Public health

Is the ethos of medical practice in community paediatrics compatible with that in public health?

Public health and community paediatrics go back a long way together. At times, in their history, the two have been so closely linked as to be indistinguishable. Two early "public health" initiatives in the UK—the establishment of the school health services, and of maternal and child welfare clinics—bear witness to early awareness that measures to improve children's health may be important for the health of adults. Infant mortality rates have long been regarded as a key indicator of the overall health of a nation in international comparisons, and in the UK doctors working in community child health services were first based in departments of public health. At other times the two specialties have seemed very separate. The 1974 NHS reorganisation and the concomitant development of two separate medical specialties—community child health (as community paediatrics was then called) and community medicine (as public health medicine was then called) pulled them apart. Several different forces are encouraging the two back together again: the political glasnost on social inequalities in health, and recognition at professional level that these inequalities have their most noxious impact on children[1 2]; the need to join forces, in the face of powerful financial interests, to advocate for a healthier environment for children (against the tobacco industry, the motor industry, and baby milk manufacturers); the need to maintain high levels of immunisation and the need to modernise the child health surveillance programme[3]; the rediscovery of the "life course approach to health"[4 5] and of "cycles of disadvantage"[6]; and the publication of research which shows that it is possible to have an impact on intractable adult public health problems by intervention in early childhood.[7 8] Some have proposed that the development of a new specialty—child public health—is the best way to have an impact on some of these problems. This article looks at some of the similarities and differences between medical practice in public health and community paediatrics. It also looks at some of the aspects of medical practice that make improving health a challenge for both specialties.

Principles of public health practice

An enduring definition of public health is that of Acheson in 1988: "The science and art of preventing disease, prolonging life, and promoting health, through the organised efforts of society". This definition springs from an essential premise of public health practice, that health is determined by social and environmental factors, and that health improvement depends primarily on interventions made outside clinical practice. Public health doctors have, in the past, had greater resources at their disposal than they do now, but they have never been in a position to "organise society". What they have achieved in this respect has been achieved through persuasion. They have gathered evidence, made speeches, written reports, identified collaborators, established coalitions. By the time that their proposals are implemented, their initial involvement may be forgotten. The main benefits of public health interventions are often felt when they have become an accepted and invisible part of the social fabric. Public health is therefore a specialty in which people need to be able to derive job satisfaction from playing a small part. Heroism and personal acclaim are rarely on offer.

Principles of community paediatric practice

Community paediatrics is primarily a clinical specialty, revolving around the suffering of individual children and their parents. The essential premise of clinical practice is that doctors can help sick people get better, and disabled people have a better quality of life. When clinicians' interventions work, their patients' lives are made easier in a way that is often clearly attributable to the intervention of the individual clinician. The relationship, when it works well, is a very personal one of appropriate and timely support, and appropriate and rewarding gratitude. Community paediatrics has some similarity with public health in that the interventions are not necessarily "clinical" and delivery is often the responsibility of a group of people. The doctor may have acted as an advocate for the provision of services, which are not under their control—housing, or environmental modification of a school—but the intervention is still made on behalf of, and felt by a single individual or family, and is attributable to the team leader, who is most often the doctor.

These are stereotypes, and reality is rarely so clear cut. There are plenty of examples of public health doctors needing and seeking personal acclaim for their achievements, and there are an equal number of examples of unsung heroism in community paediatrics. When the previous government was in power, public health doctors spent most of their time on NHS purchasing, focusing, like their clinical colleagues, on clinical interventions. At the same time some community paediatricians have taken a lead in intersectoral initiatives to develop, for example, accident prevention or parent support programmes. Many have worked with head teachers and schools to develop policies on medication, which mean that all children with asthma can have access to their inhalers when needed. So it is more helpful to view the two specialties as covering a spectrum of approaches, where the means differ, but the confidence intervals overlap.

The promotion of health in clinical practice

Public health and community paediatrics therefore share many goals. Tensions between the two specialties, in so far as they exist, arise from the clinical practice component of community paediatrics and they do so because clinical practice has very different goals from public health. Public health has the goal of preventing disease and enabling health improvement, clinical practice of enabling recovery from ill health, and mitigating the impact of disability. These goals need to be met in different ways. Problems arise because medical education is tailored primarily to enable doctors to treat sick people and, at undergraduate level, provides little in the way of support to developing doctors whose practice will in future include the promotion of health (public health, community paediatrics, and general practice).

In clinical practice doctors are required to take decisions, often under pressure, on behalf of sick patients,

and in doing so may shoulder a huge burden of responsibility. All doctors are therefore schooled in the ability to take charge in difficult situations. Effective treatments may be unpleasant or painful, and particularly when treating children or mentally ill people, doctors sometimes have to resort to coercion to aid recovery. Patients afford their doctors a high level of trust in believing that short term harm may be necessary for long term benefit. An essential characteristic of medical practice is therefore the ability to assume responsibility and to act on behalf of people who are vulnerable. Doctors are respected for this ability, and are valued for this by their patients. Their respect and gratitude makes them prepared to listen to what we have to say, and gives the medical profession a powerful voice in community affairs and in the political arena.

This skill, which is so essential a part of clinical practice, is however, a disability in the practice of health promotion. Health promotion usually requires adults to change their beliefs or their behaviour, and as those involved in the process of helping people give up smoking have found, these changes can be very difficult to achieve. Doctors who have tried to change their own behaviour will understand this at an experiential level, but the development and testing of theoretical models in health promotion research also provides insights into the essential prerequisites for behaviour change (see Tones and Tilford for a more detailed discussion[9]).

In order to achieve behaviour change people need to believe that the change will benefit them. For this they need to have acquired knowledge, either from their own experience or from pedagogic teaching (health education). For the latter to have the desired effect, the source of new information needs to be creditable and trustworthy. For people to change entrenched attitudes and beliefs, the new information may need to be heard from multiple creditable sources. While doctors have been shown to be particularly effective in this respect they are only one source and may not be sufficient on their own. Doctors who are "economical with the truth" about treatment effectiveness and side effects or prognosis may forfeit some of their credibility. Secondly, to achieve behaviour change, people need to believe in the possibility of personal change or development. Those who have entered the adult world with a belief that their efforts at self improvement are rarely successful, and that taking the initiative usually lands them in trouble, are not likely to believe this easily. Such change may depend on them finding someone who believes that, in spite of their previous experiences, they are capable of personal development.

This sort of support is different from the sort of support people require when they are sick. Sick people want others to take charge of their lives and make them better. People with poor self belief, and little sense of self worth, need people to help them discover that they can help themselves. This may require patience, understanding, and compassion. Enabling people to believe in their capacity to take control of their own lives is the process of empowerment, a key component of the practice of health promotion.[10] Such processes focus on the development of mental and social wellbeing, rather than of physical wellbeing, but as the new century dawns, mental and social wellbeing are beginning to assume some primacy as determinants of health.[11–13]

Ideally doctors would be trained in both approaches, using, in their clinical practice, whichever benefits their patient best. But deciding which to use, and when, is not a simple matter, particularly for community paediatricians, when caring for families of children with chronic illness and disability. Action orientated medical training encourages doctors to err on the side of doing things for their patients, which may reinforce their own sense of achievement, at the expense of their patients'.

Promoting health in communities and societies

Doctors working in public health concern themselves with improving health through social and environmental change, rather than through contact with individuals. They need to be skilled in working with groups of people from widely differing professional backgrounds. These skills are different from those required for one to one work in clinical practice. In this work, however, they face a dilemma parallel to that of clinicians; their choice is between disease prevention and health promotion. Disease prevention—immunisation, screening, road safety measures, legislation against tobacco advertising—is a way of protecting other people's health with minimal active involvement on their behalf. Public health professionals decide that a new programme of immunisation is worthwhile, persuade the government to fund it, and then persuade people to take one small step to achieve a lifetime's protection. Disease prevention can be achieved by coercion or by manipulation. Drink–drive legislation is an example of a coercive approach; exclusion from society of people with contagious diseases is another. Screening campaign literature, which plays down information about harmful side effects and plays up the potential benefits, encouraging people to take part in programmes under false pretences, is manipulative. The distinction between coercion, manipulation, persuasion, and support is not nearly as clear cut as it might seem. Most people knew that front seat belts were a good idea when legislation was introduced and welcomed the encouragement to wear them that the new law provided; as a result compliance is very high. The balance between too much and too little information in health education materials is difficult to get right.

Compulsory school based physical activity programmes may be a subtle example of coercive health promotion. These programmes are effective in getting children fit,[14] but experience would suggest that they may have a negative long term impact on exercise participation. Diseases can be prevented by coercion, but it is unlikely that health, in the positive sense, can ever be improved by this method. Coercion or manipulation may achieve short term benefits. However, the process of submitting to a more powerful individual or group of individuals, against one's personal interest or will, or allowing oneself to be fooled into believing something which is not true, are both disempowering, and likely to be destructive of social and mental wellbeing in the long term.

Health promotion encourages people to take charge of their own destinies, both individually and in groups. A health promoting approach to injury prevention would aim to inform communities about their injury risk, and support the community in coming to their own solutions for prevention. It is important that there are resources to ensure the implementation of these solutions, otherwise the collective belief of community members, that it is not worth trying, will only be reinforced. One problem with bottom up approaches such as this, is that agendas may clash. The health authority may have made accident prevention a priority in the same year as members of the community with the highest rates of injury have just decided that they really want to work on environmental improvements. In such a situation it would be respectful and empowering for the powerful health authority to agree to facilitate the less powerful community's agenda, before embarking on its own. Like clinical practice, public health therefore requires a delicate balancing act between top down control and bottom up initiatives; the key principles for both are mutual respect, trust, and fairness.

Health improvement programmes almost always require the cooperation and collaboration of organisations, such as local authorities, health authorities, and non-government organisations. The specific organisations depend on the task. Those working in public health therefore need to be able to establish multidisciplinary, intersectoral collaboration. The skills needed to do this work have a lot in common with the skills needed to empower individuals and communities. The attributes which ensure effective intersectoral working are mutual trust and respect. These approaches do not work when one individual, group, or organisation aims to take charge without the consent of the others. They are, therefore, a challenge to those working in "clinical practice mode" who may assume that taking charge and top down control is what is expected of them. Respect and trust are the only way to ensure that all those contributing to the process feel they have an equal voice; it is the only way to achieve confidence that collective solutions will be fair. Such attributes cannot be relied on to be present in intersectoral activities, and the conflict between the need to empower and the need to control is often very evident. Doctors working in "public health mode" need to be able to model helpful ways of working. In such circumstances it can be valuable to remember that health is unlikely to be improved by coercion or deceit. The process of implementing health promotion interventions is very important in determining their success.

Conclusions

Public health and community paediatrics have some common and some different goals. The different goals arise from the clinical elements of the latter. Clinical practice requires different skills from public health practice and provides different rewards; doctors will differ in the extent to which they feel comfortable with one or other approach, but they are not incompatible and in an ideal world we would all be able to do both. Health promotion is a skill which is applicable to both clinical practice and to public health. It demands ways of working and relating to colleagues and patients which differ from those that have, in the past, dominated medical practice in both specialties. The key attributes of health promotion practice, respect, trust, and fairness, are however now beginning to be incorporated into medical education. They are being incorporated, primarily, because they have been shown to improve patient satisfaction with clinical consultations. Perhaps in demanding something slightly different of the medical consultation, patients are showing us how doctors could be more helpful in improving health.

SARAH STEWART-BROWN

Director, Health Services Research Unit,
Department of Public Health, University of Oxford, Oxford, UK
email: Sarah.Stewart-Brown@dphpc.ox.ac.uk

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