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Beyond the bedside: understanding and overcoming barriers to patient advocacy among practicing physicians

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Abstract

Background Patient advocacy is a fundamental dimension of physician responsibility recognised in every major code of medical ethics, yet substantial gaps persist between this normative expectation and routine clinical practice. Surveys consistently show that physicians who recognise advocacy as a duty often refrain from advocating when they perceive the need.

Purpose This commentary analyses the multilevel barriers that constrain advocacy by practicing physicians and proposes a coordinated framework for overcoming them, with attention to healthcare systems in Georgia and similar transitional settings.

Scope Six categories of barriers are identified — time and workload, fear of retribution, inadequate training, systemic complexity, cultural and hierarchical impediments, and ethical role conflicts — operating at individual, institutional, and systemic levels and reinforcing one another. Drawing on international evidence and ethical frameworks, the analysis maps stakeholder-specific interventions across physicians, healthcare institutions, professional societies, policymakers, medical educators, and patient organisations. Particular attention is given to employment vulnerabilities, hierarchical professional cultures, and resource constraints characteristic of healthcare systems in transition.

Conclusion Effective advocacy is not the moral achievement of unusually committed individuals but a structural property of well-designed healthcare systems. Repositioning advocacy as essential rather than optional requires coordinated action across individual physician development, institutional culture, professional organisation leadership, and health policy reform.

Keywords patient advocacy; physician professionalism; healthcare ethics; physician burnout; health policy; clinical practice; medical education; Georgia

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1. Introduction

The conception of the physician as advocate is woven into the foundational documents of medical professionalism. The World Medical Association's Declaration of Geneva commits physicians to make the health and well-being of their patients their first consideration [1], and the American Medical Association's Code of Medical Ethics treats advocacy as a constitutive obligation of clinical practice [2]. Comparable language appears across national codes and across academic accounts of medical professionalism [21].

Yet between these normative commitments and the realities of contemporary practice lies a substantial

and well-documented gap. Empirical work across specialties consistently finds that physicians recognise advocacy as a professional duty but report being unable, unprepared, or unwilling to act on it in concrete situations [3,4]. The disconnect is not a minor matter of professional aspiration: it has measurable consequences for patient outcomes, health system performance, and the legitimacy of the medical profession itself [12].

Patient advocacy is multilevel. At the individual level it involves intervention on behalf of specific patients — appealing insurance denials, navigating administrative obstacles, addressing social determinants, and protecting patients from inadequate or discriminatory care. At the community level it extends to action on behalf of patient populations, including those exposed to health inequities. At the systemic level it includes engagement with policy, public discourse, and reform of practices that demonstrably harm patients [3,9].

In Georgia, as in many countries with healthcare systems in active transition, these challenges acquire particular urgency. The shift from Soviet-era institutional structures to a market-based system has reconfigured physician roles, employment relationships, and professional autonomy in ways that bear directly on the conditions for advocacy. Patterns observed in such settings are instructive for healthcare systems globally — particularly those undergoing institutional transformation or operating under sustained resource constraint.

This commentary examines the barriers that prevent physicians from fulfilling advocacy responsibilities and proposes evidence-based strategies for overcoming them. The analysis draws on the international literature, on ethical frameworks for medical professionalism, and on contextual considerations relevant to Georgia and comparable settings, with the dual aim of advancing conceptual understanding and informing concrete reform.

2. Defining patient advocacy in clinical practice

Before barriers can be analysed, the object of analysis must be specified. Advocacy in physician practice spans a continuum, not a fixed activity, and the barriers and remedies relevant at one level of the continuum differ from those relevant at another [5,6].

2.1 Individual patient advocacy

At its most direct, advocacy involves action on behalf of a specific patient: intervening when an insurer denies a medically necessary treatment, securing access to specialised services or medications, addressing social needs that affect health outcomes, navigating bureaucratic obstacles, and protecting vulnerable patients from discrimination or inadequate care. This is the bedside dimension that physicians most readily associate with the term [20].

2.2 Community and population advocacy

Beyond the individual encounter, physicians observe patterns of need that affect entire communities or patient populations. Advocacy at this level includes identifying and naming health disparities, contributing to public understanding of health threats, supporting underserved communities' access to care, and using clinical expertise to inform community health initiatives [10].

2.3 Systemic and policy advocacy

At the broadest level, advocacy involves efforts to change healthcare systems, policies, and structures that demonstrably harm patients: engaging with legislative processes, contributing to media discourse on healthcare, participating in organised advocacy through professional societies, and — where necessary — disclosing dangerous practices through legitimate whistleblowing channels [9,19]. This form often carries the greatest professional risk and, potentially, the widest impact.

These levels are not discrete categories but a continuum along which physicians move depending on circumstance and opportunity. Recognising the continuum matters because the structural conditions that enable bedside advocacy differ substantially from those that enable systemic advocacy.

3. The current state: advocacy in practice

Despite universal acknowledgment of advocacy as a professional responsibility, the empirical evidence reveals consistent shortfalls. Multi-specialty surveys document a recurring pattern: a near-universal endorsement of advocacy as a duty, paired with widespread reports of feeling unprepared to advocate effectively and of having declined to advocate in situations where the respondent considered it warranted [4,9]. **Figure 1** illustrates this advocacy gap.

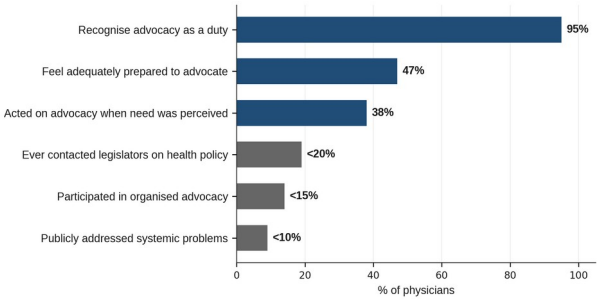

Figure 1. The physician advocacy gap. Recognition of advocacy as a duty is near-universal, but engagement falls sharply across each successive level of action — particularly at the systemic level. Indicative ranges synthesised from multi-specialty survey evidence [3,4,9].

Studies of physician responses to insurance denials — a paradigmatic individual-level advocacy scenario — document frequent acceptance of denials without appeal, even when physicians disagree with the underlying decision. Time and administrative burden emerge as primary drivers, with physicians calculating that the effort required to advocate exceeds the time and energy available [13].

Engagement in policy and systemic advocacy is more limited still. Population-level surveys consistently show single-digit or low double-digit participation in legislative engagement, organised advocacy campaigns, or public communication about healthcare system failures [9]. Systemic advocacy — arguably the most consequential form — is the most underutilised.

In transitional healthcare systems, several distinctive patterns emerge. Physicians in such contexts frequently report particular reluctance to engage in systemic advocacy because of employment vulnerabilities, professional hierarchies, and cultural norms discouraging public criticism of institutions. Yet the need for advocacy is often acute in these settings, producing the troubling paradox that advocacy is simultaneously most needed and most constrained.

4. Barriers to patient advocacy: a multilevel analysis

The persistence of an advocacy gap despite genuine professional commitment requires examination of barriers operating across individual, institutional, and systemic levels. These barriers interact and reinforce one another, producing environments where advocacy becomes professionally risky or practically impossible. **Table 1** summarises the six barrier categories and the levels at which each predominantly operates.

Table 1. Six categories of barriers to patient advocacy, with predominant level of operation and illustrative manifestations.

Barrier category	Predominant level	Illustrative manifestations
Time and workload constraints	Individual; institutional	Productivity quotas; documentation burden; absence of compensated time for advocacy work; advocacy as economically irrational under fee-for-service incentives.
Fear of retribution and professional risk	Institutional; systemic	Employment-based sanctions for “disloyal” advocacy; reputational risk in hierarchical cultures; non-disparagement and gag clauses; chilling effects on junior staff.
Inadequate training and skills	systemic	content in undergraduate, postgraduate, and continuing medical education; absence of policy, communication, and ethical reasoning competencies.
Systemic complexity and bureaucratic obstacles	Institutional; systemic	Insurance appeal complexity; opaque institutional decision channels; learned helplessness from repeated bureaucratic failure.
Cultural and hierarchical impediments	Individual; institutional	“Stay in your lane” professional norms; deference to seniority; risk aversion transferred from clinical to advocacy domains; gendered and minority-specific obstacles.
Ethical tensions and role conflicts	Individual	Resource stewardship vs zealous individual advocacy; loyalty conflicts between patients, employers, and colleagues; uncertainty about legitimate scope of physician advocacy.

4.1 Time and clinical workload

The most frequently cited barrier is insufficient time. Modern healthcare imposes intense productivity pressures on physicians, with appointment schedules, documentation requirements, and administrative burdens leaving little time for activities outside direct patient care. Advocacy — whether writing appeal letters, identifying patient assistance programmes, or engaging in policy work — requires time that many physicians do not have [13].

The problem extends beyond raw scarcity to the underlying economics of medical practice. In fee-for-service and productivity-based compensation models, advocacy generates no revenue while consuming time that could be spent on billable services. Physicians working under productivity quotas face direct financial penalties for time spent advocating. The result is a structural environment in which advocacy is economically irrational despite being ethically imperative.

Physician burnout, now reaching epidemic proportions internationally, compounds the problem [14,15,16]. Burned-out physicians describe themselves as emotionally depleted and lacking energy for additional responsibilities beyond immediate clinical duties. The irony is acute: the systemic problems that demand

advocacy are themselves contributors to physician burnout, generating a feedback loop in which exhausted physicians lack the capacity to address the systemic causes of their exhaustion.

4.2 Fear of retribution and professional risk

Advocacy, particularly at the systemic level, can carry significant professional risks. Physicians who publicly critique institutional policies, challenge insurance practices, or speak out about healthcare system failures may face retaliation. This is not paranoid speculation but a documented reality.

Employment-based consequences are a primary concern. Physicians employed by large healthcare organisations may face disciplinary action, negative performance reviews, reduced privileges, or termination for advocacy viewed as institutionally damaging [7]. In Georgia and similar contexts where most physicians are employees rather than independent practitioners, this employment vulnerability creates a substantial chilling effect.

Reputational risks extend beyond formal employment consequences. Physicians worry about being labelled as troublemakers, damaging collegial relationships, losing referral networks, or encountering obstacles to career advancement. In hierarchical medical cultures, junior physicians particularly fear that advocacy will mark them as insubordinate.

Legal risks also constrain advocacy. Concerns about defamation exposure, regulatory sanctions, or violations of employment contracts containing non-disparagement clauses are common. In some jurisdictions, gag clauses explicitly prohibit physicians from discussing certain topics publicly. While their enforceability is often legally questionable, such clauses exert intimidating effects independent of formal enforcement.

4.3 Inadequate training and skills

Most physicians receive little formal training in advocacy skills during medical education or residency. Clinical training focuses overwhelmingly on diagnosis and treatment, with advocacy addressed superficially if at all [7,8]. The result is a skills gap: physicians may recognise the need to advocate but lack practical knowledge of how to do so effectively.

Specific deficits include unfamiliarity with insurance appeals procedures, limited understanding of policy-making mechanisms, no formal training in media communication, lack of awareness of patient assistance resources, and absence of structured frameworks for ethical decision-making in advocacy contexts. Without training, physicians acquire advocacy skills through trial and error — an inefficient approach that many simply avoid.

The training gap is particularly pronounced for systemic advocacy. Effective policy engagement requires understanding of legislative processes, political strategy, coalition building, and public communication — competencies entirely absent from standard medical curricula. Physicians interested in policy advocacy must acquire these skills independently, creating barriers to entry that many cannot overcome.

4.4 Systemic complexity and bureaucratic barriers

Modern healthcare systems are extraordinarily complex, with multiple payers, regulatory bodies, institutional policies, and administrative processes. Navigating this complexity to advocate effectively requires substantial effort and expertise.

Insurance bureaucracy exemplifies the problem. Appealing denied authorisations requires understanding specific policy provisions, identifying relevant coverage criteria, gathering documentation, following precise procedures, and persisting through multiple appeal levels. Each insurer maintains different processes, and tracking these alongside clinical responsibilities becomes overwhelming.

Institutional bureaucracies create additional obstacles. Advocating for change within healthcare organisations requires navigating committee structures, understanding organisational politics, identifying decision-makers, and following established channels. Physicians often find these processes opaque, producing what may be termed learned helplessness — the conclusion, drawn from repeated bureaucratic failure, that advocacy is futile. This belief becomes self-fulfilling: the conviction that advocacy will not succeed prevents advocacy attempts, ensuring that nothing changes.

4.5 Cultural and hierarchical impediments

Despite its rhetoric of patient-centeredness, professional medical culture often discourages advocacy through implicit norms [22,23]. The “stay in your lane” norm encodes the view that physicians should focus exclusively on clinical care, leaving administrative, financial, and policy matters to others. This narrow conception delegitimises advocacy as outside the proper physician role.

Hierarchical medical cultures, prevalent in many contexts including Georgia, create additional barriers. In highly hierarchical settings, questioning authority, challenging established practices, or advocating for change may be perceived as disrespectful or inappropriate. Junior physicians and those from marginalised groups face particular difficulty in such environments.

Cultural risk aversion within medicine — understandable given clinical stakes — extends to advocacy activities. Physicians trained to minimise risk in patient care may transfer this orientation to professional activities, avoiding advocacy that could generate controversy. In cultures that emphasise conformity and social harmony, the inherently confrontational character of advocacy generates discomfort.

4.6 Ethical tensions and role conflicts

Advocacy generates genuine ethical dilemmas that themselves operate as barriers, even for physicians otherwise motivated to act. The tension between individual patient advocacy and resource stewardship is a fundamental challenge: zealous advocacy for expensive treatments for one patient may divert resources from others. Physicians struggle to balance individual advocacy against population-level allocation concerns, particularly under resource constraint [12].

Loyalty conflicts add ethical complexity. Physicians have duties to patients but also to employers, colleagues, and institutions. When institutional policies harm patients, physicians face conflict between patient advocacy and institutional loyalty — a conflict that intensifies when employment depends on institutional good will.

Uncertainty about the legitimate scope of advocacy poses a further barrier. Should physicians advocate strictly on the basis of clinical expertise, or also on policy, economics, and social questions where their expertise is less direct? These boundary questions generate hesitation, with physicians uncertain whether advocacy exceeds the appropriate professional role.

5. Consequences of inadequate advocacy

The barriers above have significant consequences extending beyond individual frustration. For patients, inadequate advocacy means treatable conditions go untreated when insurance denials are not appealed; necessary medications remain unaffordable because assistance programmes are unknown; social determinants of health are not addressed; discrimination and substandard care persist unchallenged; and patients' voices in healthcare decision-making remain unheard.

At the system level, the absence of advocacy allows harmful policies to persist, inefficiencies and waste to continue, health inequities to deepen, patient safety issues to remain unaddressed, and healthcare organisations to prioritise financial performance over patient welfare without physician pushback [12,17].

For the profession, the failure to advocate undermines medicine's social contract. The privileged position of medicine — professional autonomy, self-regulation, and societal trust — rests on physicians fulfilling public-serving responsibilities including advocacy. When advocacy fails, professional legitimacy erodes [21,24].

Individual physicians who recognise advocacy duties but feel unable to fulfil them experience moral distress — the psychological suffering that arises when one knows the ethically right action but institutional constraints prevent taking it. Moral distress contributes to burnout, cynicism, and exit from clinical practice [14,16].

6. Overcoming barriers: a multilevel framework

Addressing barriers to advocacy requires interventions at multiple levels: individual physician development, institutional culture and policy change, professional society support, and systemic healthcare reform. **Figure 2** presents a conceptual framework linking the three levels of determinants to advocacy capacity and downstream outcomes. Coordinated approaches addressing multiple levels simultaneously are most likely to succeed.

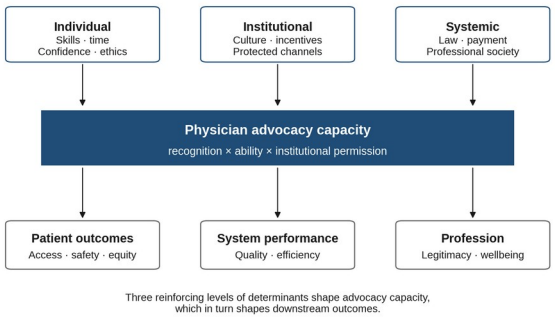

Figure 2. Multilevel determinants of physician advocacy capacity and downstream outcomes for patients, healthcare systems, and the profession.

6.1 Individual physician strategies

While systemic change is essential, individual physicians can take concrete steps to overcome barriers. Building advocacy skills through available resources — online courses, professional society workshops, mentorship from experienced advocates, and engagement with advocacy organisations — provides a foundation [8]. Beginning with individual patient advocacy before attempting systemic engagement allows skill development at lower personal stakes.

Strategic time management can mitigate workload constraints. Physicians describe integrating advocacy into existing workflows — dictating appeal letters during documentation time, connecting patients with resources during visits, using templates and standardised processes — as making advocacy more

feasible. Setting boundaries and protected time, even modest amounts, prevents complete crowding out.

Coalition building and collective action reduce individual risk. Advocating jointly with colleagues provides safety in numbers, distributes workload, amplifies impact, and provides mutual support. In Georgian contexts, forming informal physician networks focused on advocacy could provide protected space for collective action.

Documenting advocacy efforts and outcomes serves multiple purposes: it demonstrates impact, generates evidence for policy arguments, protects against allegations of impropriety, and builds the case for institutional support. Careful documentation is also a protective measure should retribution occur.

6.2 Institutional reforms

Healthcare institutions must create environments in which advocacy is supported rather than punished. Essential reforms include explicit advocacy policies stating that patient advocacy is expected and protected; grievance procedures with anti-retaliation guarantees; resourcing for advocacy through social workers and patient navigators; recognition and reward for advocacy efforts; and visible modelling of advocacy by senior leadership.

Protected time for advocacy represents crucial institutional support. Some healthcare systems allocate specific time for quality improvement and advocacy work, recognising these as legitimate professional activities rather than personal pursuits. Resource-constrained settings may struggle with this, but even modest allocations signal institutional commitment.

Creating formal advocacy structures within institutions — patient-advocate positions, ombudsman offices, ethics committees with advocacy mandates — provides channels for raising concerns without individual risk. Transparency and accountability mechanisms — including reporting on appeal rates, patient complaints about access, and physician feedback on advocacy barriers — create accountability and identify problem areas.

6.3 Professional society leadership

Medical professional organisations have essential roles in supporting advocacy. Key functions include providing advocacy training; publicly supporting individual physicians who face retaliation; engaging in systemic advocacy and policy work; developing advocacy toolkits; and creating networks connecting physicians interested in advocacy.

Professional societies can leverage collective voice on issues that exceed individual physician capacity — through position statements, policy recommendations, media engagement, and legislative testimony. For Georgian contexts, strengthening professional medical associations and their advocacy capacity could substantially increase physician effectiveness. Importantly, professional societies must model ethical advocacy: transparency about funding sources and conflicts of interest, ensuring advocacy genuinely serves patient rather than guild interests, involving diverse physician voices, and maintaining independence from political and commercial influence.

6.4 Systemic healthcare reforms

Ultimately, removing barriers requires systemic reforms addressing root causes. These include payment reform that moves away from pure productivity models toward value-based care that rewards advocacy and care coordination [17]; addressing physician burnout through workload management, administrative burden reduction, and well-being support [13,16]; regulatory reforms protecting physician advocacy through anti-retaliation laws, prohibition of gag clauses, and whistleblower protections; and transparency requirements for insurance decisions, institutional policies, and system performance.

For transitioning healthcare systems such as Georgia's, specific reforms might include strengthening employment protections for physicians, creating independent regulatory bodies that protect professional autonomy, ensuring physician representation in health policy development, investing in health system transparency and accountability, and supporting civil society organisations focused on healthcare advocacy.

7. Implications for Georgian healthcare and similar contexts

The analysis has specific implications for healthcare systems that share characteristics with Georgia's: recent transition from a different system, evolving regulatory environments, resource constraints, strong professional hierarchies, employment-based physician practice, and developing civil society. In such contexts, physician advocacy faces intensified barriers but also increased necessity. Resource constraints make physician advocacy for equitable allocation crucial. Transitional regulatory environments create policy windows in which physician advocacy could shape system development. Yet employment vulnerabilities and hierarchical cultures generate particular risks for advocates.

Priority interventions include strengthening professional medical associations' capacity for collective advocacy, creating legal protections for physician advocates, developing physician leadership in health policy, building bridges between physicians and patient advocacy organisations, ensuring

physician voices in healthcare governance, and addressing cultural barriers through dialogue and modelling. International partnerships and learning networks could support Georgian physicians in developing advocacy capacity, including connections with physician advocacy movements in other transitioning systems and access to advocacy training resources.

8. Recommendations for action

Specific recommendations emerge for each stakeholder group. **Table 2** consolidates these into an action matrix.

Table 2. Recommendations for action by stakeholder, mapped to barriers addressed.

Stakeholder	Concrete actions	Barriers primarily addressed
Individual physicians	Recognise advocacy as a professional duty; build skills; begin at the patient level and progress to systemic engagement; document outcomes; seek coalition partners.	Training; cultural; ethical tensions
Healthcare institutions	Codify advocacy policies; establish anti-retaliation protections; allocate protected time and support staff; reward advocacy; model it through leadership; create formal channels for raising concerns.	Time; retribution; complexity
Professional medical societies	Provide advocacy training and toolkits; support physicians facing retaliation; engage in systemic policy work; maintain independence and transparency about interests.	Training; retribution; cultural
Health policymakers	Create legal protections for physician advocates; reform payment systems; address burnout systematically; ensure physician representation in policy; require system transparency; prohibit gag clauses.	Time; retribution; complexity
Medical educators	Integrate advocacy into undergraduate, postgraduate, and continuing medical education; teach systems navigation, policy engagement, communication, and ethical reasoning; support student and resident advocacy initiatives.	Training; cultural
Patients and patient organisations	Support physician advocates facing institutional pressure; partner on shared advocacy goals; educate the public on the importance of physician advocacy; hold systems accountable for retaliation.	Retribution; cultural

9. Conclusion

Patient advocacy is an essential yet endangered dimension of physician responsibility in contemporary healthcare. Although medical ethics universally recognises advocacy as a core professional duty, substantial barriers — operating at individual, institutional, and systemic levels — prevent physicians from fulfilling this responsibility. These barriers reinforce one another to create environments in which advocacy becomes professionally risky or practically impossible.

The consequences are profound. Patients suffer when treatable conditions go untreated, necessary care remains inaccessible, and their voices go unheard. Healthcare systems perpetuate inefficiencies, inequities, and harmful policies that advocacy could address. The medical profession's social contract erodes when physicians cannot fulfil public-serving responsibilities. Individual physicians experience moral distress when unable to honour ethical obligations, contributing to burnout and demoralisation.

Yet the barriers are not insurmountable. Evidence from diverse healthcare contexts demonstrates that coordinated interventions at multiple levels can create environments in which advocacy flourishes. Individual physicians can develop skills and strategies for effective advocacy. Healthcare institutions can implement policies that protect and support advocates. Professional organisations can provide training, resources, and collective voice. Health systems can undertake reforms addressing root causes.

For healthcare systems characterised by transition, resource constraint, and evolving governance, attention to physician advocacy is particularly urgent. These contexts face acute need for advocacy to address inequities and system failures, while also presenting heightened risks for advocates. Strengthening physician advocacy capacity in such settings requires targeted interventions addressing cultural barriers, employment vulnerabilities, and institutional weaknesses while building on existing strengths.

The way forward requires recognition that patient advocacy is not an optional activity undertaken by particularly committed individuals but an essential component of ethical medical practice that demands systematic support and protection. Creating healthcare environments in which physicians can advocate effectively requires courage from individuals, commitment from institutional leaders, engagement from professional organisations, and vision from policymakers. The question is not whether physicians should advocate — ethical consensus on this is clear — but how healthcare systems can be reorganised to make advocacy possible and sustainable.

Abbreviations

AMA — American Medical Association
CC BY 4.0 — Creative Commons Attribution 4.0 International License
CME — Continuing Medical Education
COI — Conflict of Interest
DOI — Digital Object Identifier
GMJ — Georgian Medical Journal
IMRaD — Introduction, Methods, Results, and Discussion
NCD — Non-Communicable Disease
ORCID — Open Researcher and Contributor ID
PHIG — Public Health Institute of Georgia
UHC — Universal Health Coverage
WMA — World Medical Association

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Authors' contributions

IPk: Conceptualisation; methodology; writing — original draft; writing — review and editing; final approval. TJ: Methodology; investigation; writing — review and editing; final approval. KK: Investigation; resources; final approval. MR: Investigation; data curation; final approval. GP: Conceptualisation; supervision; methodology; writing — review and editing; final approval. TT: Investigation; validation; writing — review and editing; final approval. All authors read and approved the final manuscript.

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