CONTROVERSY

Exploring the scope for advocacy by paediatricians

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Abstract

***Aims*—To ascertain the type and extent of problems requiring advocacy in paediatrics. To develop an approach for analysing problems according to their root causes and the level of society at which advocacy is needed.**

***Methods*—Nine paediatricians kept detailed clinical diaries for two weeks to identify problems. Classifications were developed to categorise problems by cause and the level of society at which they needed to be addressed. The press was surveyed for one week for childhood issues attracting media attention.**

***Results*—60 problems requiring advocacy were identified. Root causes included failures within agencies, between agencies, and inadequate provision. In addition to advocacy required individually, "political" action was needed at the community level (16 issues), city level (16 issues), and nationally (15 issues). 103 articles were found in the press, these did not relate closely to issues identified by clinicians.**

***Conclusions*—Many opportunities for advocacy arise in the course of daily work. A systematic way of analysing them has been developed for use in planning action. To optimise the health and health care of children, there is a need to train and support paediatricians in advocacy work for local as well as national issues. Ten issues were identified that might be prioritised by paediatricians working on an agenda for action.**

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In 1996 Fellows and Members of the Royal College of Paediatrics and Child Health unanimously voted in support of the College taking a more proactive role in advocacy.[1] The following year the document *RCPCH strategy: a children's health service* was published.[2] Advocacy and equality form one of the strategic points, and the agenda for action includes the injunction: "To identify and prioritise issues where the College has a major role in advocacy for children."

According to *Collin's English dictionary,* advocacy is the active support of a cause or course of action. The question is, how should the College undertake its task of identifying and prioritising issues that require its active support?

It is relatively easy to draw up a list of problems besetting society, and to express concerns as a professional body that they be addressed. With such a list the College would be seen to be entering the political arena—something it has not before done. However, creating an agenda in this way may not be the best way of undertaking the task. Although issues requiring advocacy at a governmental level are likely to be highlighted, it is less likely that local problems will be identified or that much responsibility for action will be placed with paediatricians practising across the country.

In an attempt to address this issue, this study was designed with three aims:

- to ascertain the type and extent of problems requiring advocacy that arise in the course of paediatricians' daily work
- to develop an approach for analysing the problems both according to the cause at the root of the problem and for the level of society to which advocacy would need to be directed.

Only on accomplishing these aims was the third undertaken

- addressing the Royal College's agenda for action on advocacy.

Methods

The study was carried out by nine hospital and community paediatricians (three consultants, two speciality registrars, and four non-consultant career grade doctors) from Yorkshire, Manchester, and Cheshire who were teaching or attending the MMedSc course in child health at the University of Leeds. Their clinical work was based in inner city, suburban,

Table 1 Types of problems that arise in the course of clinical work

Type of problem	*Definition*	*Example*	*Problems identified (n)*
I. Family issue	Where provision is available but not accessed by the family	Parental refusal to send a child with chronic fatigue syndrome to school despite medical advice to do so	15
II. Within-agency issue	A system has failed the child or family	Excessive waiting lists for child mental health services	24
III. Interagency issue	Interaction between agencies has failed	Lack of coordination of health needs in children moving from one foster placement to another	13
IV. Inadequate or absent provision	A problem has arisen which requires a political solution	Lack of respite care for children with complex disabilities	7
V. There is an element of discrimination	Family suffers apparent racist response from service	Home education service and educational psychology input denied due to family's lack of English	1

Table 2 Hierarchy of levels of advocacy

Level at which advocacy is required	*Example of issue requiring advocacy*	*Number of incidences**
A. Individual level	Inadequate housing for a family	53
B. Public health level within community†	Disability access at a primary school	16
C. Public health level within city†	Insufficient provision of day care facilities	15
	Road safety near schools	
D. Public health level nationally	Breast feeding	15
	Poverty	
	Children's rights	

*> 60 as problems could require advocacy at several levels.
†Levels B and C were exclusive of each other as level C advocacy would include level B.

Table 3 Issues appearing in the media

Child abuse/protection	20
Parental: smacking	15
Education	15
Health	14
Environmental safety	9
Violence on the streets	9
Inadequate parenting	7
Disability	6
Positive parenting	4
Family conflict/divorce	4

and rural areas, and their clinical experience in general paediatrics ranged from 5 to 23 years.

Taking the workable definition of a problem requiring advocacy as "Any child health problem where the system is at fault, and political action is required", we prospectively kept diaries for a two week period and identified and recorded problems occurring in the course of clinical work.

By a process of debate and consensus, two systems were developed to categorise the problems. Table 1 shows the classification constructed to identify the root causes underlying the problems. Table 2 shows the classification identifying the level of society at which advocacy would need to be directed to solve the problem. Each problem was then discussed and categorised according to the two schemes.

As an important aspect of advocacy is working with the media, the group also surveyed newspapers (eight national and seven local) for one week to find out what child health problems appeared and to determine whether there was any relation between the clinical problems they had identified as needing advocacy and media interest.

Lastly, in an attempt to address the College action point: "To identify and prioritise issues where the College has a major role in advocacy for children", the group drew up a list that, by a process of debate and consensus, they felt could be used as a basis for discussion in setting an agenda politically.

Table 4 Prioritised action list

	Issue	*Suggested action*
General advocacy	Promotion of advocacy by paediatricians	Appoint a staff member with responsibility for taking on advocacy in the College and setting up a web site for advocacy on the lines of the American Academy of Pediatrics*
General advocacy	Primary care groups	Ensure that paediatric interests are represented on all primary care groups
Poverty	Disadvantaged children	Highlight the health benefits of high quality early nursery provision, especially in disadvantaged areas
Special needs	Lack of liaison for children who move out of one authority or area to another	Highlight the need for better continuity of care and transfer of information for children who move across agencies or geographical areas
Mental health	Increasing prevalence of emotional and behavioural difficulties (EBD)	Ensure adequate training in EBD for all paediatricians, and speak out with the Royal College of Psychiatry for increased psychological support for and within schools
Parenting	Loss of parenting skills in the population	Promote the enhanced role of health visiting and highlight the need for resources to do this
Health	Passive smoking	Advocate for further legislation against smoking in public places
Health	Unacceptable levels of risk taking behaviour in teens: sex, substance abuse, smoking	Promote school based clinics in secondary schools and the provision of school nurses with enhanced skills
Child protection	Inadequate help for victims of child abuse	Promote therapeutic services by setting up a working group to ascertain the evidence base for effective therapeutic services
Safety	Unacceptable high rate of road traffic accidents	In conjunction with SUSTRANS, advocate for safe paths to schools

* Already commissioned by the College.[2]
SUSTRANS is a charity that designs and builds routes for cyclists.

Results

Sixty problems were recorded; these included long waiting lists for occupational therapy and psychology services, lack of interpreter service and respite care, difficulties in obtaining statements of educational needs, inadequate social service involvement, poor transfer of medical information, bullying in schools, and insufficient neonatal beds.

Tables 1 and 2 show an analysis of the problems. Most were caused by failures in within-agency or between-agency working, or from a lack of provision of facilities (problems II–IV, table 1). Happily, only one discriminatory event was noted. In 15 cases the provision of resources or facilities was not deemed to be at fault, but advocacy was required on behalf of a child where the family was not accessing the available service.

Most of the 53 problems requiring advocacy at an individual level also needed further political action: 16 at community level, 15 at city level, and 15 nationally (table 2). Only 15 problems were deemed to require some sort of national action.

In the national and local papers surveyed, 103 articles were found relating to children's health or wellbeing. The focus of the articles could be summarised as the 10 issues shown in table 3. The list did not relate to the issues identified clinically. Table 4 shows the prioritised list of issues that might be tackled by paediatricians as a body.

Discussion

Most paediatricians are involved in advocacy at some time. Common examples are writing letters on behalf of a family to the housing authority or social services, or raising the issue of excessive waiting lists for therapeutic services. However, these actions are usually taken without a clear plan in mind. To be truly effective, advocacy must start by determining the source of the problem and then deciding how to target the action.

In carrying out this study, it was evident that for most problems identified yet another letter to the housing authority was not the solution. Furthermore, the repetitive nature of many of the problems across geographically different areas suggested that public health solutions were commonly required, in addition to the response on behalf of the individual that paediatricians usually take.

The study aimed to identify the scope for advocacy that arises in the course of paediatricians' work. A considerable number of problems were identified by the study, and the many opportunities that exist for paediatricians to take on a role in advocacy have been highlighted. An approach to analysing problems was developed, and this has potential in the development of plans to tackle issues demanding advocacy.

Two important issues emerge from the findings of the study. First, we found that most problems requiring public health advocacy resulted from a breakdown or inadequate collaboration within or between agencies, rather than from the lack of provision of services or facilities. This finding suggests that improvements in the health care of children may be attainable by simple political tactics and not only by provision of additional resources. Second, we found that most problems did not demand advocacy at a national level. Instead action was required by work at either a community or city level.

The analysis of the press showed many articles relating to children's health and wellbeing. Perhaps not surprisingly the list did not relate well to those issues identified clinically. One aspect of advocacy will therefore need to be directed towards getting the attention of the media, and ensuring that health issues considered to be clinically important also reach the public; paediatricians will need to learn to work effectively with the media, especially locally.

This work provides an important message to paediatricians who are taking a lead in setting an agenda for action in this country. If advocacy on behalf of children is to be effective, the College will need to support and train paediatricians in the skills required to become effective advocates in their own communities in addition to its national advocacy role. The American Academy of Pediatrics, which has placed advocacy as a high priority since its foundation, does this in the form of supplying training on residency training programmes,[3] providing paediatricians with information packs, and having an active website (http://www.aap.org/advocacy/), as well as being a powerful political lobby. This model might well be adopted here.

Having invested time and energy in analysing the need and processes of advocacy, the group felt they were in a position to attempt "To identify and prioritise issues where the College has a major role in advocacy for children". The list that was compiled (table 4) was intended to hold a balance between national public health and more local issues, between issues where there is public concern and those less "popular", and to include a variety of issues so that different skills and approaches would be exercised. While this list is not intended to be comprehensive, and is certainly subjective, it might be used as a basis for setting an agenda.

The authors are paediatricians working in Yorkshire, Manchester, Teesside, and Cheshire, and are students, staff, or external examiners on the MMedSc course in child health at the University of Leeds. This paper was a collaborative effort with all authors contributing to conception, design, analysis, and interpretation of the data, as well as drafting or revising the article.

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1 Speaking up for children: The work of the College Advocacy Committee. *RCPCH Newsletter*. London: Royal College of Paediatrics and Child Health, December 1998:5.
2 Royal College of Paediatrics and Child Health strategy: a children's health service. *RCPCH Newsletter*. London: Royal College of Paediatrics and Child Health, September, 1998.
3 Berman S. Training paediatricians to become child advocates. *Pediatrics* 1998;**102**:632–6.

Commentary

"Advocacy", like "counselling", is one of today's a buzzword: it glorifies an activity that any decent doctor does as part of his or her job. The Royal College of Paediatrics and Child Health (RCPCH) has honoured the term by cautiously including it in a major strategy document. The RCPCH would not be much use to the world's children if it failed " . . .*to identify and prioritise issues where the College has a major role in advocacy for children*". The implication is that, having done its *identifying* and *prioritising*, the College will then do something useful. Indeed that is why the British Paediatric Association became a Royal College: to give paediatricians collectively more political clout.

We all write letters to public bodies in respect of our patients' needs: a larger house here, a disabled toilet there, and a letter or telephone call to a schoolteacher on how best to cope with syringes in a newly diagnosed diabetic child. Community paediatricians are particularly likely to have to deal with larger social agencies, and an ability to deal with the mass media should be one of their skills. We quickly learn that our letters carry more weight if we are recognised to be discriminating in our support of patients: not every family can be given a new house just because a member has a chronic illness.

The same is true at national and international levels: if paediatricians are to be taken seriously by governments they have to be seen to be reasonable in their advocacy, and not simply following a fashionable political ideology. They must remember that their authority arises specifically from their expertise in the diseases of children: while matching, I suppose, their adult medical or surgical colleagues in intelligence, paediatricians are not necessarily wiser than their fellow citizens. Feeling passionate about the welfare of our young patients and, indeed, children in general, may be a good starting point, but an awareness that the road to hell is paved with good intentions is also necessary.

When doctors lobbied for the compulsory wearing of car safety belts, or bicycle helmets, or on the dangers of smoking, they were giving advice with an authority that only they had, whereas on subjects such as poverty, family breakdown, or whether a slap on the back of a hand constitutes child abuse, we have to be certain that our views are based on hard medical evidence (dare I use the term evidence-based?) rather than reflecting our individual *Weltanschauungen*.

Those of us present at the first annual meeting of the RCPCH in 1997 were given an uncomfortable reminder of that when our patron, Princess Anne, the Princess Royal, had to gently but firmly chide some of the more passionate among us that shouting loudly about women's and children's rights is, in many developing countries, more likely to result in rapid deportation, than any benefit to the women or children of that country. Most paediatricians have come across single issue fanatics and know just how disturbingly powerful they can be.

We are fortunate to have a sister college in the USA from whom we can learn much: Berman's commentary,[1] cited by Rudolf *et al* reflects the approach of the American Academy of Pediatrics. It has passages of icy realism of which Machiavelli would be proud: I commend it to anyone who really wishes to be involved in the passage of legislation for the benefit of children. His approach could be a guide to anyone pushing for new legislation in any field:

Develop a clear mission
Implement a strategy of small wins
Identify friends and build coalitions
Identify adversaries and attempt to neutralise their opposition
Be pragmatic and willing to compromise
Don't burn bridges and never compromise a legislator
Hire an effective lobbyist
Develop a good relationship with the media
To the extent possible, minimise looking self serving

The paper by Rudolf *et al* is modest in its aims. Indeed, it states, "It is relatively easy to draw up a list of problems besetting society and to express concerns as a professional body that they be addressed . . .". Nevertheless it covers an important area of a paediatrician's work, that of acting as an advocate for the individual child or his family: most paediatricians are not directly involved in advising the government on child health issues.

The report consists of the combined opinions of nine paediatricians regarding the situations they have encountered in their daily work in which advocacy might be appropriate. Some are hospital based and others community paediatricians, but we know nothing of their experience, and hence, to some extent, the authority of their opinions. The evidence on which the opinions were based is not given and this is the report's fundamental weakness. We have no means of deciding what an "apparently racist" response from the education service is, still less why a paediatrician might be better qualified to judge the matter than any other intelligent citizen. The desirability of breast feeding does not go unpublished: the walls of maternity clinics are plastered with posters hectoring mothers to be to breast feed, or else!

The predictability of the prioritised action list depresses me: no shibboleths are challenged here. Yet every paediatrician working in the UK today is an observer of one of the greatest secular changes in history: the decline of the family as an institution. This has been aided and abetted by many of the organs of the state, including much of the intellectual establishment: after Anthony Giddens' 1999 Reith lectures (BBC Radio 4) there can be little doubt about this.

Why are paediatricians—who can observe the misery and health problems caused by family breakdown better than any other group—so inhibited when it comes to pointing out the advantages to children of being conceived and raised in a family with two parents committed to staying together or, put another way, the dangers to children's health of being born out of wedlock to mothers living a dependent existence with a succession of partners? Are not these risks, at least in the Western world, even greater than those of not being breast fed?

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1 Berman S. Training paediatricians to become child advocates. *Pediatrics* 1998;**102**:632–6.