

# The Surgeon and Advocacy

Mwenda AS<sup>1</sup>, Mwachiro MD<sup>2</sup>

1. Aga Khan University Hospital, Nairobi, Kenya
2. Tenwek Mission Hospital, Bomet, Kenya

**Correspondence to:** Stanley Aruyaru. P.O Box 30270-00100 Nairobi. Email: arumwesta@gmail.com

Advocacy in healthcare is as old as the practice of modern medicine. It started in the era of Rudolf Virchow (1). It may involve advocacy for the patient and for the health care provider. There has been debate whether advocacy for the healthcare provider is a selfish agenda that contradicts the physician obligation of advocacy for the patient (2)

Advocacy for the healthcare is an expectation from all of us (1, 3). While it is a common expectation that every doctor will engage in advocacy, the extent and the setting are not explicit. As a result, various regulatory bodies have placed patient advocacy as an expectation among their physicians; with some stretching this to the limit by expecting their members to involve in socioeconomic advocacy and political activism (3).

There are three main levels of advocacy (4): At the patient level, advocacy at the clinical (say pushing for a patient to acquire some intervention that's not readily available) and paraclinical (engaging social players towards individual patient care such as applying for welfare considerations) settings (4) are scenarios we are all familiar with. Systems to address this have been put in place in various countries. Patients are also able to acquire care that would at times be out of reach via advocacy programs that help to highlight their plight but also may raise funds towards these goals. Every year, scores of children's lives are changed because of access to cardiac surgery and funding is raised from the public via runs and other charity events (5, 6). Surgical camps – as has been demonstrated by the surgical society of Kenya annual camp also form a crucial link in the chain by providing specialized care at a specific time. At the global level- advocacy has helped to protect patient care by legislating and regulating number of hours that surgery trainees and surgeons can practice without endangering their patients from fatigue (7). How many of us have had to postpone surgeries because of lack of blood? Isn't it time we took up the sensitization and the organisation of blood donation

drives from the other cadres of healthcare? If we implore all our elective patients' relatives to donate a unit or more, our blood banks will be ready to handle emergencies.

Advocacy at the practice level (agitation for quality improvement in our institutions) is the second level. It may be commonly applied among clinicians at administrative/managerial level. It is also common practice among our public health colleagues (4). It is here that surgery intersects with other disciplines- including human resource management. The surgeon as the leader has to play the part of being the link between what happens in the operating room and how the hospital administration handles and resolves problems pertaining to constant provision of supplies. The other element of advocacy at this level involves litigation issues. Many surgical societies globally have put in place systems for ensuring that their members have access to legal advice and representation should the need arise; besides providing critical information regarding to licensing matters and compliance to various state and international regulations. In addition, this also involves international regulations. This element forms a critical cornerstone of provision of surgical care.

The third level of advocacy is advocacy at the community/system level (4). This involves public campaigns, activism and knowledge exchange with regard to having systems that improve patient care. Surgeons have been accused of concentrating on the clinical work and paying less attention to the public health aspect of surgery. A look at the millennium development goals might attest to this; none of the health related goals focus directly on a surgical disease. The formation of the Bellagio Essential Surgery Group has not mitigated this to international threshold (8). The World Health Organization has been campaigning for safer surgery through implementation of the Surgical safety checklist (9). This simple initiative, that has its origins from the

aviation industry, has helped to streamline patient care, ensure provision of standardized care while at the same time reducing errors. Globally, many studies have shown efficacy of implementation of the surgical safety check list which has directly reduced morbidity and mortality (9). The reproducible nature of such an intervention makes it easy to introduce to different surgical fields and even in resource poor settings (9, 10).

Advocacy improves both clinical and public health outcomes of patients (11). Where do we surgeons stand today? We can practice advocacy for patients who are victims of violence (11) in order to reduce future violence against them or other vulnerable citizens (11). We have all handled victims of violence (whether domestic or regional terrorism related). Standing with the victims and collaborating with the authorities in their pursuit of perpetrators who may land in our hands as patients would help fight a common enemy (11).

At the system level we can lead advocacy for appropriate legislation to improve healthcare funding. This is achievable if our surgical societies would take public positions on matters of health importance, run media campaigns about certain common surgical diseases/conditions, publish periodicals and pamphlets that provide the public with information about certain diseases and educate them on where to seek help and as to which services are available where (12). This approach has been demonstrated to bear fruits in addressing diseases (12).

Many surgeons globally have to deal with the menace of trauma almost on a daily basis. The burden of trauma is immense, as has already been elucidated before. Many countries are now working on multiple road safety campaigns and trauma registries and there is a lot of room for advocacy and legislation in this aspect (13). The surgeon gets to experience first-hand the cost that the patient has to pay in not just accessing care, rehabilitation but also the lost man hours in both directions. Locally, tracking of cases and evaluating the impact of trauma is ongoing and a number of studies have been published on motorcycle accidents (14). Advocacy can rely on this data for the prevention of these injuries. Improvement of care can be done via research into protective programs and other associated risk factors that can lead to public health change like the association of iodination and goitre (15). Another area we can push for better care is in ensuring provision of care to all. A good model of this is South Africa where a lot has been done to lower the age of consent to ensure even children have access to surgery should they need it and have to make the decision (16).

Hubinette et al tell us that advocacy is a team work (17). Establishing advocacy teams and networks would work more effectively to address practice level and system level changes (17). As such, having standing committees on health advocacy may bear more fruits than leaving it to individual surgeons.

We have a role to be the champion for the patient's cause. Going forward, the following might be helpful in improving our advocacy at all three levels

- Formation of standing committees in our surgical societies to deal specifically with advocacy
- Introducing patient advocacy as a training module in our residency programs. This has been suggested elsewhere and can be achieved through theoretical teaching or through role modelling (4)
- Supporting fellow surgeons who are involved in advocacy at system level. We all know who have devoted themselves to work in unsafe environments and doctors who have taken on the political establishments to head countries (1). We can surely support our own and count on them to advance the advocacy agenda at political /system levels.
- Become crucial partners with Non-Governmental Organisations and Community Based Organisations that are involved in health related activities. This way we shall win more influence
- Regular media interviews on health topics of surgical importance will raise our population's awareness levels.
- Engaging governing structures and fiscal authorities to allocate more funds to research, public health initiatives and equipping facilities to ensure there is access to basic surgical care for all.

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