ORGANIZATION FOR SOCIAL PEDIATRICS *

Cicely D. Williams, D. M., F.R.C.P., D. T. M. and H. **

A great deal has been written and talked about sccial pediatrics, but it is not always clear how services can be organized in order to implement its pious aspirations. It is obvious that there is no one pattern that will suit every country, but it is necessary to study existing patterns and their relative efficiency in order to achieve progress. Many definitions of «Social Medicine» have been given. Perhaps one of the best is the simplest : «follow - up.» Social pediatrics should ensure follow - up of the background from which the patient ccmes, mental and physical, in addition to follow - up of the subsequent fate of the patient after he leaves intensive medical supervision.

When anyone wishes to be thoroughly caustic about the medicai profession he says, «The operation was succesful, but the patient died.» This accusation is not only levelled at surgeons, but at physicians who spend the greatest care in diagnosing and treating a patient while he is in hospital, but pay little attention to what happens after his discharge. This is particularly regrettable when children are sent back to those same conditions that produced the disease without efforts to instruct the parents or to improve the environment. It is to correct this that the concept of «Social Pediatrics» is emphasized.

Child health must include the child, the whole child and everything to do with the child, including the family and especially the mother. It was René Sand, the father of social medicine, who said «Why separate child welfare from pediatrics? or mental clinics from psychiatric services? It would surely be more convenient and more economical to make the hospital into one integral medical organization comprising all curative and preventive services.» *** But in any organization there must be some division of function, while

* Paper based on a contribution to the Symposium on «Social Pediatrics» at the Second Middle Eastern - Mediterranean Pediatric Congress in September 1961 in Ankara. To be published also in the Archives of Diseases in Childhood.

** Visiting Professor of Maternal and Child Health, School of Public Health, American University of Beirut, Lebanon.

*** Rene Sand «The Advance to Social Medicine» — 1952, London, P. 1. 100.

it is most desirable that there should be continuity of care and supervision for individual patients. One of the chief criticisms of the National Service in the United Kingdom is that patient care is divided between different organizations - the private practitioner, the government hospitals and the local authority clinics. Confusion arises when a department of public health, unfamiliar with clinical medicine, undertakes the care of mothers and children, infectious diseases, tuberculosis and so forth. All of these necessitate considerable training, experience and some clinical facilities. In fact, patients are getting good care by any standards, but the existence of three separate types of organization makes for overlapping and expense and creates unnecessary difficulties in follow-up.

The words «public health» have different meanings in different contexts and ideologies. In some areas it is equivalent to «people's health,» or the health of the people as a whole. In other areas it means the major health concerns only, and we hear the statement «This disease has now become a public health problem.» In yet another context the phrase may mean those health measures undertaken by the community. It was an American who said «Public health is any transaction in which the patient does not pay the doctor directly.»

Many people use «public health» as if it were synonymous with «preventive medicine.» But we know that preventive medicine must be undertaken at the individual as well as the mass level. It is of little use to provide a pure water supply unless individuals learn to drink it out of a clean cup and to appreciate the technique of the toilet. It is of little use to enforce pure food and market laws if the malnourished, including the diabetics, continue to spend their money on aerated waters and lollipops.

The division of functions should come between mass medicine and individual medicine. There should be no separation between preventive and curative medicine *as applied to individuals*. Pediatrics, obstetrics, maternal and child health and school health are essentially services to individuals.

It will be seen that mass medicine has its most important role in preventive measures and considerable importance in diagnostic, but (with the exception of mass treatment campaigns against yaws, and more doubtfully against intestinal worms) there is little curative medicine that can be accomplished by mass methods.

When we consider individual or personal medicine on the other hand each patient should receive all the curative, diagnostic and preventive services which he needs or is capable of using.

Perhaps it would be possible to discard that confusing word «public» and simply call the whole system «health services.» It is then possible to imagine two distinct sections, one with the community or mass approach, the other applied to individuals. The training of personnel can be adapted accordingly. The integration of preventive and curative services to individuals could then be implemented. Hospitals would become headquarters from which Health Clinics would act as outposts, and follow-up of patients could be maintained. Health Centers in rural areas would, of course, have many activities not necessarily associated with hospitals.

There are many parts of the world, such as Kenya, where health centers are undertaking both mass and individual medicine, both curative and preventive functions. This is essential in primary centers all over the world. These dual functions are not incompatible. In fact it is found that because the district doctor is concerned with treating the diarrheas and the typhoid, he is effective in getting members of the community to join together to protect their water supply.

The training of personnel for health work must be a perpetual concern to those responsible for organization and for application. With the present illogical types of organization it follows that training programs are often illogical and uneconomic. When it is recognized that some gap exists in the services, instead of refocusing the training of the basic workers, there has been a tendency to train and employ a new type of specialized worker.

The need for improved health education, nutrition and social medicine has been recognized. Is it wiser to introduce numbers of specialist health educators, nutritionists and social workers or to modify the training of doctors, nurses and midwives according to obvious needs? It is invariably claimed that the curricula for doctors and nurses are already so burdened with natural sciences that nothing can be added. But in education, as in nutrition, it is essential to provide a balanced diet in accordance with needs and resources.

At one time the health services used to provide special staff for school health, child welfare, tuberculosis, venereal disease and so forth. It was found that this multiplicity of agents, all contacting and counselling the same families, was a mistake, and did not make

for cooperation or efficiency. Some areas are in danger of repeating the same mistake with a different plurality of personnel. This is especially dangerous for the poorer countries who have not yet been able to provide even the minimum medical care. Their need is to train and supervise health workers at a number of educational levels. But it appears more economical to have broad functions at each level rather than to create a number of categories. It is then possible to make the training and education closely related to needs and resources, and adapted to changing patterns.

At present there is too much empiricism in social medicine. Standard concepts of preventive medicine, public health administration and public health practice are being taught and imposed. Experiments are needed in organization and observations should be recorded, and results evaluated in those areas where experiments are being or have been made. Benjamin Paul's «Health, Culture and Community» presents a collection of such experiments, but only assesses their social impact and gives little information about organization, cost, record keeping and effectiveness.

Table 1 lists a few of the patterns of organization that have been tried and adapted to local conditions. A collection of such attempts, with some sort of evaluation, should be assembled and made available to teachers and to students of social pediatrics.

There is no mystique about the words «social medicine» or «maternal and child health,» «Social medicine» attempts to consider all the various factors which affect health. «Maternal and child health» focuses attention on the members of the community who are most in need, and attempts to organize the available services in the most effective and efficient way.

TABLE 1

ORGANIZATION OF HEALTH SERVICES

	PREVENTIVE	CURATIVE	DIAGNOSTIC
MASS MEDICINE By governments, local authorities, industrial firms, etc.	Water - Sewage - Refuse Pest Control rats, mosquitoes, lice, etc. Food Hygiene Mass Inoculations typhoid, cholera, smallpox, etc. Town Planning - Housing transport, recreation Health Education radio, newspapers, posters	Anti - Yaws Campaigns Anti - Worm Campaigns	Laboratories Vital Statistics Health Statistics
INDIVIDUAL MEDICINE By governments, local governments, voluntary agencies, industrial firms, Insurance agencies, private practitioners.	Hospitals, Ward and Outpatient Departments Health Centers - Dispensaries Home Visits Health Education at Personal Level Inoculations for Individuals School Health Services Maternal and Child Health (essentially a service to individuals)		

ADDITIONAL READING

1. The Kentucky Frontier Nursing Service.
2. Fendall, N. R. E.: Health centres in Kenya, E. Af. Med. J. 37: 171, 1960.
3. Susser, M., et al.: Medical care in a South African township, Lancet 1: 912, 1955.
4. Kahn, E., and Wayburne, S.: The Baragwanath premature baby unit, S. Af. Med. J. 28: 453, 1954.
5. Chesterman, C.C.: The training and employment of auxiliary personnel in medical and health services in Africa, J. Trop. Med. and Hyg. 1953, p. 123.
6. Williams, C. D.: Maternal and child health in Kumasi in 1935, J. Trop. Ped. 2: 141, 1956.
7. Morley, D.: Child welfare at the Wesley Guild Hospital, Ilesha Western Nigeria, (paper presented at the International Paediatric Meeting — Montreal, 1959).
8. Calderwood, M.: The development of the rural maternal and child heath centres in Singapore island, Mother and Child 30: 69, 1959.
9. WHO survey report, 1959. Child Health in Yugoslavia.
10. Yankauner, A.: Prospectus for a child health service built around pediatric clinics, J. Trop. Ped. 6: 122, 1961.