THE PLACE OF SOCIAL MEDICINE IN THE REORGANIZATION OF HEALTH SERVICES*

BY

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I propose to deal with my subject by attempting to answer the following three questions: (1) What is social medicine? (2) Why should social medicine be included in the reorganization of the profession? (3) How should that process be carried out?

The intimate association of medicine with cures and remedies dates from the earliest ages, and the art of remedial medicine has at all times made a powerful appeal to the human heart and mind. Its fascination has been constantly reinforced in modern days by the immense progress of clinical observation on the one hand and by the invaluable contributions of the scientific laboratories on the other. It is therefore scarcely to be wondered at that the glamour arising from correct diagnosis and efficient treatment has largely dominated the interest of medical men themselves, and also that of the public, in the activities of our profession. While it is true that parallel progress has been made in the field of public health and preventive medicine, those responsible for it have been obliged to work in an atmosphere permeated by apathy rather than by sympathy on the part of the public and without the measure of encouragement so readily afforded to those concerned with the relief of suffering. The public still cherishes much of its ancient fatalistic attitude towards the incidence of disease and disability, and is slow to appreciate the knowledge which has accumulated concerning their origins and the consequent increment, both actual and potential, in our preventive armament. Nor must we forget that our social system is so constituted that neglect of health preservation, ignorance of the laws of good health, and ill-health itself provide the dividends on which the livelihood of most doctors depends.

Various factors, therefore, have combined to put remedial medicine in a strong position. It has received so much support from the State, from the local authorities, and, in particular, from the generous public that, with improvements in its organization, its future progress may be regarded as well ensured. And this position is still further secured by the numerous centres devoted to teaching and research scattered throughout the country.

A Field for Research

Preventive medicine is, comparatively speaking, neglected, not so much by the State or by the local authorities as by the general public. Teaching in this branch of medicine has never received the encouragement and respect which it deserves, while research, though often brilliantly executed, has been largely restricted to such subjects as environmental and personal hygiene, epidemiology, and parasitology. And yet there is a vast field for research which has been little explored and which is best indicated by the term "Social Medicine."

Social medicine is not a new subject. It embraces a number of branches of medical, sometimes combined with lay, activity which are already being carried on under various names. Clinics associated with infant welfare and child guidance, the ante-natal departments of hospitals, school medical services, and institutes of industrial psychology and of tropical medicine are all examples which illustrate this fact. Nevertheless, it is difficult to avoid asking whether all these activities, all this effort, are making their full contribution to the advance of knowledge. Is this enormous mass of social material and social observation being so utilized as to hasten the attainment of the ultimate object of medical endeavour—the promotion and preservation of health and the prevention of disease?

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As we have already seen, remedial medicine is well provided with hospital and university centres where the investigation of pathological conditions is thoroughly carried out, where much light has been and is being thrown on the nature of disease, and where advances are constantly being made in methods of diagnosis and treatment. But the question why do certain individuals suffer from some forms of illness and others from different ones is rarely answered. We know the nature of a peptic ulcer, we may even be able to produce one in animals experimentally; we know how to diagnose it and how to treat it, but we are a long way from determining its incidence—why Smith is a victim and Jones escapes. But an answer to this question, as to many others, is not only essential to the promotion of public health but may perhaps be found only as the result of work in the social field, from a scientific study of the conditions under which both the sick and the healthy live and work.

We believe, therefore, that the time has come when preventive medicine should possess, like remedial medicine, centres of research staffed by men and women giving their whole time to the solution of a number of problems, many of which at the present moment seem to be nobody's business. They should be closely associated with the university medical schools on the one hand, and with hospitals or groups of hospitals on the other, the former providing the facilities for research and the latter the access and the key to material. We still await the establishment of the first chair and the first department of social medicine in this country.

The Scope of Inquiry

We should, I think, attempt to define the long-term policy of such a development. Its chief aim would be to expose the sources and bases whence arise ill-health and disability, by investigating the influence of social, genetic, environmental, and domestic factors on the incidence of human disease. Such a definition brings within the scope of inquiry such varying agents as heredity, nutrition, climate, and occupation, and does not disregard the part played by individual and mass psychology.

A second and equally important aim may be described as the search for and promotion of measures, other than those usually employed in remedial medicine, for the protection of the individual and of the community against such forces as interfere with the full development and maintenance of man's mental and physical capacity.

If, in the course of time, any success attends these two efforts we should see grow up an increasingly healthy and capable race and one much less dependent on the help of remedial medicine for its fitness and its survival. It would indeed be something worthy of these efforts if, a quarter of a century hence, the demands for hospital accommodation and the calls on private practice were to present a descending rather than an ascending curve. Some of you might even live to see the day when the pride of hospitals in the number of their in-patients and out-patients and in the length of their waiting lists gives place to a pride on the part of health services in the diminished and diminishing need for hospital accommodation.

I hope I have said enough to satisfy your curiosity on two points: (1) that there are to-day branches of our profession actively engaged in the promotion of public health the value of whose efforts might be enhanced by better organization, guidance, and co-ordination; and (2) that there is ample scope for more work and more skilled workers in the same field, which may be designated appropriately as that of social medicine.

Improving Professional Organization

The third question requires further consideration. How can these deficiencies in our professional organization be best met? I have already indicated that the first step is the establishment of professional departments or institutes of social medicine in close association with hospitals, and I entertain no doubt that we shall see this development in several centres of this country in the next few years, following the example of what is already taking place elsewhere.

• An indirect result of this step, one that many of us would welcome, would be the influence which a professorial department of social medicine would bring to bear not only on research in its own subject but on the medical curriculum. If improved public health is the aim of our health services it is essential that the general practitioner be enlisted in the ranks of the social medicine army, and for that reason alone his training must in some measure, and in much greater measure than it is to-day, be directed to that end. With him, in his daily round, lies the opportunity of observing and assessing the evidence of malnutrition, of overstrain, of hygienic ignorance, of dental neglect, of psychological maladjustment, and of many other defects arising largely out of our social system. To him also is given the opportunity, by reason of his intimate relations with his clients, of educating the public in all matters of health and sickness. With ready access to a centre of social medicine to which he could bring both his observations and his problems, and where the latter would be the subject of intensive study and research, the practitioner might well find himself, to quote the apt words of our chairman, Sir Robert McCarrison, engaged in "piloting the ship safely to port instead of spending the greater part of his time in salvaging wrecks."

At this juncture it would be impossible as well as unwise to attempt a description of the accommodation, the equipment, and the staff required by the head of a department of social medicine. It is inevitable, and indeed desirable, that these should be determined by the interest of the individual professor or director in one or more of the innumerable problems open to him in the field of his choice.

Thus, it may be that in one department of social medicine the personal bias of its head may be in the direction of nutrition and the physiological and the biochemical problems with which that subject is bound up; in another his chief interest may lie in genetics and its bearing on eugenics; and in a third his predilection may lead him to investigate the statistical aspects of disability. In each, however, some member of the staff should be responsible for collating information from the social field and for co-ordinating the activities of the social services already in existence and carrying out valuable work. I envisage close collaboration of this department with such auxiliary services as those provided by hospital almoners, district nurses, and health visitors. In effect, departments of social medicine should play a prominent part in that co-ordination of health services, of voluntary or local authority origin, which seems to be the accepted policy of post-war planning.

Conclusions

To sum up my conception of the part to be played by recognized centres of social medicine, I would describe them as destined to fulfil the following needs: (1) To promote research in a subject of vital importance to the health of the nation hitherto inadequately explored. (2) To reorientate the aims of the medical curriculum in such a direction that the doctor of the future will be trained not only to fight disease but to be an architect of personal and public health. (3) To organize post-graduate training in social medicine. (4) To co-ordinate and guide the activities of social and health services already established or to be established in the future.

Owing to some statements that there is so acute a shortage of health visitors, especially in Lancashire and Yorkshire, as to justify the appointment (in four towns already) of unqualified persons, the joint consultative committee of institutions for the training of health visitors has conducted a survey. The number of persons who took the health visitor's certificate in 1941—245—was certainly lower than in the immediately preceding years, but was almost equal to the average of the ten years 1928-37. From the figures of those preparing to take the examination in 1942, the early months of the present year may yield another 195. Local authorities with unfilled vacancies have been circularized, but only 22 still wished to fill vacancies of long standing, and half of these were offering salary scales with a maximum of less than £250 a year. Seven of these 22 areas are either on the East Coast or the Thames estuary. The conclusion is that although there has been some reduction in new entrants since 1938, there is no widespread or acute shortage, and no justification for "dilution." Difficulties are due to inadequate salaries and other unattractive conditions, which were operating even before the war.

War Surgery of the Extremities

This is one of a short series of articles based on lectures given at the British Postgraduate Medical School, Hammersmith

THE MANAGEMENT OF BURNS

BY

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Burns were originally divided by Dupuytren into six degrees. A first-degree burn caused erythema, a second-degree burn vesication, and a third-degree burn affected the whole dermis. The remaining degrees affected successively the subcutaneous tissue, the muscle, and the whole limb. As treatment and prognosis are the same for each of Dupuytren's last four degrees, no purpose is served by separating them, and nowadays any burn which affects the dermis or penetrates more deeply is known as a third-degree burn.

Cause of Shock

Let us first consider the effect of a burn on the patient as a whole. Within a few seconds or a few hours he may suffer from "shock." I have the good fortune to lunch and sup daily with a scientist who has studied "shock" perhaps as closely as any man living. Every time I say to him, "Tell me, G—, are you yet able to inform me what 'shock' is?" he shakes his head sadly and says, "No." He then says that he comes across patients whom we surgeons tell him are "shocked" and in whom he finds the greatest diversity of physical signs. Some are pale, some are blue, some are euphoric, some apathetic. Most have a low blood pressure, some have a normal blood pressure, and others have a high blood pressure. In most the pulse rate is rapid, in a few it is slow. Some appear to be suffering predominantly from fright or from cold, others from blood loss, and yet others from a mixture of these or from none of them. This state of affairs is the greatest stimulus to the research worker, but must be a source of perplexity to the clinician. As I possess all the qualifications for stepping in where angels fear to tread, I will give you a definition of "shock" which will at least enable us to understand each other. "Shock" is the general reaction of a patient to nociceptive stimuli of a physical, chemical, thermal, or psychological nature. The patient usually feels ill; his skin temperature is usually low, his pulse rate rapid, and his blood pressure below normal. I suppose that others have dealt fully with the theoretical aspects of shock, but I should like briefly to recapitulate some of the theories as to its causation and see how these fit in with our clinical experience.

Crile first suggested that shock was due to nerve impulses from the site of the injury, and he based his views on the effects of nerve section in the traumatized limbs of experimental animals. More recently the late Major O'Shaughnessy has revived this theory, following the results of his cross-circulation experiments. We, as clinicians, are unable to appraise these experimental findings, but we do know that any increase in the nociceptive stimuli to a wounded or burnt patient aggravates his shock. We know that these patients must be moved with the care and gentleness accorded to a piece of Dresden china, and that, if possible, it is better not to move them at all. We know, too, that morphine in full doses is our greatest pharmacological ally. In burnt patients the use of sedatives is so important that it is necessary to have a clear idea of the dosage to be given to every class of patient, and the accompanying table should be memorized.

Dale and Laidlaw later propounded the toxic theory of shock. According to them a histamine-like substance was liberated from the site of the trauma which, being absorbed into the blood stream, brought about the changes described as shock. This theory has a bearing on the value of the tourniquet for traumatized limbs; but, in regard to burns, the absorption of toxic products assumes greater importance at a later stage when the