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REVIEW ARTICLE

ADVOCACY IN SHOULDER SURGERY: THE AMERICAN PERSPECTIVE

ORĘDOWNICTWO W CHIRURGII BARKU: PERSPEKTYWA AMERYKAŃSKA

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ABSTRACT
Advocacy in medicine is the process of promoting the best interests of patients, providers, and the health care community to the governmental, financial, institutional, and regulatory entities which control or otherwise influence the delivery of health care. Advocacy activities involve participation in professional societies, engagement in the political process, development and promotion of health policy, and formation of relationships with lawmakers, administrators, and regulators. Multiple levels of advocacy exist – from local and state efforts to national and international endeavors. Advocacy can seem intimidating and foreign, especially to medical professionals who have spent their careers developing expertise in entirely different domains, with discrete skill sets distinct from those typically associated with policymaking. With appropriate education, training, experience, resources, and teammates, however, health care providers can prove very effective at advocacy. In our complex and rapidly changing world, shoulder surgeons and related professionals must understand and engage in advocacy in order to fulfill the deepest responsibilities of their sacred commitment to always work for the good of their patients. This manuscript seeks to review the concept and practice of advocacy within the American system, with the hope of sharing our knowledge and experience with our Polish friends and colleagues.

Keywords: advocacy, shoulder and elbow surgery, american perspective, political advocacy, AAOS OrthoPAC, relationships

STRESZCZENIE
Orędownictwo w medycynie to proces promowania najlepszego interesu pacjentów, pracowników służby zdrowia oraz całej społeczności medycznej wobec instytucji rządowych, finansowych, administracyjnych i regulacyjnych, które kontrolują lub wpływają na funkcjonowanie systemu opieki zdrowotnej. Działania w zakresie orędownictwa obejmują uczestnictwo w stowarzyszeniach zawodowych, zaangażowanie w proces polityczny, opracowywanie i promowanie polityki zdrowotnej oraz budowanie relacji z ustawodawcami, administratorami i organami regulacyjnymi. Istnieją różne poziomy adwokatury – od działań lokalnych i stanowych po inicjatywy krajowe i międzynarodowe. Może się ona wydawać skomplikowana i odległa, zwłaszcza dla profesjonalistów medycznych, którzy przez całą swoją karierę rozwijali umiejętności w zupełnie innych obszarach, odmiennych od tych związanych z kształtowaniem polityki zdrowotnej. Jednak przy odpowiedniej edukacji, szkoleniu, doświadczeniu, zasobach i wsparciu zespołu, pracownicy ochrony zdrowia mogą skutecznie angażować się w działania

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adwokacyjne. W naszym złożonym i dynamicznie zmieniającym się świecie chirurdzy barku oraz inni specjaliści związani z tą dziedziną muszą rozumieć i uczestniczyć w adwokaturze, aby w pełni realizować swoje fundamentalne zobowiązanie – zawsze działać na rzecz dobra pacjentów. Niniejszy artykuł ma na celu przedstawienie koncepcji i praktyki adwokatury w amerykańskim systemie opieki zdrowotnej, z nadzieją na podzielenie się naszą wiedzą i doświadczeniem z polskimi przyjaciółmi i współpracownikami.

Słowa kluczowe: orędownictwo, chirurgia barku i łokcia, amerykańska perspektywa, adwokatura polityczna, AAOS OrthoPAC, relacje

Introduction

As medical professionals, we have all spent many years studying science. We probably started as children, loving our grade-school classes in biology and the natural sciences, then finding even more joy and fascination as we progressed into chemistry and physics in our university courses. In professional school, we learned to love anatomy, physiology, embryology, pathology, pharmacology, and the other foundational intellectual "tools of our trade." Some of us spent even more years digging deep into the intricacies of the musculoskeletal system, with a particular focus on our favorite joints – the shoulder and the elbow. All along this road, however, the term "advocacy" was likely absent from our academic pursuits. If it did appear, the word probably showed up during a Clinical Medicine course as we learned to be an "advocate" in the clinical sense for our patients and their families – using our hard-earned scientific knowledge to choose the best treatment plan in every situation.

We probably never learned, or even considered, that we would need to engage in "advocacy" for our patients and ourselves outside of medicine. Many of us, in fact, probably actively avoided entanglement in the political, governmental, and regulatory domains. The personal and intellectual skill set that makes us good at science sometimes runs antithetical to making us good at areas of study and civic life that find their roots in the "soft subjects" of history, economics, law, human resources, business negotiations, and the like. Indeed, many of our mentors and predecessors often *discouraged* medical professionals from engaging in advocacy activities – claiming and preaching that "medicine is holy and should not be tarnished by engaging in such base activity as politics," (Source: unknown but could easily be attributed to several of my early-career teachers). Unfortunately, however, the realities of modern medical practice demand that we understand and engage in advocacy on behalf of our profession, our colleagues, and our patients.

Defining "Advocacy"

My friend and mentor Dr. Richard Hawkins frequently challenged his students to remember the words of Voltaire – *"If we are to converse, then first we must define our terms."* The term "advocacy" can prove difficult to define. *Oxford Languages* defines advocacy as "public support for or recommendation of a particular cause or policy" (Williams, 2025). The Alliance for Justice defines advocacy as "any action that speaks in favor of, recommends, argues for a cause, supports or defends, or pleads on behalf of others." (Williams, 2025). Hafiz Kassam, an American expert in advocacy affairs, defines it as "a multifaceted endeavor championing the interests of patients, health care providers, and the broader community within the health care system. It encompasses efforts to raise awareness about health care issues, influence policy decisions, and promote initiatives to enhance health care delivery and outcomes. At its core, health care advocacy seeks to ensure fair access to high-quality, affordable health care services while aligning

policies with the best interests of patients and providers." (Davis, 2021, Kassam, 2025). Indeed, advocacy involves a departure from our "comfort zone" of the actual practice of medicine and performance of surgery into the complex world of policy, government, and finance that underlies and informs our ability to deliver care.

Levels of advocacy

Dr. Kay Kirkpatrick, a retired hand surgeon and now a multi-term State Senator in Georgia, declares simply that advocacy is critical to surgeons at both "the state and federal level because of the many issues that are affected by the government" (Kirkpatrick & Gurman, 2020). Although commonalities exist between state and federal government systems, each level is unique and will impact the provision of care in different ways. Both levels require involvement and attention, but often also demand slightly different skill sets for those seeking to advocate (Lefever *et al.,* 2021).

In the United States, laws and regulations governing health care can vary significantly between different states. Consider the political "hot button" of abortion, a "medical" issue which has pitted liberal and conservative forces against each other for decades. The battle seems almost like a civil war in our nation, as different states have dramatically different laws governing the availability of abortion pills and procedures. In recent years, transgender surgery and hormone therapy have taken a similar path of variance in access along state lines – further distinguishing the culture in "red states" and "blue states." In addition to the availability of certain medical procedures, state laws also govern issues such as medical licensing and scope of practice, medical malpractice (tort law), malpractice insurance coverage, Medicaid programs, and some facets of the health insurance industry. State laws also can require a "Certificate of Need" (CON) for opening new health care facilities or upgrading existing ones – an issue that dramatically influences a surgeon's ability to operate in a surgery center versus a hospital. As such, advocacy at the state level can prove vital – as state governments can often move more quickly and decisively than the federal government. Relationships, the key to advocacy, often prove easier to form at the state level due to the smaller size and geographic scope.

The federal government, meanwhile, also influences the practice of medicine through both legislation and regulation. Federal law governs, among other things, physician-owned hospitals, some aspects of the private health-insurance industry (such as Medicare Advantage), and policies regarding access to drugs and medications (Moor, 2025). Most importantly, the federal government holds the purse strings for funding a huge percentage of the annual expenditures on health care, paid out through Medicare and Social Security (federal programs), and indirectly through Medicaid (a state-level program) and private insurance companies – both of which often base their policies and payment rates on those of Medicare. The Centers for Medicare and Medicaid Services (CMS) is a federal regulatory agency that determines the intricate rules of healthcare under the federal system, influencing care in all states and territories. Although it is overseen and funded by Congress, it ultimately functions with some level of independence – requiring surgeons to understand regulatory advocacy in addition to political advocacy. National-level advocacy therefore differs greatly from state-level advocacy in that the system is larger, slower, and more resistant to the formation of meaningful individual relationships due to its size, scope, and geographic challenges.

While advocacy in America mostly focuses on issues at the state or national level, it can also extend down to the local level and up to the international level. Local medical advocacy issues can include programs for healthcare outreach, free clinics, blood drives, sports physicals, or other public health measures. International medical advocacy issues can include access to orthopedic implants, cross-cultural training and education, and disaster

relief. Advocacy at these levels, however, tends to take a different approach than the more familiar (and similar) approaches to advocacy at the state and national levels.

Methods of advocacy

A large spectrum of "advocacy activities" exists, and it ranges from simple to complex. As single constituents, we can write emails or letters to our elected representatives about important issues – but these communiques often end up on the desk of just a low-level staffer or even in the trash bin. We can meet with insurance executives to discuss coverage and reimbursement – and they likely will just look on patronizingly, nod, smile, and ignore us. In today's vast system, the individual voice often finds itself woefully soft and unheard unless it is somehow tied to an effective means of entry.

The most common means of entry to the advocacy process lies in the power of numbers. Through collaboration as a profession, our *collective voice* can reach a volume loud enough to make a difference. As such, our various American orthopedic and specialty professional associations form the backbone of effective advocacy. At a minimum, all providers should support their professional societies' advocacy efforts through membership in the society and financial contributions to advocacy. Not every medical professional will have the ability or interest to engage directly in advocacy work, but there is no excuse not to support those who do – specifically through financial means. Some individuals may choose to participate more deeply and actively in these organizations through committee work and leadership, but their efforts will be limited without meaningful financial backing from the members of the organization. In advocacy, leaders ultimately will prove only as powerful as the commitment of the membership they represent.

Ultimately, the most effective means of entry into advocacy lies in *relationships* (Bushnell, 2017, Port & Joyce, 2025). A myriad of relationships across an interpersonal network characterizes many successful advocates. Surgeons can communicate with colleagues, professional association staffers, friends in other industries, society leaders, and others to coordinate advocacy efforts (Goltz *et al.,* 2025). While much less common and much harder to achieve, however, personal relationships with "difference-makers" such as high-ranking administrators, regulators, and even actual lawmakers have no equal in terms of efficacy (Port & Joyce, 2025). That same constituent's individual text, phone call, or email to a lawmaker mentioned above will take on significantly more gravitas if the sender has a personal relationship with the recipient. Leaders of professional societies can much more effectively advance their agenda if they have a relationship with powerful individuals that can influence policy in their favor. Policymakers may even seek out physicians with whom they have a relationship to ask for advice on various issues or votes related to health care (Port & Joyce, 2025). In short, relationships are *advocacy gold*.

Relationships in advocacy, however, take time and intentional planning to identify and build – like playing chess instead of checkers. Good relationships cannot be rushed – they take a long time to build and nurture (Kirkpatrick & Gurman, 2020). As such, relationship and network building can never begin too early in one's medical career! Likewise, participating in or contributing to the campaigns for political leaders early in *their* careers can pay dividends when they reach greater heights later. For example, the local candidate for the school board may ultimately run for Governor or Senator, and likely she will remember and retain relationships with her supporters from the early days more so than the latecomers who appeared only after she had attained some notoriety.

Access to policymakers often requires financial contributions and commitments, which must be rationed and targeted effectively. Access for relationship-building can also be obtained through professional societies, lobbyists, and political organizations.

In the United States, many groups will travel to Washington, DC, and to state capitals to interact with lawmakers (Kassam, 2025, Kirkpatrick & Gurman, 2020, Lefever *et al.,* 2021, Williams, 2025). Surgeons can participate in these efforts as first-timers getting to know their representatives, and also eventually as "old friends" coming to visit with their elected officials (Sethi *et al.,* 2013). On the other hand, physicians can invite policymakers to join them in their place of practice (or even to come and shadow them through a day in surgery!) to expose them to the proverbial trenches of health care delivery (Goltz *et al.,* 2025, Kassam, 2025).

Health care advocates must often put their own personal political leanings aside and work with candidates or representatives with differing political views on non-medical issues. Indeed, bipartisan success at any level usually hinges upon personal relationships that cross ideological lines. While engaging in advocacy on behalf of their patients or their profession, surgeons must always remember to keep the advocacy agenda as a professional one rather than a personal one. For example, a conservative surgeon may oppose a liberal representative's stance on taxes or disagree with them about social issues – but they must be willing to work with that lawmaker if they share common goals regarding health care policies. In short, the relationship is personal but the agenda cannot be.

Advocacy resources

Founded in 1999, the Political Action Committee of the American Association of Orthopedic Surgeons (AAOS OrthoPAC) claims the throne as the best-funded and most effective national body for musculoskeletal advocacy in the United States. In fact, it often ranks as one of the best-funded and most-active of *any* medical-related political action committee. Many American orthopedic specialty societies, including the American Shoulder and Elbow Surgeons (ASES), have their own Advocacy or Health Policy committees and task forces. The specialty societies engage with the OrthoPAC for collaborative advocacy efforts and seek to present a "unified front" on most national-level issues. At times, however, specialty societies will promote specific agendas unique to their missions, with targeted activities funded in addition to those of the OrthoPAC (Kassam, 2025, Williams, 2025). ASES, for example, hosts a "fly-in" event every year in which the Frankle Health Policy Fellows will visit Washington, DC, for a few days to meet with various policymakers and discuss issues unique to shoulder surgery in addition to "big picture" policies impacting health care as a whole (Goltz *et al.,* 2025, Layuno-Matos *et al.,* 2025).

At the state level, state medical, state orthopedic, and state subspecialty societies present the prime choice for advocacy resources. The level of sophistication (and therefore success) of these organizations varies by state, and usually relates directly to the level of membership involvement and financial commitment. The national OrthoPAC also has resources that assist state societies – especially on issues that straddle both levels of government, such as insurance prior authorization requirements (Banks *et al.,* 2025, Jarrett *et al.,* 2024). Orthopedic groups, hospitals, and health systems also can have resources of their own brought to bear at the state level, where they can still often prove effective due to the relatively smaller size of the state government.

Lobbyists – professionals who spend their careers focused on government relations and seek to influence policy in favor of their clients – form an indispensable resource to any advocacy efforts. At both the state and national level, lobbyists can specialize in various industries or topic areas (such as health care), and the longevity of their career usually far exceeds that of many lawmakers (Bushnell, 2017). In other words, elected representatives may come and go, but lobbyists stick around. As such, interaction between lobbyists and professional societies is critical. Many professional societies at both the state and national levels will contract with an independent lobbying firm or even employ lobbyists directly.

At the federal level, professional lobbyists usually live in or near Washington, DC, and form a critical local access point for surgeons who may live thousands of miles away. Similar geographic models exist at the state level.

Advocacy allies

Dr. Aaron Chamberlain reminds us that "when engaging in advocacy, it is key to understand the advocacy interests of the various stakeholders and how they align or don't align on certain issues" (Chamberlain, 2025). In pursuing advocacy goals, we must always seek out allies – even in unexpected places. Even though our orthopedic professional societies usually set their own agendas and make their own efforts, certain issues may lend themselves to alignment with other professional societies, hospitals, health systems, and even insurance companies that seek similar policy changes or improvements from the government or its regulatory bodies. Allies can also exist outside of medicine altogether – exemplified by recent state-level efforts in Georgia that have seen orthopedic surgeons team up with restaurant owners and long-haul truckers to work together for reform of the tort laws that govern the otherwise seemingly unrelated fields of medical malpractice, premises negligence, and highway liability. Even the government itself may prove to be an advocacy ally, as lawmakers may directly solicit the expertise of surgeons and other health care professionals when developing policies.

Advocacy strategies

Through our various channels for advocacy, thought leaders develop strategies for both offense and defense in the realm of policy – just as a coach would design a game plan in the realm of sports. "Offense" in advocacy involves the active creation and promotion of policy and initiatives that favor patients, providers, and the health systems in which they operate. On the other hand, "defense" in advocacy involves monitoring and preventing policies, regulations, and actions that will not benefit, or may even actively harm, patients, providers, and health systems.

One example of "offense" in advocacy on display was a 2017 law passed in my home state of Georgia that protected out-of-state sports medicine physicians covering visiting teams (Bushnell, 2017). After recognizing that our colleagues were exposed to medicolegal risk by technically practicing without an in-state license, we designed a bill to solve this problem and then worked tirelessly to see it implemented into reality (Bushnell, 2017). Other examples include the creation and/or promotion of laws and policies that increase resources for at-risk patient populations, support and protect hardworking providers, or fund medical education. Examples of "defense" in advocacy involve working against reimbursement cuts for providers, fighting scope-of-practice extensions for less-qualified professionals, and speaking truth about the medical effects of legalizing harmful things like marijuana or online gambling (Abboud *et al.,* 2019, Cronin *et al.,* 2025, Kassam, 2025, Moor, 2024, Port & Joyce, 2025, Sethi *et al.,* 2013). Unfortunately, we usually find ourselves playing defense much more frequently than offense. Some advocacy projects involve a combination both "offense" and "defense" – such as exposing and seeking to improve, replace, or prohibit practices that block patient's access to care, such as baseless requirements for pre-operative physical therapy or resource-wasting prior-authorization review requirements from insurance companies (Banks *et al.,* 2025, Jarrett *et al.,* 2024).

Advocacy funding

Advocacy efforts cost money. Travel costs, publication and communication costs, political fundraising and contributions – it all adds up quickly. Physicians, unfortunately, have historically ranked at the bottom of the list in terms of their willingness to provide financial support for advocacy, relative to other professions. Lawyers, insurance companies, hospitals, and other historical antagonists to shoulder surgeons in the realm of policy,

however, usually support their own professions' advocacy efforts *much* more robustly. For example, the AAOS OrthoPAC for years has ranked as one of the best-supported health care political action committees in the country, with approximately 25–30% of orthopedic surgeons donating to the organization. The American Association for Justice (AAJ – formerly known as the American Trial Lawyers Association/ATLA), on the other hand, routinely boasts participation rates above 97%! Surgeons thus still have a long way to go when it comes to advocacy funding. In a proud bright spot, however, the ASES has led the way amongst the various national orthopedic specialty societies in terms of donation levels – winning three consecutive OrthoPAC "Hall of Fame" awards since 2022.

Future directions

As clinician-scientists, we have always understood the interplay between patient care and scientific advancement. Over a decade ago, however, Dr. Manny Sethi (who actually ran for a U.S. Senate seat in Tennessee in 2020) proposed that we re-define the continuum of care "to a trinity of clinical excellence, innovative research, and effective advocacy" (Sethi *et al.,* 2013). Using Sethi's trinity model, we hope that all medical professionals will shift their views on advocacy from its position as a "third rail" (i.e., an issue too controversial to mention) to a "third column" critical to our professional success. Today's leaders within American orthopedic surgery have embraced this recommendation and continue to work tirelessly to integrate advocacy training and advocacy efforts into the curricula of postgraduate internship and residency, as well as into the lifeblood of our state and national professional organizations and specialty societies (Daniels *et al.,* 2013, Goltz *et al.,* 2025). We have analyzed the advocacy efforts of our societies and sought to tailor programming towards it (Abboud *et al.,* 2019, Cronin *et al.,* 2025). We have funded advocacy fellowships, through which we look forward to a new generation of advocates creating innovative ways to accomplish our goals (Layuno-Matos *et al.,* 2025). We have intentionally made focused, specific inclusion of advocacy research and discussions in our professional literature (Bushnell, 2025). We have discussed advocacy and advocacy research at our educational meetings and events (Kassam, 2025, Layuno-Matos *et al.,* 2025, Williams, 2025). As our profession grows ever-more intertwined across the globe, we hope to share these advocacy adventures and lessons with our colleagues abroad, as well as to learn from their experiences as well (Aurich *et al.,* 2025, de Marinis *et al.,* 2025, Lech *et al.,* 2025, Lubiatowski *et al.,* 2025, Sandow & Gill, 2025, Sugaya, 2025).

Lessons for Poland

I cannot claim to understand Poland's history and system of government well enough to offer advice of any considerable intricacy or specificity regarding advocacy. As a relatively young Western democracy, Poland in its present form lacks the longstanding history and traditions of American government. But it also can learn from the many mistakes we Americans have made along the way. Likewise, Polish health care professionals can also benefit from the experience we in America have gained along our advocacy journey. I would propose that successful advocacy within our field of shoulder and elbow surgery ultimately finds five critical pillars at its foundation: 1) commitment by a critical mass of surgeons to a professional society acting in the collective interest of its members; 2) dedicated and continuous financial support of advocacy efforts of these professional societies by all stakeholders; 3) leadership in advocacy by surgeons with interest and skill sets appropriate to the task; 4) effective partnership with government relations professionals and other allies; and 5) perhaps most importantly, meaningful personal relationships with policymakers.

In America, we orthopedic surgeons still have much to learn about advocacy. You do here in Poland as well. I am so thankful for

the opportunity to be a guest of your Polish Shoulder and Elbow Society this year to discuss this critical and fascinating topic. In doing so, I hope that we can help each other refine the *what*, the *when*, and the *how* of advocacy to reach maximum effectiveness. We will appreciate our commonalities, but we will certainly see differences as well. Most importantly, we can definitely agree upon the *why* of advocacy contained in the words of our shared Hippocratic Oath – "I will remember that I do not treat a fever chart, a cancerous growth, *a data point, or an algorithm's suggestion,* but a *human being*" (Mesko & Spiegel, 2022).

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