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

Dear Dr. Walsh,

Thank you for sending us this paper and giving us the chance to consider your work. We sent it out for external peer review and discussed it at the Analysis manuscript committee meeting (present:
Jocalyn Clark, Tasnime Osama, Huseyin Naci, and myself).

We enjoyed reading this paper. The topic is important, and we think it will be of interest to our readers. We would like to offer you a Major Revision on this paper. We ask you to please revise your text in response to comments from the editors and reviewers and resubmit your manuscript within 4-6 weeks.

The reviewers' comments are at the end of this letter, and the editors' comments are below:

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.

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.

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.

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

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. 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.

6. 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

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.

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.

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I hope you will find the comments useful. Please don't hesitate to contact me if anything is unclear or if you have any questions.

Best wishes and we look forward to your revised paper,

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Reviewer: 1

Recommendation:

Comments:

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.

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

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?

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'.
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.
3. 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).

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

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Recommendation:

Comments:
Many thanks for giving me the opportunity to review this short, well-written analysis paper,

which addresses an interesting and important topic.

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).

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.
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.

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?

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.

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?

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