Power to Advocate for Health

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This is the seventh and final editorial in a series about integrative approaches to promoting health and personalized, high-value health care.[1-6] This editorial examines how we can develop the power to act on key values, knowledge, and principles to advance health for people, communities, and the population. This article asks the following questions:

1. What is moral authority and why is it important?
2. How can we understand the process for developing moral authority to advocate for health?
3. How might we act differently as individuals and as organizations if we developed this moral authority?

The article concludes with a summary of the 7 pieces in this editorial series and an invitation to join the online discussion.

WHAT IS MORAL AUTHORITY?

Moral authority is the power to influence others to do the right thing. It is granted to those using their power for a larger good than promoting narrow self-interest, and originates from self-awareness, truthfulness, compassion, and from making personal sacrifice for a societal good. Moral authority comes from walking the talk—from living with congruence between thought, word, and action. It can be enhanced by having lived through a challenge with integrity and compassion. Moral authority requires the capacity to evaluate and decide on what is the right or wrong course of action.[7] It does not require perfection, but continued striving.

Moral authority is shown by those who embody the message they speak. It is no accident that Gandhi, who said, "be the change you want to see," had great moral authority. While advocating for a free India, he would cancel a protest if only one person, even a person who did not acknowledge Gandhi as his leader, engaged in violence. Living simply and reflectively, and personally engaged in promoting the welfare of those who opposed his efforts, he embodied nonviolence, personal sacrifice, and working together toward a larger shared purpose.[8]

From the Dalai Lama to Viktor Frankl, Nelson Mandela, Amnesty International, Mother Theresa, Albert Einstein, and many others—those who have developed moral authority can inspire us to overcome short-term, narrowly selfish action to work toward a larger good that is both personal and transcendent.

But a hero model of moral authority is limited and often inaccurate. Elevating people to superhuman heights risks diminishing everyone else's sense of personal responsibility to advocate for a larger good. Hero models make for good tabloid fodder when the hero turns out to have human flaws, but promote the common good only when we are inspired to change our thought, word, and action.

A model of moral authority now emerging is less about heroes who fall and are blamed when things go wrong. Rather, what is emerging is a new focus on developing shared moral purpose. This focus is seen in cooperative movements,[9-20] new approaches to economic development that emphasize solidarity,[21,22] and a weariness with the unfulfilled promises of unfettered competition, efficiency, and so called productivity.[23-27]

MORAL AUTHORITY IN MEDICINE

The moral authority of physicians has been in decline for decades. Imber[28] and Loxterkamp[29-31] note that this decline parallels a shift away from a view of doctors as practitioners of a sacred vocation that includes but transcends the provision of health care services. At the same time, medicine has placed an increasing emphasis on delivering commodities of technology-driven and narrowly focused health care,[27,32-34] rather than on working for the health of people and communities.[1,35] As a result, not only has medicine's moral authority declined, so has its sense of shared moral purpose.[23]

Moral authority is diminished when power, particularly power that is conferred by others or society, is used for personal advancement. Many recent calls to reemphasize professionalism in medical training and conduct[27,28,36-42] emanate from a sense that the power conferred on physicians too often is used for self-advancement and not enough for the larger public good.

As the focus of health care is less on promoting personal and community health[27,33,43,44] and more on buying and selling narrow commodities and services, individuals, families, and communities find diminished

options for a trusted partner in the pursuit of health.[45] Despite some halting advances in shared decision making[46,47] and patient-centered,[48-50] relationship-centered,[51-55] and goal-oriented[56] care, a sense that something important has been lost lurks behind breathless assertions of the gains of the medical-industrial complex.[57,58] Increasingly, health care in the modern age is an experience of loneliness and abandonment in a sea of technology and fragmentation.[1,59,60]

What is trying to emerge in medicine, as in our larger society, is not a hero model of moral authority, but movement toward shared moral purpose.[23] This shared purpose is less about promoting health care than it is about advancing health. It is less about physicians on white horses than it is about relationships and partnership. In the information age it is less about protecting professional privilege and knowledge than it is about developing shared understanding.[6] It is about individual accountability, but also about collective responsibility and developing systems that support rather than hinder doing the right thing.

I believe that there are 3 reasons that moral authority of health care professionals, particularly physicians, has diminished. Medicine has (1) focused more on promoting health care rather than health and healing; (2) not openly considered the nature of power in health care; and (3) not recognized the developmental effects of thoughts and actions on the moral authority of individuals and organizations, and the ability of systems to support or encumber moral authority.

These 3 dimensions of moral authority and the opportunity to work together toward a shared moral purpose of promoting health are explained below.

THE PROCESS OF DEVELOPING MORAL AUTHORITY TO ADVOCATE FOR HEALTH

Promoting Health Care or Advancing Health and Healing?

The well-intentioned focus of many health advocates and organizations on promoting health care often has the unintended consequence of reducing the health of individuals, communities, and populations.[24,61-66] This is because access to adequate health care is only a small part of health, and because our view of health care has been narrow and fragmented.[1] As a result, the prevailing view of improving health focuses more on delivering commodities, and less on healing, relationships, and meaning.

In contrast, the World Health Organization (WHO) articulated a focus on health when it stated:

The ultimate goal of primary health care is better health for all. WHO has identified 5 key elements to achieving that goal:

- Reducing exclusion and social disparities in health (universal coverage reforms);
- Organizing health services around people's needs and expectations (service delivery reforms);
- Integrating health into all sectors (public policy reforms);
- Pursuing collaborative models of policy dialogue (leadership reforms); and
- Increasing stakeholder participation.[67]

Implicit in this goal statement is raising the gaze of health advocates from diseases to people, and from developing systems just for the individual to developing systems that serve the interconnected good of the population. The WHO statement also has room for consideration of the social[68] and environmental[58,69-78] determinants of health, including education, access to employment, adequate housing and food, public safety, equitable resource distribution, sense of belonging in family and community, and clean air and water. Recognizing the failings of its own narrowly disease-specific initiatives, the WHO recently called for refocusing efforts on promoting primary health care.[79-81] Because primary health care focuses on ongoing relationships with whole people and its boundary-spanning role in the health care system and community,[2,82-84] it is positioned as the place where a renewal of vision and purpose can evolve.[79-81,85]

But what is health? Seedhouse[86(p40)] identifies 4 theories of health that lead to 3 approaches to fostering health. The theories describe health differently:

- As an ideal state (such as the oft-quoted WHO definition that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.")[87]
- As physical and mental fitness to accomplish social roles
- As a commodity that can be bought or given
- As personal strengths or abilities that can be either innate or developed, and which can be supported or lost

The 3 approaches to health improvement evolve from these theories:

- Sociological—is concerned with diverse factors that influence health and its inequalities
- Medical science—emphasizes clinics, hospitals, biology, statistics, and measurement of pathological conditions against normal standards, and is focused on disease causes and the effects of drugs and surgery to cure or prevent disease
- Humanist—regards health as a personal goal in which disease may coexist with health, recognizing people as complex whole, developing beings connected with physical and spiritual dimensions

Seedhouse synthesized these theories and

approaches by defining health as conditions that enable a person to work to achieve his or her biological and chosen potential.[86(p84)]

Fine and Peters[88] define health as "the biological, social, and psychological ability that affords an equal opportunity for each individual to function in the relationships appropriate to his or her cultural context at any point in the life cycle."[88(p136)]

Berry goes even further in emphasizing the relationship, communal, and ecological aspects of health, declaring that health is membership in community.[58]

Egnew[89,90] and Scott,[91,92] using both theory and empirical evidence, define healing as the transcendence of suffering.

Together, these thoughtful definitions move well beyond the common conflation of health with health care. They emphasize that health involves the capability to function to meet societal roles and personally meaningful goals that vary with innate capacities and different times in life. These definitions include connection with self[93] and with transcendence of self,[94] and thus allow for health-promoting efforts that consider the good of the whole community and include the possibility of a meaningful death.[89,90,95]

I would simplify the definition as follows: *Health is the ability to develop meaningful relationships and pursue a transcendent purpose in a finite life.*

Understanding the Nature of Power in Health Care

Moral authority to advocate for health requires focusing different kinds of power on promoting health. While not specifically addressing moral authority, Howard Brody is one of the few philosophers/ethicists to consider the use of power in medicine. Drawing on the work of Patterson,[96] Siegler and Osmond[97] and Starr,[98,99] Brody identifies 3 kinds of power[100]:

Charismatic power stems from a physician's personal characteristics, such as character and charisma. These qualities are not transferable and are an important potential source of a healing beyond the technical aspects of health care.[101,102]

Social power comes from the societal and community status of the physician. Part of this power comes from the implied contract that gives the profession authority over medical truth in return for using that authority to reduce suffering from illness and to promote health. Social power also can include cultural power if physicians are drawn from higher societal classes.

Aesculapian power comes from training in the discipline of medicine. It is based on knowing and being able to apply specific facts, skills, art, and craft affecting health and illness. This power is impersonal, transferable, and independent of social status or class.

In considering the responsible exercise of power, Brody asks us to take into account whether power is owned, aimed, and shared. Power that is owned is acknowledged, and responsibility is taken for its ethical use. The act of sharing power contains within it the possibility for correcting many potential abuses of power. Aiming power requires identification of a useful target for that aim. Brody's book *The Healer's Power*[100] contains a much fuller consideration of the implications of power and its use in medicine.

Regarding the development of moral authority, it is helpful to acknowledge (own) the sources of power to advocate for health. This acknowledgment can help us as individuals and organizations to develop our power to work toward a larger good than immediate, apparent self-interest. If the different kinds of power are aimed at promoting health in ways that are meaningful to individuals, communities, and populations, the capacity for moral authority is enhanced. If, however, power is focused on promoting narrow aspects of health care without collaborative consideration of how those health care services or systems affect health, the effect is to diminish moral authority, particularly if the self-interest of the powerful is advanced. If shared power is widely shared, if owned power is focused on a larger good than self-interest, and if aimed power is directed at advancing personal and population health, shared moral purpose to advocate to optimize health for all can be fostered.

DEVELOPMENT OF MORAL AUTHORITY

Moral authority doesn't just happen. It can be bestowed. It evolves. It can be developed through thoughts, words, and actions—both small and large—across owned, aimed, and shared power.

In individuals, moral authority is developed by reflection, truthfulness, compassion, and sacrifice. Moral authority to advocate for health is available to people outside health care, particularly those who have relevant vision, expertise, or experience. Individual health care workers seeking to develop their moral authority to advocate for health can develop themselves beyond the narrow technician role[103] that is increasingly the main focus of health care training. This growth involves developing as professionals who see their contract with society as evoking responsibility for the person and the common good more than pursuing privilege for the profession.[29,104-107] Further growth involves developing as leaders and healers and citizens focused on meaningful relationships. Biomedical health care can foster moral authority when it moves beyond clinician-centered care to patient-centered care to relationship-centered care to goal-oriented care.[4] Each step in this path transcends and includes the one before,

bringing together the clinician's and patient's knowledge to develop relationships that enable health that is meaningful to the goals of the patient, family, and community.[56,91]

Health care and health promotion teams can foster their moral authority to develop shared moral purpose[23] by developing from multidisciplinary groups in which members work in their own realms, to interdisciplinary teams working together on the common problem of fostering health, to transdisciplinary teams that develop shared common understanding, to healthy communities that go beyond disciplinary roles to live, learn, and work together to foster healthy and healing relationships.[108,109]

Organizations evolve moral authority along a similar path that involves interpersonal reflection, truthfulness, and development of shared experience and understanding,[9] which leads to shared goals and the possibility of both shared sacrifice and shared abundance.[110-113]

Health care systems can develop moral authority when they include disease-focused systems but transcend that focus to also include patient-oriented systems that foster relationships and healthy and healing environments.[4] Health care systems develop the ability to enable moral authority when they move beyond supporting technical care to develop systems that help integrate and prioritize care and focus on fostering healing and health. Individuals' and organizations' ability advocate for health is advanced when these systems both support disease-specific, technical, and vertical integration of care for specific diseases[114,115] and support horizontal integration,[64,65,116,117] personalization, and prioritization[2-4] among diverse aspects of health care and the social and environmental determinants of health.[50,58,68,72,118,119] These integrating, personalizing, and prioritizing functions are central to primary care, but they can also be enacted when more narrowly defined interests raise their gaze from the disease, the product, or the technique to the person, and from the person to the community and population.[2-4,100]

Although it is harder to do the right thing in a wrong system, systems that are unsupportive occasionally can serve as the stimulus for doing good. Broken systems sometimes can even stimulate the development of a Gandhi or a Médecins Sans Frontières. This happens through personal work and then interpersonal efforts to progress from awareness and reflection to truthfulness, compassion, and shared goals that enable personal and shared sacrifice for a larger good.

ACTING DIFFERENTLY AS INDIVIDUALS AND AS ORGANIZATIONS

How might individuals and organizations act differently to evolve shared moral purpose that improves

health as the ability to develop meaningful relationships and pursue a transcendent purpose in a finite life?

As individuals, we might make time for reflection as well as for action—taking time each day to increase our awareness of the diverse factors affecting health and how they interact, contemplating how our thoughts, words, and actions can contribute to health and healing. The societal focus on competition, efficiency, and productivity makes this difficult. We might do it anyway, focusing that energy on personal spiritual development and service.[94] To do so, we might follow any number of ancient or modern practices, developing our capacity for discernment and compassion along the way.[52,120-122] We might work to embody this awareness, turning it into action to improve health for those in our circles of influence.

If we work in health care, we might consider where to aim our medical knowledge in the information age, when knowledge is common but understanding and wisdom are rare.[6] We might participate in a new kind of knowledge generation, in which personalized medicine[123-128] means knowing the person,[1,2,4] not just their genome. Where personal knowing is used to integrate and prioritize care to promote healing and health,[4] not just to tailor pharmacotherapy.[129] In deciding how to live our lives, we might begin to balance self-effacement and self-sacrifice with relationships and interests outside medicine,[36] and in so doing, move from the heroic vision of the healer to being a fellow traveler with our patients/friends.

Working in small teams and large groups, we might look for opportunities for moral leadership[130] in working with others toward system change,[131] in both the larger systems and those in our own practices and communities. We might seek to develop new partnerships with patients, colleagues, and community organizations. We might focus these partnerships on fostering the emergence of new models of health care[132-135] and health promotion to emerge[136,137]—working together to develop the awareness and truthfulness that lead to common experience and understanding that facilitate shared goals and the possibility of shared sacrifice that generates collective abundance.[111-113,138,139]

As organizations, we might work to refocus our mission on advocating not only for the narrow interests of members, but for the health of the people our members serve. A nonprofit organization that declines funds from commercial, health-related entities has the potential to develop great moral authority. When organizations open themselves to diverse interests in promoting health, they can ignite the idealism and sense of purpose of people yearning to work toward a larger good.[140-142] Such partnerships can bring together those who are disenfranchised by the current medi-

cal-industrial complex[143] to develop coalitions to truly restructure health care, not to feed health care industry special interests,[27,33,44] but to foster health and sustainable, evolvable health care[135] and to support the social and environmental enablers of health.[68,118]

This is the hard work of redesigning practice. This is the hard and personally transforming work of developing teams.[144] This is the hard and political work of redesigning systems, organizations, and communities.[9,53,145-148] This is the work of reinventing what it means to provide personalized health care and promote health in the information age.[149-151] Health care in the United States and around the world is nearing a flash point at which a rapid cycle of creative destruction and renewal is poised to reward innovation focused on providing value in promoting health.[5]

This work is exciting and worthwhile. It is worthy of both generalists[66,152] and those with narrower expertise.[2] It is the multilevel work needed to foster shared moral purpose to advance health.

MOVING FORWARD IN USING GENERALIST KNOWLEDGE TO PROMOTE HEALTH AND HIGH-VALUE HEALTH CARE

The articles in this editorial series address the following:

- The problem of fragmentation[1]
- The generalist approach: ways of being, knowing, seeing, thinking, and acting that foster integration, prioritization, and personalization of health care[2]
- The paradox of primary care: how despite apparently poorer care of individual diseases compared with secondary or tertiary care, systems based on primary care have similar quality of disease care for whole people, better quality of care for populations, lower cost and less inequality[3]
- A science of connectedness: how understanding development across multiple levels of health care can enable the higher level generalist functions that provide added value[4]
- Making sense of both inertia and radical changes in health care systems by understanding adaptive-renewal cycles[5]
- Ways of knowing, learning, and developing that advance from data to information to knowledge to (shared) understanding to wisdom[6]
- How moral authority to advocate for health can be understood and developed.

In the ongoing *Annals* online discussion, each article has stimulated both criticism and amplification that help to advance understanding and application of generalist knowledge. This knowledge is vital if health care is to evolve in ways that foster health. This knowledge is deeply understood but often lost as we live courses of action based on more narrowly construed concepts.

I invite readers to comment online by clicking on Submit a Comment in the upper-right corner of each article. If your comment relates to the entire series, please comment on this last article on moral authority. A limited number of print copies of this series, including comments received before April 30, 2010, will be published. Please send requests for print copies to sac@cwru.edu .

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