The authors claim that doctors are uniquely positioned (and have a duty) to speak up and be involved in advocacy. Can they clarify why this is so? Objectively, medical education does not necessarily prepare doctors to do this well, unlike, say, epidemiologists. They only briefly touch on this but more could help.

We agree that it is important to justify why we take this position, rather than to assume it. We had covered some of the historical context in the introduction, but we now introduce a specific consideration of this point in the new section 'the value of doctors acting as health policy advocates':

> "This responsibility is rooted in the many centuries that doctors have held a unique vantage point into the lives of their patients, and into the community conditions that act as determinants of health and disease. From their position as medical leaders, doctors have a moral and professional obligation to give voice to (or amplify) those whose concerns may otherwise go unheard, and to strive to health-promoting societal action."

We then support this assertion further with examples of successful health advocacy, and the relevant aims of key medical bodies like the BMA and the RCP which explicitly validate this position.

We also agree with the point that medical education does not necessarily train doctors to do this well, which is why we feel this piece is so important for your readership and why we include the focus later in the piece on postgraduate training criteria.

2. The authors allocate a lot of space to defining what advocacy in health policy refers to (page 5, line 45 onwards). I wonder if this could instead be included in a box.

The definition is now presented in Box 1 (with the information on what is contained within current Royal College guidelines now Box 2).

3. On page 6, the authors discuss the pitfalls of advocacy. But before doing so, would it be useful to have a section about the effectiveness of advocacy? Does it actually work? Can they provide some concrete examples? This will help fine-tune the authors' argument by considering the 'benefit-harm' balance of advocacy. These could show practical application of the recommendations provided and offer concrete illustrations of the challenges and strategies.

Following this, and other comments from the reviewers, we have now done some restructuring. We have now added a section after the introduction, and before the pitfalls (now 'challenges'), entitled 'the value of doctors acting as health policy advocates'. This new section retains as an introduction the explanation of why advocacy is necessary and why doctors have a responsibility to do it (in response to point 1 above), and then goes on to give concrete examples of health policy advocacy and where it has been effective. It then highlights the need for it to be part of medical education curriculum.

4. The section on pitfalls is highly theoretical. Examples can help bring this section to life.

Thank you, in the revised and more focused version of this section (and throughout the piece) we have provided more examples in order to bring considerations to life. Examples presented in this section include:
"subjective truth, e.g. that personal preferences for interventions are not based solely on scientific evidence"
"objective truth e.g. that agreed scientific knowledge alone can determine the appropriate policy"
"For example, citing study A because it supports your position whilst ignoring study B of equal quality which is null; or overclaiming the strength of evidence based on the findings of subgroup analyses, without due mention of more conservative results in primary analyses of the whole cohort"
"For example, the National Rifle Association in the US, closely aligned with the Republican party, instructed "self-important anti-gun doctors to stay in their lane":
"e.g. wearing stethoscopes and being arrested) at such protests"
"issues like imposition of pandemic lockdown measures, or the ongoing conflict in the Middle East"

5. The authors might want to separate their discussion of what good advocacy looks like and counterpoints. Discussing them alongside each other in the same section is confusing. Instead, they can first outline what they are calling for, then present potential problems, and finally suggest a balanced way forward.

Thank you, we have adopted this structure. We have restructured the 'pitfalls' section to focus on 'challenges'. We move the text which focusses on 'how to do it well' into an expanded recommendations section which now seeks to outline the balanced way forward more fully.

6. Authors could expand on the need to be careful that doctor advocacy doesn't just give a louder voice to powerful medical groups while silencing those who don't have a strong voice or disagree. What about the potential impact of advocacy roles on the doctor-patient relationship? Patients may see advocacy efforts as imposing the drs personal belief onto their medical care and as a result undermine the trust

We have added this as a (now) 4th point within the 'challenges' section.:

> “In using their voice to advocate, doctors must be cognisant of their trusted and privileged role within communities. Change movements can be inclusive of many actors, with many motivations, and advocates must be aware of who they may be sharing a platform with, and in doing so, whose voices they may be amplifying. The proliferation of social media and the internet into society has significantly increased the speed with which such movements can grow, and removed historic barriers to who can participate in them. Doctors must ensure that any advocacy role they take on is kept quite distinct from the direct doctor-patient relationship and that such activity does not inappropriately affect their standing within the community. They should avoid areas in which they have little expertise. These considerations are particularly relevant to highly controversial issues like imposition of pandemic lockdown measures, or the ongoing conflict in the Middle East.“

7. The recommendation section could be strengthened and made more scholarly, currently it is worded in a very advocacy-like language. Recommendation 2 could be broken down into two parts with more detail added: ‘Be explicit about the role you are acting at any given time’ being the first part. I would also add here articulating clearly what their goals are as this can improve trust. ‘If citing medical credentials…’ being the second part. I would also add why disclosing potential COI and affiliations is important i.e. transparency is key in developing and maintaining trustworthiness. Recommendation 3 and 4 also need more work. I feel that recommendations 3 and 4 are related and may be merged into one. To minimise white hat bias, the authors could discuss use of an interdisciplinary approach i.e. working with other stakeholders (HCPs, policy experts etc.) to ensure advocacy efforts take into account various perspectives.
Thank you, we have revised this section, in light of these comments, and also to be reflective of the revised structure. We consolidate arguments into 4 recommendations which are more fully explained, referenced where appropriate, and with more explicit links to maximising trustworthiness.

Reviewer: 1

General

This article is a useful contribution to the literature on physicians as policy advocates and its positioning as an editorial will give the issue some of the prominence it deserves. I'm very glad to have had the opportunity to review it.

Thank you

The article's recommendations for advocacy practice are written engagingly and are likely to resonate with readers as being both apt and achievable.

Thank you

The method requires clarification if the reader is to be able to understand the authority for the positions taken in the article.

Specific – major

1. The section on contributors and sources is comprehensive. I was unable, however, to find a panel that corresponded exactly to the line-up of authors or the topic the paper addresses. Forgive me if I am incorrect here – the link to the event didn't work, so I am going by a version of the program I found after a google search. If I am correct, I think the authors might need to do more work to explain how the paper emanated from the event. There might be a need, for example, to include the role of other discussants or audience members in the generation of the ideas in the paper. It would seem important to make it clear whether the information was gleaned solely from the notes/presentations of the speakers or from a broader discussion – either would potentially offer adequate authority for the views expressed in the paper. In any event, either in this section or the body of the paper, there needs to be a more comprehensive theoretical or empirical account of how the three 'pitfalls' were identified – why these? why not others?

We apologise that the link did not work for you – it does appear to be working for us, perhaps the editors can check at their end (link: https://cph.shorthandstories.com/cph-showcase-keynote-speakers/index.html). The agenda from the event in question can be found here: https://www.cph.cam.ac.uk/files/cph_showcase_agenda.pdf and the panel involving DS and DTR is clearly marked. However, only the videos for the keynote presentations themselves are online, rather than the panel discussions itself.

More directly to the comments regarding provenance and authority. This piece was inspired by (rather than being a transcript of) an element of the panel discussion, which specifically involved DTR and DS, and centred around the legitimacy of different professional groups (e.g. doctors compared to, say, epidemiologists) engaging in advocacy. This particular section of the debate did not involve other panel or audience members significantly. SW and CB were audience members. SW's interest was piqued by this discussion, and along with CB, approached DTR and DS afterwards to discuss further and suggest writing up this piece. Thereafter the discussions were collaborative between the four authors. Each of our experiences and expertise regarding health, health policy, and advocacy are described already in the section. We thank the reviewer for flagging that this needed more explanation, and we have now updated the text in this section to reflect better the above.

Regarding the selection of pitfalls to discuss, the ones raised are those we felt as an authorship group were most relevant to the present discussion. There was no formal methods to select these rather than any others, and we feel this is appropriate for an analysis piece such as this. However, we are happy to add other elements to the piece if the reviewer thinks that specific arguments are missing from the revised version and would benefit from inclusion.

Specific – significant

1. Since trustworthiness is at the core of the paper, it needs a serviceable definition, stronger authority for the claims about its centrality in advocacy and the damage that can be caused by its absence or compromise, and a clearer link between it and the 'pitfalls'.

Thank you. We have added a definition of trustworthiness (Onoro O'Neill's) to the introduction. And we have made clearer the links throughout the piece to the arguments we make and to this central message.

2. The authors might wish to consider whether making a special case of public health medicine from time to time (starting page 4 line 42) is essential. The issues and recommendations (and Box 1) seem to apply more broadly. Likewise, it is not clear why the advocacy role is being associated with medical researchers, when doctors from clinical and other service roles (including public health physicians) also engage in policy advocacy. (page 6 line 15, and elsewhere in the paper).

Thank you for these comments. We agree that our piece has broad relevance to 'doctors' as a professional group. We have therefore been through the piece and generally removed the use of other terms in order to keep the language and messaging consistent. We only retain specific mention of public health in the introductory paragraph ("but medicine, and in particular public health medicine, has a long-standing history of doing more than advising") and this statement is elaborated upon in the new 'The value of doctors acting as health policy

advocates' section in which we outline why doctors (and then why public health doctors) have specific roles. ("Public health physicians have a particular role in advocacy to affect societal action such that it is health and equity promoting [ref Faculty of Public Health]").

Public health medicine is defined by an ambition to affect societal action such that it is health and equity promoting. In this way, public health is the branch of medicine to which notions of advocacy is most obviously applicable. So we do think this is worth acknowledging in the piece. But overall we want the piece to be clearly aimed at doctors as an overall professional group, and hopefully the edits we've made in response to your helpful comments have now clarified this.

Specific – minor

1. Page 4 Lines 14-22: It would be good to say a little bit about what these aphorisms were intended to communicate (at the time).

To clarify, we think the reviewer is referring here to the opening paragraph of the piece, in which we quote three aphorisms:

1. "scientists advise, ministers decide"
2. "Medicine and politics cannot and should not be kept apart"
3. "politics is just medicine on a grand scale… physicians are the natural attorneys of the poor"

The first one is explained, "…when explaining the role that scientists have in informing government policy". The other two are provided within the context of us generally establishing our position that medicine is not a passive observer of health policy, but that they have a historically active role. This assertion is now more clearly justified and explained a little further down, in the new section 'the value of doctors acting as health policy advocates' (see response to editor's comment #1). We don't think, on reflection, that these quotes need further explanation than is now provided in the revised piece. And we are keen to keep the introduction of the piece concise for impact. But if the reviewer/editor think these phrases do need more explanation within the introduction, we'd be happy to do so.

2. Page Line 24: 'COVID-19 pandemic'

Thank you, actioned.

3. Page 5 lines 7-18: The material here relates to significant comment 2. This is where further work might be done to define key concepts and their consequences. In my opinion, reflexivity (which is pivotal to the recommendations) could do with more focus and might be more usefully positioned later in this section or early in the following one.

Thank you, on reflection we agree. We have restructured the piece so that the pitfalls section is more focused only on challenges, and reflexivity is now given more weight in an expanded recommendations section.

4. Page 6 Box 1: It does not seem that the contents of Box 1 match its heading. The listed items seem to be roles or obligations (occasionally, perhaps, competencies) rather than training requirements. The material in the box is helpful – and seems to signal that the interest of the paper is in doctors broadly (and not just researchers of public health physicians).

Thank you, we have updated this title to more accurately reflection "mentions of" advocacy in these documents.

Reviewer: 2
Comments:
Many thanks for giving me the opportunity to review this short, well-written analysis paper, which addresses an interesting and important topic.
Thank you

As a global public health academic who engages in public communication, the article was very relevant to my work—and will be relevant to the work of many BMJ readers. The pitfalls in advocacy are nicely described and summarized, and many of us will recognize the ways in which we have fallen into these traps (I certainly do).
Thank you

The COVID-19 pandemic hyper-charged many of the problems that the authors outline, so the piece is timely: this is a good moment to reflect on some of the evidence-to-policy communication "stumbling blocks" of the last four years.
Thank you

Having said this, I think there are a number of areas that could be strengthened—some are substantive and some are minor.

SUBSTANTIVE
One problem with the piece as currently written is that it argues forcefully that when engaged in advocacy, doctors should stick to what the evidence shows and recognize and highlight the uncertainties in the evidence. I agree with this. But then, somewhat ironically, the article itself gives a series of recommendations that right now don't seem to be based on cited evidence. To me this seems like a missed opportunity. It's true, as the authors say, that "more evidence is needed to understand how complex risk evidence can be communicated truthfully and impactfully," but the landscape is not devoid of all evidence. The authors themselves are internationally recognized scholars in generating this evidence—and I'd like to see the recommendations grounded in what the research says. Indeed, I was excited to see, early in the piece, this statement: "some evidence suggests that it is possible to communicate scientific uncertainty in a way that is understood whilst maintaining public confidence." This was tantalizing, and I thought the piece would go on to lay out this evidence—but it didn't materialize. The second, related substantive issue, I believe, is that the overarching "story" of the pitfalls feels at times contradictory and could leave readers with a little bit of confusion (rather than clarity). For example, the piece argues that doctors should embrace and communicate uncertainty but then immediately says uncertainty can weaponized (e.g., by commercial actors) to cast doubt about a position. It argues that pushing newsworthy angles is risky but then also says that in the face of rising populism, the public desires simplicity. Both these examples point to how, at the end of the piece, I wasn't really sure what the key take home messages are. You urge readers, ultimately, to be "cautiously bold," but I think the two issues above leave readers a little unclear on what exactly this means.
Thank you, on reflection we agree with you. We have restructured the piece to follow the introduction with a short section justifying why doctors should advocate and examples of effective advocacy. We then consider the pitfalls (now 'challenges' to be a bit more inclusive of risks that are not necessarily in the advocates gift e.g. heat from the NRA). We have removed considerations of how to do advocacy well from this section, so that it hopefully addresses your concerns described articulately here that it was a little back and forth without a clear narrative for the reader. We close with an expanded 'recommendations' section (now 'recommendations for maintaining trustworthiness and advocating effectively') which more fully proposes a balanced way forward, grounded in evidence (though still stopping short of being a more formal evidence review, as we believe this is out of the scope of this piece). This new structure hopefully leaves the reader with a much clearer sense of take home points.

MINOR
This piece is mainly targeted, I think, at those working in public health. Using the term 'public health medicine' suggests that it is public health doctors you're hoping to reach—but I wondered what proportion of public health professionals who communicate science are actually medical doctors? What do you gain (and lose) by narrowing the audience of this piece to doctors alone?
Thank you. This mirrors a similar comment from reviewer 1 (significant comment #2). In response we have been through the piece and made it much clearer that our target audience is "doctors" as a professional group, which is inclusive of, but not exclusive to, public health doctors. We agree that public health medicine (which, as you astutely point out, is practiced by both doctors and other professionals) is the most obvious and specific example of doctors at the medicine and policy interface and with a professional obligation to act as advocates). However, we agree with both reviewer 1 and 2 that the messages of the piece are relevant to doctors as an overall professional group, and we have now made the text more consistent in this regard.

I had not heard the term 'white hat bias' before, and I suspect it will be unfamiliar to many BMJ readers—so I would either avoid using it in key messages or add a brief definition. I think it would be helpful to say a little more about the term and its original use in relation to obesity research.

Agreed – we have re-phrased the key points to avoid the use of terms people will not be familiar with. We have expanded the explanation of white hat bias with examples, but in general have tried to avoid delving in too much detail into any single policy area to ensure broad relevance of the piece.

Finally, while I appreciate the dangers and risks of health professionals being seen as affiliated with a particular political party, here in the US at least it is very unrealistic to argue that such professionals should stay out of politics or political party affiliation. You hint at this with the gun violence and climate change examples. Given this reality, what is your recommendation?

On reflection, we agree that affiliation can mean various things and we have removed this paragraph. Our considerations of how to be trustworthy are relevant to those wanting to be party politically active, in whatever guise, as well as those who do not. We retain the points about the politicised nature of advocacy, but now stop short of making recommendations about party political affiliation – this is clearly highly context-dependent (some of the Members of Parliament in the UK are current doctors and therefore clearly aligned to a political party) and probably deserved a whole piece in its own right.