EDITORIAL

"Palliatives Will No Longer Do": The Deep Roots and Continuing Dynamic of Community-Oriented Primary Care

It is well recognized that the tradition that now calls itself community-oriented primary care (COPC) traces its roots to the work of Sidney and Emily Kark and their colleagues, who set up an innovative socially oriented clinic and public health outreach program in a rural area of Natal, South Africa, in the early1940s.[1] They first organized primary health care services and then, when this approach proved inadequate to address the multiple health and disease problems of the community, implemented a strategy of community assessment.

In a community assessment or diagnosis, health practitioners viewed the entire community as the "patient," and they often found that social, cultural, economic, and environmental determinants were more important than particular disease-causing agents.[2] Sidney Kark, for example, traced the high prevalence of syphilis to the system of migrant labor. Because families were required to live in small reservations in the rural Native Territories, men were forced to travel into towns to seek work, returning to their homes only for visits. This pattern of segregated housing and labor broke up families, led to the proliferation of prostitution in the towns, and exposed both urban and rural dwellers to the transmission of venereal diseases.

At Pholela, the Karks initially selected a defined community of some 130 families who were visited by health workers and intensively studied, surveyed, educated, counseled, and assisted. This defined community was gradually expanded and eventually grew to some 10 000 persons. Interdisciplinary teams of doctors, nurses, and health educators worked in and with the community to address health problems and improve sanitation and nutrition. As a response to widespread malnutrition, for example, community members were encouraged to grow vegetable gardens and thus to enrich their diets with a wide range of fresh fruit and vegetables. These highly successful experiments in social medicine and community development declined in the 1950s because of political opposition from provincial authorities, the resistance of large sections of the medical profession, and the rise to power of the National Party and its apartheid regime.[3] The Karks and many of their colleagues left South Africa over a 10-year period, settling in the United States, Israel, and other countries.

Given these historical roots, it is especially interesting that in the early 1990s, around the time of Sidney Kark's 80th birthday, Derek Yach and Stephen Tollman traced Kark's own roots farther back, indeed back another century, to the 1840s, Europe's "decade of revolution," and especially to 2 of the leading figures of that decade:

> South Africans in the 1940s were influenced not only by the results of their own empirical studies but also by earlier work from the 19th century, such as that of Friedrich Engels and Rudolf Virchow. Engels' work, published in1845, showed that mortality in England was inversely related to social class, not only for entire cities, but also within geographic districts of cities. . . . Virchow developed a broad theory of multifactorial etiology. He emphasized that various material deprivations interacted to produce disease in the individual and transmit it throughout the community. . . . Virchow's policy recommendations included a series of profound economic, political, and social changes such as increased employment, better wages, local autonomy in government, agricultural cooperatives, and a more progressive tax structure. His medical solutions, however, were rather limited.[4]

It is curious that in these paragraphs Yach and Tollman express a certain ambivalence about the heritage of social medicine ideas from the revolutionary context of the 1840s. They praise Engels for showing that mortality was related to class or socioeconomic status but omit mention of his broader political analysis and agenda; they likewise praise Virchow for his "multifactorial etiology" but seem to criticize him for having only limited medical solutions. It is probably not accidental that in the background lay several major presentations of the ideas of community-oriented primary care elaborated in the 1980s, which mediated in various ways between an earlier radical tradition and the economically and politically conservative tenor of the times.

The Institute of Medicine created a Committee on Community Oriented Primary Care, chaired by Joyce Lashof, and sponsored a conference in 1982, organized by Fitzhugh Mullan, at which Sidney Kark and H. Jack Geiger presented the lead papers.[5] A second Institute of Medicine

Committee on Community Oriented Primary Care then attempted to produce an "operational definition" and "operational model" of COPC and to assemble a database describing the operation, costs, and impact of COPC initiatives. This second committee tried to define COPC to fit within the models of health services research, cost-effectiveness analysis, and outcomes measurement. Its model of community-oriented primary care prescribed a 4-step process: (1) definition of a practice community, (2) identification of a health problem, (3) intervention to improve the health problem, and (4) evaluation of the intervention to modify and improve its effect on health.[6] This reconstituted version of COPC removed "community development" from the list of "essential features" of COPC and emphasized rigorous, stepwise, and quantitative methods for measuring the efficacy of professional interventions. (Four members of the committee protested the omission of community participation as a key feature of the model.)

If we go back to Kark's early papers on Pholela, it is evident that in his formative years he was very aware of, and explicitly sympathetic to, the much broader perspective of Virchow and Engels. His papers begin with graphic descriptions of the social conditions of the people living in the Native Territories, the system of forced migrant labor, the denudation and devastation of the land, and the extensive and severe malnutrition that afflicted the population.[7] He notes that medical services per se did not, and could not, prevent or modify the basic causes of ill health. While hundreds were being treated, thousands more were developing similar diseases. Clinical services had to be brought within a larger social framework before they could make their best contribution to national health, and health practitioners had to work with agricultural, housing, and sanitary personnel as well as with community members if they were to begin to address the real causes of morbidity and mortality.

In a 1945 essay on "the practice of social medicine,"[8] Sidney and Emily Kark generalized further. Scientific and technical advances during the 19th century succeeded in improving the health of populations only because "[t]he French Revolution of 1789–94 introduced an era of social change characterized by revolutions of one kind or another. This revolutionary era required a revolutionary philosophy, and the leading thinkers of the age were born into an environment which no longer accepted the order of things as being static and ever-lasting."[8(p285)]

A passage the Karks seemed to have in mind was this famous formulation by Rudolf Virchow, in his epochal 1848 "Report on the Typhus Epidemic in Upper Silesia":

> Medicine has imperceptibly led us into the social field and placed us in a position of confronting directly the great problems of our time. Let it be well understood, it is no longer a question of treating one typhus patient or another by drugs or by the regulation of food, housing and clothing. Our task now consists in the culture [socioeconomic condition] of 1½ millions of our fellow citizens who are at the lowest level of moral and physical degradation. With 1½ million people, palliatives will no longer do. If we wish to take remedial action, we must be radical. . . . If we wish to intervene in Upper Silesia, we must begin to promote the advancement of the entire population, and to stimulate a common general effort. . . . The people must acquire what they need by their own efforts.[9]

This political vision was very much part of the Karks' original Pholela model, and H. Jack Geiger carried it forward when he translated that model to the United States during America's "war on poverty" in the 1960s.[10] It has also come back in recent years, especially nurtured by health activists who want to jettison a prescriptive stepwise COPC model in favor of a more fluid and dynamic understanding that emphasizes community engagement and embraces sociopolitical objectives.[11–13] It may thus be helpful to remember the deep roots and ultimate inspiration of the Karks' original model of COPC. Stepwise progress and evaluative rigor are fine things, but we should not focus only on technical issues. More precious are the moral engagement and dedication to social justice that started it all and that will be the sustaining energy of innovative programs in the future. ■

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