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BRITA E. LUNDBERG, MD '91 (PG '94)

Physician Turns Her Expertise Toward Advocacy

by Masarah Van Eyck

When Brita E. Lundberg, MD '91 (PG '94), decided to leave the practice of medicine and return to the classroom for patient advocacy training, it was easy to imagine herself back at the University of Wisconsin-Madison. After all, having earned her medical degree at the UW School of Medicine and Public Health (SMPH) and completed an internal medicine residency at UW Health, she says the academic medical center's exceptional clinical training has informed her practice and served her well throughout her career.

So, when she learned about the UW Law School's Center for Patient Partnerships—directed by its founder, Martha (Meg) Gaines, JD, distinguished clinical professor of law—she thought, "What wonderful symmetry. UW-Madison gave me my first career as a physician, and it will offer me the gift of a second career as a health advocate."

Lundberg's First Career

The robust training she received to become a diagnostician and her practice experience—at the SMPH and UW Health, followed by an infectious diseases fellowship at the University of Colorado and teaching, research and patient care positions in the Infectious Diseases Division at Atlanta-based Emory University and Grady Health System—formed the foundation of her first career. Lundberg points to a strong mentor at the SMPH, Dennis Maki, MD '66, emeritus Ovid O. Meyer Professor of Medicine in the Divisions of Infectious Diseases and Pulmonary and Critical Care Medicine.

"I learned from him both as a clinician and a person," she recalls.

Maki's teaching, research and patient care still inspire her in her role as founder and CEO of Lundberg Health Advocates, a Boston-based patient advocacy service.

"He has the most comprehensive way of thinking about a patient and case, and that mental rigor and thoroughness was reflected in his clinical chart notes," she says of the longtime SMPH faculty member. "They were inspiring to read."

She continues, "Today, as the medical system moves farther away from the model of physicians as great diagnosticians, it is less common to come across notes with the degree of complex, high-level thinking that I learned to value as a student."

Instead, pressed for time and pressured to take on impossible caseloads, physicians less commonly offer clinical summaries that "give thought to the whole gamut of what a case could represent," she says, adding that they often merely reiterate a patient's symptoms and recommend a procedure.

"We are creating a model that is neither patient- nor physician-centered. This is really the crux of what our patients are facing today," Lundberg says, adding that, as a member of the Society to Improve Diagnosis in Medicine, she is interested in taking on this challenge in her second career.

The Other Side of the Exam Table

With hindsight, great shifts in personal and professional trajectories can look like little more than new chapter titles. Yet, amid the changes, that path can feel dark, figuratively or—as for Lundberg—literally.

Her first big shift occurred when she took time away from her practice "to become a human pancreas." With a young daughter diagnosed with type 1 diabetes, Lundberg says long nights of checking and treating her blood sugar levels felt "like being a resident for 12 years, except the call schedule was more challenging—there was no time off."

She felt she could not practice at that point because she worried that the resultant sleep deprivation would have prevented her from providing her patients with an equal quality of care. Then her parents were diagnosed with heart failure and Parkinson's disease in rapid succession. Around that time, Lundberg says, other relatives and friends called upon her for advice regarding their medical circumstances.

"I thought, 'Maybe instead of going back to practicing medicine, I would be more valuable to patients on this side of the exam table, helping them navigate the system rather than being a direct care provider,'" Lundberg recalls.

From her experience with family members, she saw the potential many times for the details of patient care to fall through the cracks. In addition, she hoped that she might serve as a megaphone for the patient voice by supporting those who felt they hadn't been heard by their doctors.

After research led her to the Center for Patient Partnerships, Lundberg completed a semester of introductory coursework and a clinical clerkship in patient advocacy. She was fascinated to learn about the history of advocacy and, as part of her community advocacy requirement, penned a resolution on the human health impacts of fossil fuels—specifically, natural gas, an issue she championed as a member of the Massachusetts Medical Society's Occupational and Environmental Health Committee.

Lundberg exclaims, "My experience at the Center for Patient Partnerships was transformational!"

The Power of Knowledge

In less than two years since she completed her training, Lundberg has started a private health advocacy business and published on environmental health matters. She also regularly testifies to local government bodies and talks to boards of health and other interest groups across Massachusetts. And she dreams of someday providing health advocacy services to all patients in need, whatever their means. It's a bold, rewarding vision for a physician who was trained to tackle complex problems, and it satisfies her deep quest for solutions.

Most rewarding is the opportunity to empower her clients as they navigate difficult diagnoses and decisions.

"My clients are smart and knowledgeable about their conditions. They engage the medical system at a high level, but they usually find some aspect of the system that they can't untangle," Lundberg says.

That's where her expertise and resources come in, whether through reviewing a patient's chart, sharing medical research from such sources as UpToDate or reaching out to colleagues around the country.

Having been a practicing physician helps, Lundberg acknowledges.

"It's easier to get questions answered because I speak the language," she says.

For example, a client wanted to explore cardiac stenting instead of open-heart surgery, as a physician in his area had recommended. Lundberg contacted a cardiologist with whom she trained to get his thoughts.

She notes, "Once I learned that this was potentially not an unreasonable option, I was able to direct my client to the top expert in his area and ask, 'What do you think?'"

Lundberg emphasizes that her goal is to support her fellow clinicians, who often say they are grateful to have her there because it makes their jobs easier. Take, for example, a client who was prescribed digoxin for atrial fibrillation and heart failure but was reluctant to take it. Because Lundberg was familiar with the patient's adherence to Buddhism and meditation and his wariness of new medications, she reassured him by saying, "Oh, digoxin! That's derived from the foxglove plant. It's been used to treat patients with heart failure for more than 200 years!" The result: improved patient adherence.

Lundberg finds it rewarding to be able to help patients address and cope with their conditions, which often interfere with their quality of life and can cause anxiety and helplessness.

"Giving knowledge to patients is critical," she explains. "Knowledge is power, and it lowers anxiety."

In this era of payer-centered care and time limitations for providers, Lundberg says, "I feel fortunate and privileged to have time to connect with patients and medical specialists—and to close the loop so miscommunication is less frequent."

Being the Change

Lundberg does not regard the emergence of health advocacy as the answer to the industry's larger limitations. Instead she hopes that eventually "the real sea change will be made within the medical system, allowing my role to become superfluous." The goal should be to value high-level thought processes that can lead to prompt and accurate diagnoses, while allowing providers time to connect with patients.

"We all want the same things," Lundberg explains. "The goal is to incentivize good medicine. We need to create disincentives for systems that over-reimburse for certain things and under-reimburse for the intellectual work of sitting down for half an hour and thinking through a case."

Recalling Maki's early influence, she shares, "I know there are physicians who still take the time to develop a differential diagnosis. I read their notes!"