Public Health Classics

This section looks back to some ground-breaking contributions to public health, reproducing them in their original form and adding a commentary on their significance from a modern-day perspective. To complement this month's theme of the *Bulletin*, Mahmoud F. Fathalla reviews the 1952 paper by Dugald Baird on preventive medicine in obstetrics. The original paper is reproduced by permission of *The New England Journal of Medicine*.

When medicine rediscovered its social roots

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Hippocrates wrote in about 400 BC: "Whoever wishes to investigate medicine properly should proceed thus: in the first place to consider the seasons of the year. Then the winds. In the same manner, when one comes into a city in which he is a stranger, he should consider its situation, the water which the inhabitants use ... and the mode in which the inhabitants live, and what are their pursuits."

At least since the time of Hippocrates, medicine has been practised in a social context. The conditions in which people live and the ways in which they behave have been of great significance, as medicine is a profession for both care and cure.

Then came the age of biology and technology. Spectacular scientific advances had a tremendous impact on the practice of medicine. On the positive side, physicians had tools to achieve curative wonders in ways that were never available before. But on the negative side, the more physicians became technically oriented, the less they were socially conscious. As they learned more about cell and molecular biology, they tended to forget that these molecules and cells constitute human beings with a life of their own. Machines stood between physicians and their patients. Medicine lost its "pastoral" function of administering tender loving care to the anxious patient.

The paper by Professor Baird is a public health classic in the sense that it attempts to bring back the social perspective to the practice of medicine (*1*). When asked to give a lecture on preventive obstetrics, he used the platform to highlight the impact of social factors on the health of mothers and children and to give voice to women's perceptions of "modern" medical practice. The words he quoted probably still echo today: "There is a lot to be said for the old-fashioned doctors. I am sure they would have been a lot more helpful. ... Excuse criticism, but I feel very strongly about it."

It is not strange that this call for social consciousness in medicine should come from the field of obstetrics. The social perspective is relevant to all areas of health care, but it is the more vulnerable groups who suffer most from the lack of it, and children and women are among the first of these. As Baird rightly remarks, "any deterioration in living standards is reflected immediately in a rise in mortality in the period of one to twelve months". Maternal mortality likewise: there is no other health indicator with such a discrepancy between the rich and the poor. The lifetime risk of a woman dying from pregnancy and childbirth ranges from less than 1 in 10 in some African countries to 1 in several thousand in European countries (1 in 8700 in Switzerland, for example) (*2*).

The socioeconomic conditions that had an adverse impact on the reproductive performance of women in the city of Aberdeen in the 1940s and 1950s still have that impact on the health and lives of hundreds of millions of women and their babies in developing countries in the world today. Every year, about 9 million babies are either born dead or die within the first 28 days of life (*3*).

Experience in the past few decades has taught us three important lessons. The first is that while the poor fare worse than the better-off on all health indicators, some countries attain far better health conditions for their poor people than others (*4*). Poverty is not an insurmountable barrier to health when policies are right.

The second lesson is that gender has a lot to do with it. Awareness of gender as a health determinant is relatively recent. When the founders drafted the Constitution of the World Health Organization more than fifty years ago, they wrote: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". They forgot one thing: distinction of sex. Dugald Baird, in highlighting that tall women are more efficient in reproduction than small

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women, states: "many women are small not because of heredity but because they are stunted and not fully grown (possibly as a result of faulty living conditions and deficient diet in the growing years)". He cites evidence that as the environment deteriorates the percentage of small women increases. We now know that it is not simply a question of environmental deterioration but of gender discrimination: the girl child is particularly vulnerable to neglect. The Fourth World Conference on Women, held in Beijing in 1995, emphasized this: "Existing discrimination against the girl child in her access to nutrition and physical and mental health services endangers her current and future health. An estimated 450 million adult women in developing countries are stunted as a result of childhood protein–energy malnutrition" (*5*). The International Conference on Population and Development, held in Cairo in 1994, urged governments to eliminate discrimination against the girl child (*6*).

The third lesson we have learnt is that improvement in perinatal health needs more than improvement in socioeconomic conditions. Women need to have access to essential obstetric care. While, globally, infant mortality declined markedly between the early 1980s and late 1990s, most of this improvement was among older infants (*3*). The perinatal death toll during the same period fell only slightly from 64 to 57 deaths per 1000 births (compare with the Aberdeen figures in the late 1940s of 38.9 and 15.2 for the maternity hospital and private facility, respectively). Infant mortality is a sensitive indicator of socioeconomic development. Perinatal mortality, on the other hand, is an indicator of the level of care which women receive in pregnancy and childbirth. Health statistics usually classify perinatal mortality as a category on its own, a condition that affects both males and females (*7*). Perinatal mortality and morbidity are outcomes of a pregnancy and delivery for a woman; as such, they should appropriately be added to the count of the disease burden on women (*8*). Women make a major investment of themselves in pregnancy and childbirth; an unfavourable perinatal outcome of pregnancy, including low-birth-weight babies, can be a frustration or an additional burden.

Has the health profession become more socially conscious? The record is mixed. The cult of high technology still attracts fervent followers. While most health professionals are willing to concede that a major proportion of ill-health results from socioeconomic factors and that there is a limit to what modern medicine can achieve without social interventions, there is no consensus on the implication of these facts for the health profession. It can rightly be argued that the health community has limited capacity and limited credibility for taking direct action outside the health sector. However, the profession has a social responsibility to study the effect on health of actions taken or not taken outside the health sector and to disseminate this information. It must also play the role of advocate for vulnerable groups in society and uphold their right of access to health care without discrimination. We do not treat diseases: we treat people in a psychosocial context. The health profession cannot bury its head in the sands of biology and turn its back on the reality of people's lives.

When the International Federation of Gynaecology and Obstetrics issued its first World Report on Women's Health in 1994, the thrust of the message was that future improvements in women's health will need more than science and the health care profession. Women need societal action that has long been overdue to correct injustices (*9*). Sir Dugald would have been happy to see that report. ■

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