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HEALTH AND THE 2024 US ELECTION

Reported Political Participation by Physicians vs Nonphysicians

Given their clinical expertise, physicians are well equipped to shape public policy on matters related to health, although they are less likely to vote than nonphysicians.[1,2] Voting is just 1 facet of political participation. We evaluated rates of US physicians' broader political participation between 2017 and 2021.

Supplemental content

Methods | We examined data from the Volunteering and Civic Life Supplement (VCLS) of the US Census Bureau's Current Population Survey (CPS), a nationally representative survey of the civilian noninstitutional population aged 16 years or older that is administered by telephone and in person to approximately 50 000 households each month. The CPS uses a multistage probability sampling design of households and includes base weights, which subsequently undergo nonresponse adjustment and the ratio estimation procedure to improve survey estimates. The VCLS was provided to every CPS respondent. This study was deemed exempt from review by Harvard Medical School's institutional review board, as it used publicly available, deidentified data.

We examined survey items pertaining to respondents' political participation (eAppendix in Supplement 1) using surveys administered in September 2017, 2019, and 2021. We restricted the sample to individuals aged 25 to 79 years (approximating physicians' professionally active years) and excluded individuals who did not answer any questions related to political participation. During these years, response rates for the CPS ranged from 75.0% to 86.9%, while response rates for the VCLS ranged from 98.3% to 98.6%.

We compared rates of political participation between self-identified physicians and nonphysicians using multivariable log-binomial regression to compute relative risks (RRs). We adjusted for factors known to be independently associated with political participation from prior studies, including year, age, sex, race, ethnicity, educational level, family income, region, and residence in a metropolitan statistical area.[1,2]

P values were obtained by weighted rank sum test for continuous variables and Rao-Scott χ^2 test for categorical variables. All analyses were performed in R, version 4.2.2. Data were reported as survey weight–adjusted means and proportions with 95% CIs. All tests were 2-sided; *P* values <.05 or a 95% CI that did not cross 1 defined statistical significance.

Results | Survey respondents included 683 physicians and 136 239 nonphysicians. Physicians differed from nonphysicians on most characteristics, including age, sex, race, ethnicity, educational level, and family income (**Table 1**).

Physicians' political participation varied depending on the activity but generally exceeded that of nonphysicians (**Table 2**). In the unadjusted analysis, physicians were more likely than nonphysicians to read, watch, or listen to political news (83.8% vs 73.6%); discuss politics with friends and family (81.9% vs 61.4%) or neighbors (29.5% vs 22.7%); buy or boycott products based on political values (28.6% vs 16.7%); donate to political organizations, parties, or campaigns (21.9% vs 9.6%); vote in local elections (63.9% vs 54.1%); and contact elected officials to express an opinion (19.3% vs 11.5%).

After adjusting for sociodemographic factors, discussing politics with friends or family (RR, 1.09; 95% CI, 1.04-1.13), buying or boycotting products based on political values (RR, 1.20; 95% CI, 1.05-1.37), and donating to political organizations (RR, 1.35; 95% CI, 1.15-1.58) remained statistically significant, but most other significant differences became nonsignificant, including for reading, watching, or listening to political news; discussing politics with neighbors; voting in local elections; and contacting elected officials. For attending public meetings, the statistical significance changed such that physicians were less likely to participate than nonphysicians (RR, 0.74; 95% CI, 0.59-0.92).

Discussion | Although physicians were more likely to report various types of political participation than nonphysicians, after adjustment for sociodemographic factors, being a physician was not associated with most items and negatively associated with attending public meetings. These results may be considered in light of past findings about lower voter turnout and community volunteerism among physicians after adjusting for sociodemographic factors.[1-3] Nevertheless, physicians might be expected to be more politically engaged, as several policy issues directly influence patient health and medical practice.[4,5]

Table 1. Sociodemographic Characteristics of Physicians and Nonphysicians

Characteristic	No. (%)		*P* value[a]
	Physicians (n = 683)	Nonphysicians (n = 136 239)	
Survey year			
2017	273 (40.0)	51 930 (38.1)	.04
2019	233 (34.1)	45 475 (33.4)	
2021	177 (25.9)	38 834 (28.5)	
Age, median (IQR), y	44 (35-57)	52 (38-64)	<.001
Sex			
Female	274 (40.1)	72 342 (53.1)	<.001
Male	409 (59.9)	63 897 (46.9)	
Race[b]			
Asian	121 (17.7)	6563 (4.8)	<.001
Black or African American	40 (5.9)	13 302 (9.8)	
White	512 (75.0)	112 264 (82.4)	
Other	10 (1.5)	4110 (3.0)	
Ethnicity[b]			
Hispanic	38 (5.6)	14 881 (10.9)	<.001
Non-Hispanic	645 (94.4)	121 358 (89.1)	
Educational level[c]			
Less than high school, high school graduate, or some college	8 (1.2)	69 457 (51.0)	<.001
Associate's degree	7 (1.0)	15 220 (11.2)	
Bachelor's or advanced degree	668 (97.8)	51 562 (37.8)	
Family income			
<$30 000	20 (2.9)	28 035 (20.6)	<.001
$30 000-$59 000	51 (7.5)	36 015 (26.4)	
$60 000-$99 999	67 (9.8)	33 323 (24.5)	
≥$100 000	545 (79.8)	38 866 (28.5)	
Region			
Northeast	148 (21.7)	22 067 (16.2)	<.001
Midwest	143 (20.9)	28 299 (20.8)	
South	233 (34.1)	49 663 (36.5)	
West	159 (23.3)	36 210 (26.6)	
Metropolitan CBSA size, No. of people			
Not identified or nonmetropolitan	101 (14.8)	37 171 (27.3)	<.001
100 000-499 999	72 (10.5)	20 835 (15.3)	
500 000-2 499 999	227 (33.2)	38 765 (28.5)	
2 500 000-4 999 999	93 (13.6)	14 588 (10.7)	
≥5 000 000	190 (27.8)	24 880 (18.3)	

Abbreviation: CBSA, core-based statistical area.

[a] *P* values were obtained by weighted rank sum test for continuous variables and Rao-Scott χ^2 test for categorical variables.

[b] Race and ethnicity were self-reported. Racial categories were defined by the US Census Bureau as American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, and other. American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, and other were grouped as other race in this study due to limited sample size. Race and ethnicity were assessed as sociocultural constructs given their association with voting and other political participation.

[c] Included bachelor's degree (eg, BA, AB, and BS), master's degree (eg, MA, MS, MEng, MEd, MSW, and MBA), professional school degree (eg, MD, DDS, DVM, LLB, and JD), and doctoral degree (eg, PhD, EdD). The 2.2% of physicians in other categories may represent user error, miscategorization, or translation of credentials from other countries.

Table 2. Rates of Political Participation Among Physicians and Nonphysicians

Survey item[a]	No. (weight-adjusted %)		Log-binomial regression, RR (95% CI)	
	Physicians	Nonphysicians	Unadjusted	Adjusted
Read, watch, or listen to news or information about politics at least a few times a week	571 (83.8)	101 906 (73.6)	1.14 (1.09-1.19)	1.02 (0.99-1.06)
Discuss politics with friends or family at least once a month	564 (81.9)	84 900 (61.4)	1.34 (1.28-1.39)	1.09 (1.04-1.13)
Discuss politics with neighbors at least once a month	199 (29.5)	33 190 (22.7)	1.30 (1.13-1.49)	1.06 (0.93-1.22)
Post views about politics on the internet or social media at least once a month	84 (12.8)	18 152 (13.4)	0.95 (0.75-1.20)	0.92 (0.73-1.16)
Buy or boycott products or services based on the political values or business practices of that company	195 (28.6)	24 085 (16.7)	1.72 (1.49-1.98)	1.20 (1.05-1.37)
Give at least $25 to a political organization, party, or campaign	152 (21.9)	14 099 (9.6)	2.30 (1.94-2.71)	1.35 (1.15-1.58)
Vote in the last local elections	438 (63.9)	76 751 (54.1)	1.18 (1.10-1.27)	1.00 (0.94-1.07)
Attend a public meeting	96 (12.3)	16 557 (11.0)	1.11 (0.89-1.40)	0.74 (0.59-0.92)
Contact or visit a public official at any level of government to express an opinion	140 (19.3)	18 221 (11.5)	1.68 (1.40-2.00)	1.13 (0.95-1.35)

Abbreviation: RR, relative risk.

[a] Individual survey items had nonresponse or missing item rates ranging from 0.6% to 2.2%.

Study limitations include a limited sample size of physicians, potential bias from casewise deletion, and potentially inaccurate self-reporting. Additionally, physicians are often members of professional societies that engage in advocacy and lobbying, but these are likely not reported by physicians as their own activity. Physicians could play a greater role in influencing health-related public policy given their expertise and socioeconomic opportunities.[6] Why physicians are not more involved politically should be further investigated.

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COMMENT & RESPONSE

Gender Eligibility Descriptions for Clinical Trials

To the Editor A recent Research Letter by Dr Burton and colleagues[1] revealed that almost two-thirds of the trials included in ClinicalTrials.gov reported applying gender-based eligibility between 2017 and 2022 when, in fact, sex-based eligibility was used instead. According to the National Institutes of Health, sex is considered a biological component, including chromosomes and gonads, and gender comprises social, cultural, and behavioral factors that influence a person's self-identity.[2] Sex and gender can affect health in different ways and are not interchangeable.

The current database of ClinicalTrials.gov lists gender eligibility as an optional data element under a combined section "sex/gender."[2] After entering the required sex eligibility (male, female, or both), research staff can enter additional gender eligibility as free text, if applicable. The low accuracy rate of documenting gender as an eligibility criteria revealed in the Research Letter may result from combining sex and gender in a single data section and researchers' lack of understanding of the definition of sex and gender.

Failure to differentiate sex and gender in the documentation of clinical trials makes it impossible to identify transgender and gender-diverse (trans) people. Identification of trans people is critical, given that many health conditions affect them disproportionally. These inequities are driven by discrimination and socioeconomic marginalization; it is vital that the trans population be represented in clinical trials.[3] Although Burton and colleagues did not report the actual enrollment rate of trans individuals in clinical trials, other studies examining trials registered on ClinicalTrials.gov revealed no documentation of enrollment of trans people.[4,5] These studies also indicated that sexual orientation of participants was not captured in any examined clinical trials. Therefore, the involvement of other sex and gender populations such as people who identify as lesbian, gay, bisexual, or queer in clinical trials remains unknown.[4,5]

To improve documentation of sexual orientation and gender identity data, we recommend that all researchers report whether sexual orientation and gender identity data were collected when registering a trial on ClinicalTrials.gov, as is currently done for other demographic data such as participant race and ethnicity. We also recommend separating gender from sex and providing clear instructions and definitions in the registration form, such as "self-reported gender identity" and "sex assigned at birth." Education is urgently needed for researchers and research staff about terminology regarding sexual and gender minorities and about culturally sensitive ways to collect sexual orientation and gender identity data. Such education will help ensure the accuracy of documentation, would provide a more inclusive environment for sexual and gender minorities, and has the potential to increase their participation in clinical trials.

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