On the Pleas of Humanity: the Evolution of Advocacy in Medicine

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Date Published: August 5, 2025
DOI: https://doi.org/10.18192/UOJM.15iS2.7532

The essence of a physician's role lies in the thoughtful appraisal of the biomedical, social, and historical dimensions of health as they apply to their patients and communities. Some of the implicit challenges of this role is the diversity of experience, knowledge, and predispositions held by the practitioner. The contemporary physician must grapple with ambiguous decisions. As a field, deliberate consideration of decolonization, diversity, equity, and inclusion (EDID) must be incorporated [1]. Opposing viewpoints, often rooted in outdated biases, may challenge this premise, but the inclusion of EDID principles is essential for the evolution of medical practice much like the integration of evidence-based medicine was crucial to improving patient outcomes.

Advocacy is a modern issue that calls for redefinition of professionalism and what it means to be competent as a Canadian physician. At its core, advocacy is rooted in the principles of EDID. Being an advocate is a critical function for each and every medical practitioner [2]. From advocating for a single patient's needs to influencing health policy on a national scale, advocacy manifests in many forms, all requiring a foundation of EDID principles. Advocacy is not merely an adjunct to medical practice; it is a competency that every physician must master, akin to their clinical skills or ethical reasoning.

Throughout history, warfare has expanded the challenges and responsibilities of physicians' roles [3]. For months on end, civilians are forced into a nomadic lifestyle in significant poverty. They are starved, subjected to infectious disease, and without significant relief. Every one of their hospitals is destroyed, every school reduced to rubble. All individuals suffer, especially those who live with untreated chronic health conditions. Physicians and health practitioners are met with the insurmountable task of healing in an environment where human life is not sacred.

While a medical learner in the first world sitting in the peace and seclusion of their medical education environment bears no responsibility for the unspeakable conditions and humanitarian catastrophe suffered, perhaps they may call for more to be done. Not only being one of the core principles of global and public health, but many individuals may also feel a moral imperative to act on this issue.

The challenge advocacy faces in this scenario is fear. It so happens that the academic setting, institution, hospital, or the professionals themselves may look down upon those who speak up. Perhaps they may be discriminated against in their residency applications or passed up for a job. While social media poses an immense capacity for good, any deviation from the social script prescribed to physicians presents a liability to medicine. Even if, in its agnostic, apolitical and platonic conception, the medical humanitarian imperative calls for the resolution of suffering, removal of oppression and immediate grant of life saving aid, the humanized and living, breathing, dogma of medicine will reproach it.

The ongoing genocide occurring in Palestine, where tens of thousands have been directly killed, in addition to likely hundreds of thousands more from secondary causes reminds society of the significance of medical advocacy [4]. The analogy is, when learners, physicians, or leaders speak up for a morally just cause, they are looked at with skepticism. With deceit. With disdain for challenging the status quo.

"You should focus on bettering yourself before you try to take on the world"

What medicine teaches us is to learn on the scale of a lifetime, if not more. If the physicians of Baghdad, Rome, Alexandria, or Berlin had merely punched in and punched

out, focusing solely on medical knowledge without delving into the broader societal and historical contexts, it is unlikely we would have seen the profound advances in philosophy, medicine, and healing that shape our practices today. Their legacy reminds us that medicine cannot be isolated from the world in which it operates; we must integrate this understanding into our daily work, just as they did.

To implement the concepts of EDID does not necessitate one to take on the named role of "EDI person". Too many times have we sat in meetings, in classrooms, or seminars where instructors or colleagues pass on an underwhelming and unimpressive land acknowledgement, urging sentiment to move things along. Not often enough are data based on race, gender, religion, sexuality, or any other diversity metric used in discussions amongst colleagues let alone for consideration of challenges faced by our patients. I urge every medical trainee to recognize that EDID is not a supplementary aspect of your training—it is fundamental to the practice of medicine. To overlook the intersectional nature of healthcare is not only to shortchange your patients but also to betray the core principles of our profession. Embracing EDID is essential to delivering truly equitable care and advancing the health of all communities.

There is namely a revolution occurring on this front. Despite its bleakness and the tremendous injustice fielded by those pioneers who advocate for justice, I believe a better world is coming. One where we move beyond performative actions, and the norm of the profession is to incorporate these EDID principles without sacrificing excellence. Justice for the Palestinians breeds a path to justice for all oppressed people. While there are ample issues to solve and injustices to atone for abroad and in Canada, I encourage you all to see a beacon of hope. As we strive to uphold the principles of justice and equity in our work, we must remember the words of Martin Luther King Jr.: "The arc of the moral universe is long, but it bends toward justice." Change is on the horizon, as it always has been. How readily, painlessly, and efficiently it is adopted depends only on us, the collective.

REFERENCES

1. Acosta D, Ackerman-Barger K. Breaking the Silence: Time to Talk About Race and Racism. Acad Med. 2017 Mar;92(3):285.
2. Earnest MA, Wong SL, Federico SG. Perspective: Physician advocacy: what is it and how do we do it? Acad Med J Assoc Am Med Coll. 2010 Jan;85(1):63–7.
3. Leaning J, Guha-Sapir D. Natural Disasters, Armed Conflict, and Public Health. N Engl J Med. 2013 Nov 7;369(19):1836–42.
4. Khatib R, McKee M, Yusuf S. Counting the dead in Gaza: difficult but essential. The Lancet. 2024 Jul 20;404(10449):237–8.
5. Metzl JM, Hansen H. Structural competency: Theorizing a new medical engagement with stigma and inequality. Soc Sci Med 1982. 2014 Feb;103:126–33.