Practising 'social paediatrics': what do the social determinants of child health mean for professionalism and practice?

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Abstract

Paediatrics stands at a turning point: today's health challenges are chronic, complex and connected, but health services are ill-prepared. Given the well-established epidemiological literature which shows that health status is heavily determined by social factors, the profession is now forced to redefine itself. What role should paediatricians play in the health systems of the future? How might the application of a 'social lens' and development of 'social paediatrics' help the profession to reconsider its roles and responsibilities? This paper represents a first attempt to respond to these questions. Using child poverty as an example of how socially conscious practice can broaden paediatric interventions for both the individual patient and wider population, it lays the ground for further work, which is both timely and necessary if practitioners are to be properly empowered and equipped to deal with child health in the 21st century.

Keywords child health; medical education; paediatric practice; paediatric professionalism; paediatric role; social determinants of health; social determinants thesis; social lens; social medicine; social paediatrics; socially-conscious practice

Introduction

The practice of child health in the 21st century would be unrecognizable to the mid-19th century pioneers who first established paediatrics as a specialized field of medicine. The epidemiological transition for under-5 mortality has meant that as mortality rates have declined, the relative contribution of deaths from congenital anomalies, non-communicable diseases and injuries has increased, while the relative contribution from infectious diseases — previously the biggest killers in children — has progressively decreased. Key advances in public health, the anti-microbial revolution and the ability of paediatric medicine to prolong survival for extremely premature infants and those facing otherwise life-threatening diseases have moved paediatrics from the era of addressing immediate health threats with acute and emergency care, to the era of chronic disease management and secondary prevention. We now live in a world where child health services are overwhelmed by record levels of presentations of a multifactorial nature: 1 in 10 children or young people suffer from mental health problems; almost 1 in 3 are obese; rates of alcohol consumption continue to rise; and adolescent mortality rates have remained stagnant for the last 40 years. Clearly, while more children may be surviving in the UK at the beginning of the 21st century, they are certainly not all thriving.

How can the profession best move beyond helping children to survive to helping them thrive?

Re-imagining paediatrics

The chronic, complex and connected nature of health problems faced by paediatrics today necessitates that child health systems evolve toward a third era; one informed by breakthroughs in life-course health science. Life-course health science explains the developmental origins of health and disease patterns by elucidating how environmental exposures and social experiences, including those occurring during sensitive periods of development early in life, are embedded in biological and behavioural systems. It builds on the biomedical and biopsychosocial models of disease causation, using recent breakthroughs in social epidemiology to focus more attention on the upstream social, behavioural, and developmental (that is, earlier in the life course) determinants of health. In so doing, the life-course approach takes the social determinants of health seriously, as described by Dr. Nick Spencer in this issue, and forces paediatricians at the beginning of the 21st century to ask: What is our purpose? What are the goals of child health professionals? How might our methods change in accordance with that?

This challenge forms our starting point for two reasons. First, how we define paediatrics determines how it regards its mission and how it proceeds to fulfil it. If care is directed solely at the domain of biological dysfunction, death, and dying, then the tools of clinical science are oriented towards that domain. If, however, clinical paediatrics directs itself to health, wellbeing and the whole person — not just to the biology of disease — then these tools must be coupled not only to a humane attitude of care to appropriately respond to the inner worlds of our patients, but also to the understanding that patients do not exist in isolation: each is situated within a particular set of material and social circumstances which are salient for health. Of course, an emphasis on the biomedical makes sense in some situations, for example in medical emergencies, where life-saving and survival are prime. However, the contemporary medical enterprise must also be about helping people to thrive and live well throughout the course of their lives. Second, making the significant shift from a healthcare system focused on producing medical care toward a health system focused on supporting healthy lives is

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unlikely to succeed without buy in from those who work in the system. Part of the work in reimagining what child health in the 21st century will look like needs to come from paediatricians themselves.

The social determinants thesis and the ears of the hippopotamus

If we want to re-imagine paediatrics, paying attention to the social determinants of health is a good place to start. Here, "the ears of the hippopotamus", an aphorism of the global south exchangeable for "the tip of the iceberg", provides a useful analogy. While surface issues associated with survival and specific disease entities are, much like the ears of the hippopotamus, easy to fixate on, the social determinants thesis – which is based on decades-worth of robust epidemiologic evidence – states that most disease is attributable to the social conditions in which people live and work. As Dr. Spencer lays out in his paper, the social patterning of disease is responsible for substantial mortality and morbidity among children in both poor and rich nations. Acknowledged social determinants of health – including ethnicity, socio-economic class, occupation, and the use of alcohol and tobacco – influence the effectiveness of healthcare delivery. But other social factors, such as the ability to afford medications, access to transportation, available time, and competing priorities, may influence health outcomes even more. Thus the deeper, more difficult to reach and much more dangerous hidden threats lurking beneath the surface that constitute the bulk of health problems today only come to light when the social dimensions of health and illness are properly considered.

Applying a social scientific perspective – or 'social lens' – to medicine orientates patient care towards achieving more sustainable and equitable health outcomes. The practice of "social medicine" elucidates how patients' environments influence their attitudes and behaviours, and how patients' agency—the ability to translate their values and choices into action—is constrained by challenging social environments.

Beck (2016) estimates that around 20% of paediatric presentations stem primarily from social problems. Paediatric care is frequently the point of first contact between healthcare services and children and young people with health and social problems. Given that adverse early life environments affect children's later life outcomes, paediatricians are ideally placed to identify those most at risk of later disease and to facilitate interventions for prevention, support and solidarity.

Medical institutions worldwide affirm this view, encouraging all doctors to focus "not only on individual behaviours, but to address the social and economic circumstances that give rise to premature ill health". The American Academy of Pediatrics recently called for paediatricians to routinely screen for child poverty and address socio-economic deprivation, while paediatric trainees in the UK will know that the curricular requirements of the Royal College of Paediatrics of and Child Health (RCPCH) call for a wide range of skills and knowledge around the social and psychological aspects of paediatric care (Table 1). However, research conducted by one of the authors among UK paediatricians reveals that while paediatricians are highly aware of the relevance of social determinants to their work, they feel disempowered to tackle them, and thus unable to meet such recommendations. Instead, they feel conflicted about what they should do and how far this role ought to extend.

Despite the strong case for its existence, the practice of "social paediatrics" is yet to be fully realized. Other than rhetorical support, there has been no clear guidance delimiting new roles for paediatricians, let alone the kinds of tasks such roles would entail, and nor has there been a discussion of the ethical basis and implications of such changes.

What does 'social paediatrics' look like?

The implications of the social determinants thesis for paediatric practice and professionalism should be considered as a matter of urgency. It would be easy to see patients with complex social situations as a burden—requiring extra work that is neither rewarded nor central to core clinical expertise. It is also understandable that since the social determinants are distal 'causes of causes' acting over the course of individual lives, unseen by the paediatrician and profoundly influenced by social and economic political decisions, they seem beyond the control of individual practitioners.

Rather than despairing at the scale of the challenge, we suggest paediatricians should take inspiration from the social determinants thesis; the proper application of a social lens presents opportunities for alternative avenues for socially conscious paediatric professionalism, opening up action both at the level of the presenting patient and at the level of the wider community and population at large.

To consider how a social lens might change paediatric practice we can look to a worked up example for child poverty developed with colleagues at the British Association of Child and Adolescent Health (BACAPH), a membership organization for those interested in promoting the health and wellbeing of all children and young people (Figure 1a and b).

At the level of the individual and interpersonal

Understanding social history: obtaining a more appropriate and comprehensive social history enables proper assessment of a child or young person's social environment. Many social barriers exist between patients and health professionals, but deliberate inquiry into the social environment – with careful attention to race, culture, gender and class – allows clinicians to understand behaviours such as non-adherence to treatment plans, missed appointments, or failure to fill prescriptions not as products of ignorance or willful misbehaviour but rather as results of the complicated interplay of individual factors with a complex social environment.

Relevant to child poverty, this might include recording household income. Paediatricians would be better able to: offer health and lifestyle advice suited to a family's budget; identify families for whom prescription charges (or other healthcare-related costs) may represent a challenge to adherence; and ensure patients are accessing community resources that could be helpful to them and state benefits to which they may be entitled. Greater sensitivity towards household income could directly improve the quality of healthcare received. Instead of adhering to guidelines or protocols unconditionally, a social lens encourages health professionals to balance treatment efficacy with patient

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