Advocacy and the paediatrician

Tony Waterston

Abstract

Paediatricians are faced with a growing number of so-called 'wicked' problems such as obesity, pedestrian accidents, emotional and behavioural problems, child abuse, air pollution and climate change. The determinants of the majority of these problems are related to deep-seated difficulties in society which require an advocacy approach to tackle them. This short review discusses the meaning of advocacy giving examples of advocacy offered by paediatricians and child health professionals in the past and describing the underpinning principles of advocacy in particular the role of the UN Convention on the Rights of the Child. This review highlights the role of paediatric associations with examples of advocacy which include the American Academy of Pediatrics and the Royal College of Paediatrics and Child Health. The requirements of successful advocacy are discussed and proposals on how to include advocacy in paediatric training are presented, from both the USA and UK. It makes the case that advocacy is possible and necessary but requires a commitment by paediatric leaders to ensure that all paediatric training includes both the application of the UN Convention on the Rights of the Child and the practical tactics of advocacy for better child health.

Keywords advocacy; child health; paediatrics; UN Convention on the Rights of the Child

Advocacy in clinical paediatrics

Christopher was eight when I first met him in Newcastle following a referral from the GP for difficult behaviour and bedwetting. I followed him up for about five years and found his particular problem to be one of the most challenging that I had to manage as a community paediatrician, and one that in the end was near-impossible to resolve, despite the assistance and involvement of social services, educational psychology, clinical psychology, and special needs teachers. My role as the paediatrician had to include neurodevelopment, educational medicine, counselling, advocacy and liaison across the multidisciplinary team. Of these probably advocacy was the most important. Further details about Christopher are in the box. Ultimately I would summarize his problems as being poverty, delayed development, autistic features, school drop-out, large chaotic family and a cycle of deprivation.

Adopting the role of an advocate is part of the essential work of a general paediatrician, indeed of any paediatrician in today's world. And advocacy needs to be taken as seriously as clinical paediatrics, team management, IT and communication skills, which are all necessary accompaniments — as well as accomplishments for the trained paediatrician.

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Christopher 8 year old child

Referred by GP with difficult behaviour and nocturnal enuresis.
Also had long standing concerns about poor school attendance.
He was part of a single parent family with 8 siblings — Christopher the third child. His mother was resistant to social services input and felt she 'could manage'.
Noted to have poor communication skills and emotional rapport.
He didn't like school and complained of bullying.
After extensive information collection from school and other agencies, he was referred to Child Psychiatry as possible autistic spectrum. This diagnosis was confirmed 6 months after initial referral but there were prolonged difficulties over engaging with services appropriately and finding a suitable placement.
Advocacy role: ensuring that the services responded to Christopher's needs appropriately (social services, child psychology, educational psychology, educational welfare) and supporting his mother in finding appropriate placement.

Box 1

What is different about paediatrics and child health today?

Much has been written about the impact of culture and society on health as well as the so-called 'new morbidity' which is now not so new. In the box is a list of the conditions which are sometimes described as 'wicked' — meaning those which have more than one cause and require several different approaches to resolve. The term 'wicked problems' was coined in 1973 by Rittel and Webber to refer to problems that are tough to describe, have multiple causes and don't have a single right solution. Wicked problems need different approaches from the ones that have worked in the past — namely, drug therapy or health education. There are underlying reasons in society which lead to the development of these problems and which explain why the problems are so pervasive. Given the underlying conditions which exist in society and which I explain below, it is in truth inevitable that the impact on children's health will be enormous.

Wicked problem definition (Wikipedia)

A **wicked problem** is a problem that is difficult or impossible to solve because of incomplete, contradictory, and changing requirements that are often difficult to recognize. The use of term "wicked" here has come to denote resistance to resolution, rather than evil. Moreover, because of complex interdependencies, the effort to solve one aspect of a wicked problem may reveal or create other problems.

Box 2

Examples of Wicked problems in child health

Obesity
Pedestrian accidents
Emotional and behavioural problems
Child abuse
Air pollution
Climate change

Box 3

Examples of wicked problems affecting children and young people include complex conditions such as obesity, mental ill health, substance abuse, child maltreatment, behavioural and educational problems, juvenile crime and the broader societal ones — climate change, environmental degradation, and inequalities (socio-economic, in health, education and opportunity). These wicked "health" problems are not going to be solved by health departments but by joined up interventions which take account of the complex antecedents and circumstances that result in them occurring. Thus wicked problems demand both a whole of government and a whole of society approach. They also require advocacy by those who see the consequences for children.

Another name for the causal factors in society behind the wicked problems is social determinants of health, a term used extensively by Michael Marmot — notably in his WHO Commission published in 2008 http://www.who.int/social_determinants/thecommission/en/.

The social determinants which are so pervasive in modern society in most countries of the world are listed in Box 4. Do we say that these are beyond our capacity to influence — that our role stops outside the consulting room or hospital wall—or do we read the lessons of history and follow the example of the predecessors who challenged the social determinants and enabled change to come about?

Social determinants and their consequences

Inequalities in income and wealth
Inequalities in access to education
Poverty
Poor parenting
Violence in the media
Unsafe streets dominated by cars
Lack of opportunities for exercise
Marketing of unhealthy convenience foods and large portion size
Climate change

Box 4

The impact of inequality on children is huge. According to Waldfogel ('Too many children left behind'), in the USA on the day that children start kindergarten, those from low socioeconomic status are already more than a year behind the children of college graduates in their grasp of both reading and maths. And 9 years later the achievement gap had widened by one half to two thirds.

The same author describes that children from low socioeconomic background are seven times more likely to have been born to a teenage mother, and only half live with both parents, compared to 83% of the children of college graduates. A UK perspective on the effects of inequality is shown in Box 5.

The meaning of advocacy and relevance to the work of most paediatricians

The Wikipedia definition of a health advocate is one who 'supports and promotes the rights of the patient in the healthcare arena, helps build capacity to improve community health and enhances health policy initiatives focused on available, safe and quality care'. The commonly used interpretation is *stand up for* or *speak out for*: in other words, take up and support someone else's interests (in our case the child's). The rationale for doing this is that the child does not have the capacity to speak for him or herself.

But what about the parents? Should they not be the advocates for their own child? Certainly, and paediatricians have always worked closely with the parents of the children they look after — exchanging expertise and sharing knowledge to develop a close partnership. But parents can be abusive and as a result of their own childhood deprivation may lack the feeling of empowerment

Socioeconomic Inequalities in Child Health in UK

- A boy born in Kensington and Chelsea has a life expectancy of over 84 years; for a boy born in Islington, less than five miles away, it is around 75 years.
- Children with a high cognitive score at 22 months but with parents of low socioeconomic status do less well (in terms of subsequent cognitive development) than children with low initial scores but with parents of high socioeconomic status.
- The 2003 Children's Dental Survey found that, among five year olds, 13% from social classes IV and V had never visited the dentist compared with 2% from social classes I, II and III.
- Childhood mortality from injury and poisoning fell between the early 1980s and early 1990s for all social classes; the differential between the classes increased, owing to the smaller decline occurring in social classes IV and V as compared to social classes I and II.
- Low birth weight is the strongest risk factor for infant mortality. In 1994 in England and Wales, the average birth weight in Social Class V was 115 grams lighter than in Social Class I for births inside marriage and 130 g lighter for births outside marriage registered by both parents.

Box 5