Public health

Social paediatrics and child public health—a European perspective

Why we need social paediatrics
The past 20 years have produced dramatic changes in the configuration of Europe and the health of our children. While important progress has been made in areas such as neonatal and intensive care, treatment of malignancy, and transplant surgery, paediatricians enter the new millennium knowing that many children are increasingly disadvantaged by the social and political climate of their countries.

Increasingly, sociogenic rather than biogenic but the increasing gap between rich and poor, with 3.4 million at risk.4,5 In the eastern states the numbers infected with HIV continue to rise and old enemies such as diphtheria and tuberculosis are re-emerging.

Even in those states untouched by conflict, poverty remains a resilient enemy. The most recent figures from the UK (which has the third largest child population) show an increasing gap between rich and poor, with 3.4 million children now living below the poverty line. Morbidity is increasingly sociogenic rather than biogenic but the patterns have altered. While under-nutrition remains a reality, obesity poses a much greater overall threat to children’s health; changes in the structure of society and raised expectations are associated with increasing mental health problems in adolescence. Increasing identification of abuse and neglect and of special needs has contributed to this “new morbidity”.6,2,4,5,7,8,9,10,11,12 However, community experience is regrettable absent from the European paediatric common trunk12 (the approximate equivalent of the UK paediatric senior house officer training), but Child Public Health is increasingly recognised as part of basic training of all paediatricians.7,8 However, community experience is regrettable absent from the European paediatric common trunk12 (the approximate equivalent of the UK paediatric senior house officer training), but Child Public Health is increasingly recognised as part of basic training of all paediatricians.12 However, community experience is regrettable absent from the European paediatric common trunk12 (the approximate equivalent of the UK paediatric senior house officer training), but Child Public Health is increasingly recognised as part of basic training of all paediatricians.12 However, community experience 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In the UK, Community Paediatrics has always included elements of public health, but in most other countries the epidemiology of childhood disease and disability remains the remit of adult public health services who still have responsibility for teaching the subject in the undergraduate curriculum. In the Netherlands, where there has been an increasing divergence of preventive child health and hospital based services, the University of Maastricht has attempted to close the gap by appointing a community paediatrician and has introduced the subject at postgraduate level as a series of lectures.

The mechanisms for change
There is light at the end of the tunnel. Paediatricians all over Europe, not just those whose countries have been affected by the massive shifts in population caused by war, share concerns about the change in children’s health needs and want this to be reflected in training at all levels. The responsibility for paediatric training lies with the Confederation of European Specialists in Paediatrics (CESP), which is the paediatric sub-section of the European Union of Medical Specialties (UEMS), through which it advises...
The European Parliament 

Council of Ministers 

European Commission 

EU Advisory Committee on Medical Training 

European Union of Medical Specialists (UEMS) 

Confederation of European Specialty Paediatricians (CESP) 

European Specialty Bodies 

National Paediatric Societies 

Figure 1 Structure of European paediatrics.

the European Commission (fig 1). Its first two objectives are: (a) to study, promote, and guarantee a comparably high quality of paediatric care; and (b) to ensure a high standard of paediatric training in the member countries. CESP is made up of representatives from all EU countries with observers from non-member states. At a meeting in Graz in 1996 the subject of social and community pediatrics was raised. Representatives from most countries freely acknowledged their lack of familiarity with this area of paediatrics but recognised both its importance and its absence from the training curriculum.

The Bordeaux meeting

To enable and expand the discussion following this meeting, the Association for Paediatric Education in Europe (APEE) invited the European Society for Social Paediatrics (ESSOP) to a joint conference. Prior to the meeting, which was held in Bordeaux in 1998, Macfarlane et al carried out a Delphi project in which 23 perceived experts in 11 European countries defined priorities for training.13 The results were presented and discussed and the meeting went on to address the question of whether child public health and social community paediatrics (CPH/SCP) should become a European specialty.

The overall consensus of the Bordeaux meeting was that in an ideal world many of the elements of SCP would be assimilated into general and ambulatory paediatrics as part of everyday practice, but this cannot happen until the subject is taught at undergraduate level and as part of the common trunk training of all paediatricians. Every medical student and paediatric trainee should have the opportunity to experience paediatric practice in a community setting and a multidisciplinary approach is essential to the subject. Europe has a long way to travel to reach these goals. The lack of expertise in SCP in most countries (and of most paediatricians) makes a very strong case for a recognised specialty to develop and promote the subject, and to provide the necessary academic base. It was agreed that CPH was an essential component and driving force.

When specialty status was discussed there was an important minority point of view that in spite of the fact that more and more paediatricians in all specialties now take into account the influences of developmental, environmental, and family factors, currently trainees have neither the experience of the subject nor the financial incentives to stimulate interest in this field, and that many of the best social paediatricians come to the subject at a later stage from a different career path. A move towards specialty status was perceived as premature and possibly counterproductive.14

Achieving specialty status

There is already a will in Europe to increase collaboration in the field of CPH. The first step must be to create a European paediatric specialty which combines CPH and SCP, but allows for the development of two main pathways through the curriculum. There are a number of tasks to complete if CPH/SCP is to achieve specialty recognition. The broad consensus on the content of training has to be developed into a core curriculum which allows individual countries to add modules according to their population profiles and health needs. We then need to identify university departments throughout east and west Europe which can deliver the core curriculum and/or the optional modules (some of which may appropriately be taught by specialists in adult public health). When this has been completed, application can be made via CESP to UEMS for specialty status. This process is both rigorous and arduous. (To date there are only five recognised paediatric specialties: endocrinology and diabetes; hepatology, gastroenterology, and nutrition; nephrology; rheumatology; and respiratory medicine.)

At a later stage the specialty could consider a non-compulsory exit examination in the form of a Certificate from the European Board (the training committee of the CESP). This already exists in a small number of adult specialties (including rehabilitation medicine). Although many junior doctors are highly resistant to yet more examinations, the current disparities in training, the inevitable movement of doctors throughout Europe, and the worrying levels of medical unemployment in some member states, may encourage them to seek objective evidence of a satisfactory specialist training. The process of seeking recognition takes a minimum of two years in even a small, well organised specialty, but nevertheless a start has to be made. ESSOP would be expected to take the lead and they and APEE have the basis of the necessary working groups to draw up recommendations for the undergraduate curriculum and common trunk as well as specialist training. They will need help from others in the field. The machinery of Europe moves frustratingly slowly, but it carries the weight of millions of children. Community paediatricians in the UK, who are already a long way ahead down the road, are invited to pause and put their shoulders to the wheel.

Conclusions

The conflicts and population movements of the last few years have further increased social morbidity and the disparities in children’s health needs and service provision between the countries of Europe. Paediatricians from east and west Europe have shared concerns and recognise that changes are needed in the way paediatrics is taught and practised at all levels. Although there is a European consensus that many of the elements of SCP should be assimilated into general and ambulatory paediatrics as part of everyday knowledge and practice, Europe has a long
road to travel to reach this goal. As yet these subjects are absent from the postgraduate common trunk curriculum, and inadequately taught to most medical students. A strong academic base is essential to promote and develop SCP in Europe, and this can probably only succeed if it remains allied to CPH as a single specialty. There are a number of steps that must be taken before specialty status can be achieved, and these will require hard work and cooperation.

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Smallpox in Boston a hundred years ago

Immunisation has always had its opponents and professional reactions to them have not always been exemplary. The last epidemic of smallpox in Boston, Massachussets began in 1901 and lasted for almost two years. A recent article (New England Journal of Medicine 2001;344:375–9) has described some of the excesses of medical fervour displayed in an attempt to control it.

The epidemic began in May 1901 and when it ended in March 1903 there had been 1596 cases and 270 deaths. Almost half (47%) of the cases had been vaccinated and in these the fatality rate was 11% whereas in unvaccinated patients it was 22%. In “public” (state) schools vaccination had been compulsory since 1855 and during the epidemic the rate of infection in children aged 6–10 years was about one sixth of that in pre-school children.

Initially, voluntary vaccination was offered but compulsory vaccination was introduced in December 1901. The penalty for refusing to be vaccinated was a $5 fine or 15 days in prison. Homeless and destitute people were thought to constitute a major risk to the rest of the population and men in cheap boarding houses were vaccinated forcefully by “virus squads”, often including three policemen to hold down the resisting tramp. An active minority considered compulsory vaccination to be an unacceptable offence against civil liberties and it was challenged unsuccessfully in the courts in January 1902. In an incident offensive by modern ethical standards, the chairman of the Boston Board of Health challenged those opposed to vaccination to allow themselves to be exposed to smallpox deliberately while unvaccinated. The challenge was taken up by one Dr Pfeiffer, who was taken on a tour of the smallpox hospital on 23 January 1902; by 8 February he had severe smallpox from which he recovered unexpectedly.

The last case of smallpox in Boston was in 1932 and the last case in the United States in 1949. Routine vaccination against smallpox ceased in the USA in 1971.