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‘Rules for radicals’: a subversive’s guide to putting social paediatrics into practice

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Abstract
Paediatricians witness the social determinants of health in action in their clinical practice every day. By pushing hundreds of thousands of children into poverty, the global coronavirus pandemic has only made the link between social justice and health inequalities in the UK clearer and more relevant than ever. Yet paediatricians face a glaring dearth of opportunities to meaningfully engage with the issue, and lack the resources with which to learn what can be done about it. Using real-life examples from the author’s own professional experience, this article demonstrates how ordinary paediatricians can apply a theoretical framework to clinical practice to move from why paediatricians ought to orient their practice towards the social determinants of health, to how. Rather than waiting for institutions to lead the way, this article provides ‘rules for radicals’ and makes a call for bottom-up, grassroots organizing around social justice and developing the knowledge and tools to fight it, including the exciting new initiatives of the ‘social tool kit’ and the ‘social incubator’.

Keywords child poverty; community of practice; health inequalities; professionalism; social determinants of health; social justice

Introduction
In 2018, my colleagues and I published an article in this journal as part of the Social Paediatrics symposium titled, “Practising ‘social paediatrics’: what do the social determinants of child health mean for professionalism and practice?” The article was our attempt to set out a framework for how paediatric health professionals might reframe their roles and responsibilities in light of the wider social, economic and political determinants affecting their patients’ lives. The article received some attention, but like so much academic output, it hardly went viral.

Since then, the world has both changed and stayed entirely the same.

The outbreak of the global coronavirus pandemic at the beginning of 2020 changed the world irrevocably. Even at the time of writing, COVID-19 rages on in most parts of the world, significantly restricting the expansiveness and shape of human lives. And yet, the world it is utterly the same in the sense that COVID-19 merely exposed what had always lurked beneath. Thanks to England footballer Marcus Rashford, child poverty in the UK hit the news headlines like never before, and the nation was forced to confront how the pandemic pushed as many as 400,000 children in the UK into poverty.

But what about the already existing 4 million children living in poverty in the 5th richest country in the world? Coronavirus granted lightning insights about our world, crystalizing in days what health researchers otherwise take months or years to demonstrate: that social injustice and health inequalities are closely intertwined.

In this context, a whole generation of doctors – not least frontline paediatricians - found themselves fighting not only viruses and disease, but also a tide of illness resulting from the failure of society to provide the basic conditions for a good life. I see the results of this societal failure in my clinic every day: in the rising numbers of young people with mental health problems, the harrowing cases of physical and sexual abuse in families under stress, and the overwhelming levels of obesity as children become ever more sedentary in the UK. This is the social determinants of health in action.

Sadly, the relevance of our 2018 article, and the need for a return to a Social Paediatrics Symposium, has only grown. Judging from the proliferating calls for help with dealing with this matter, paediatricians are finally coming to terms with their role in this crisis and are ready to stem the tide.

Where our original article laid the theoretical and philosophical framework for why paediatricians ought to orient their practice towards the social determinants of health, this article seeks to help those with questions of a more practical nature: how do we make this happen? My colleagues and I have written on the specifics of what clinicians can do in relation to social adversity and child poverty elsewhere, and I would direct you to the “Further Reading” list for good starting points for getting to grips with this issue. But the problem we face is huge. Despite today’s fast-paced, click-bait glare no single article or blog will be enough to equip you to deal with this issue in its entirety, and that’s in large part due to the fact that, to put it simply, this stuff hasn’t been worked out yet.

This article offers the reader three key things.

First, I make the case that the gaping holes in medical education and paediatric training in relation to the wider determinants of health lead to the kind of desperation and incapacity all too common amongst paediatric trainees today.

Second, I argue that while institutions such as the Royal College of Paediatrics and Child Health (RCPCH) are, at last, starting to respond to this desperation from their members, we should not wait. We need more and we need it faster. How can ordinary paediatricians start building the expertise and capabilities required to deal with the social determinants of health, and what I call the ‘social tool kit’ from the ground up? Using the framework of our original article, I use examples from my own experience and show how we can put each step into action.

Finally, I point towards a new initiative that attempts to draw these threads together and build both a professional knowledge base as well as forge a community of practice from the bottom up in what I call a ‘social incubator’.

Mind the gap
Poverty is the most important determinant of child health in the UK, associated with adverse health, developmental, educational and...
long-term social outcomes. As clinicians we bump up against its effects on the children we look after on a daily basis. Poor children are twice as likely to die as rich ones. Poor children are up to three times more likely to be injured. Poverty is insidious, affecting every aspect of a child’s life including their risk of serious morbidity and mortality from diseases such as cardiovascular disease, diabetes and cancer. Indelibly printed into every molecule of our being, poverty is extremely difficult to recover from. Unequivocally, paediatricians need to know about social deprivation.

And yet, as we described in “Practicing Social Paediatrics”, though paediatricians are largely aware of the relevance of social determinants to their work, they rarely feel empowered to tackle them. Instead, they feel conflicted about what they should do and how far this role ought to extend. The seismic economic and social repercussions of the coronavirus pandemic have only intensified this predicament. Research conducted among paediatricians training in the UK in 2020 reveals despair at the alarming state of child health, desperation that clinicians cannot do more for their patients in clinic, and disillusionment with the profession for failing to respond to these challenges effectively. There has been a large uptick in interest in both the previous article and those in the Further Reading list, and frequent requests from paediatricians across the country. All this suggests that today’s paediatricians do not feel that their learning and training needs in relation to the social determinants of health, and child poverty in particular, are being met, despite this being more relevant than ever.

Why are today’s paediatricians struggling so much? The answer is complicated, and a nuanced and respectful handling of it is for another arena. However, important factors at play include the medical profession’s historical over-reliance on the biomedical lens for explaining health and disease. Believing the clinical role to be confined to bodies and their ailments, medical education focuses on molecules and the microscopic at the expense of the bigger picture. No wonder then, that when faced with massive problems such as child poverty, the average clinician throws up their hands up in exasperation saying, “That’s someone else’s job”. But whose?

Decades of inaction have shown, that even if it were true that “it’s not our job” to worry about the wider aspects of our patients’ lives, if we were hoping that someone else would come along to help, we’d be waiting a very long time. Changes to the structure, duration and content of postgraduate training in recent years, means it is increasingly devoid of opportunities for paediatric trainees to consider or act on the bigger picture of the lives of their patients. Management, leadership, quality improvement and public health skills are increasingly seen as an “add on” option to a select few through special courses over and above standard training.

While the RCPCH’s Progress curriculum has made a valiant attempt to address previous curricular concerns, without real-life, on the ground opportunities for all junior paediatricians to encounter and practice the kinds of knowledge and skills required to deal with issues that do not fall within the bounds of standard biomedical training, when a child living in poverty comes through the doors of A&E, most trainees end up feeling that they are flailing blindly in the dark.

The RCPCH is currently considering how it might help prepare paediatricians for the complex world they must navigate in 2021. But large scale institutional change is slow. I argue that we should not wait for those high up to make this transformation for us. The size of the problem, and the depth of our patients’ suffering, demands a swifter and more pragmatic response. I believe that we — those who work on the frontline and who exist in the gap between what we would like to do and what is actually possible — are best placed to lead on creating the tools for helping ourselves. No doubt, we should rightly expect our professional college to provide education and support in ways we need it, but we can also help to create this knowledge ourselves, and most importantly, put it to use where it matters most: in every interaction with our patients.

We’ve had enough talk; it’s time to get our hands dirty.

Getting hands on: ‘the social tool kit’

Using the framework suggested in our original article, and with some examples from my own experience, let me now illustrate how it might be possible for ordinary clinicians to put each step into action to help develop what I call the ‘social tool kit’.

At the level of the individual and interpersonal
Understanding social history: the first step in addressing the social determinants of health in clinical settings is identification. Although most parents are happy to talk about money, housing issues and food insecurity, awkwardness and embarrassment often stop clinicians from raising these issues at all.

How can we circumvent the perceived discomfort related to probing social history taking? We developed two clinical screening tools for social risk factors: one for the acute clinical setting and one for use in community child health clinics (Table 1 and Figure 1).

Both tools represent examples of ordinary trainee paediatricians bringing their clinical and quality improvement skills to bear on solving real-world problems in their practice. Important guiding principles for this kind of work include:

- involving and engaging relevant stakeholders, including multidisciplinary staff and patients in the co-production of any potential tools with an eye to ensuring that it is ‘bespoke’ for the locality
- a low barrier to entry in that tools need to be fast, easy, and intuitive to use without sacrificing the sanctity of the clinician–service user relationship and nuance of human conversation
- universal and ‘neutral’ screening tools help to make it acceptable to clinicians and patient, at the same time as creating opportunities for deeply personal and potentially emotionally charged conversations
- a wider conception of health which allows different goals of healthcare beyond traditional measures and data to include what really matters to both staff and patients

Our work represents only the beginning; there are many potential areas for development and next steps, and we actively encourage this.

Social prescribing: discomfort with tackling social issues in clinic often arises from clinicians feeling that there is so little that they can do about the problems that might be elicited. What is the point of asking about poverty if there is nothing that doctors can do about it? Though far from a panacea, social prescribing, a
Refocusing local service provision

While applying a social lens to paediatrics ought to encourage us to reconsider what child health services look like, bringing about changes to local service provision, especially as an ordinary and often junior clinician, is not easy.

Frontline clinical staff developed the initiatives above as Quality Improvement (QI) projects. This was intentional. QI methodology was followed and project success was evaluated using predefined measures in order to justify the project to managers and colleagues. Given the resistance and reluctance of that is all too familiar to those who have ever tried to make change in the NHS, especially when that change has been in pursuit of wider societal goals considered outside the remit of health organisations, we found that the use of QI framing to justify and legitimize our work enabled it to become something of a Trojan horse—its true motivation was, at least in certain contexts, disguised or downplayed in order to ensure its smooth passage.

As I have argued with others elsewhere, QI has tremendous potential to tackle the shortcomings of health services, but requires conscientious and critical engagement of health professionals for it to lead to genuinely better and further-reaching outcomes for child health. Our experience shows that orienting improvement work and local research towards what matters in people’s lives—in the lives of children and families and in professional vocations—can lead to more ambitious improvement agendas that not only focus on narrow health outcomes but on wider social and moral goods. Aligning QI to what matters most in child health is fundamental. The work described above gained momentum and spread quickly to other sites in London. On the whole it has been spread by word of mouth and championed locally by clinicians, indicating that it feels both practicable and worthwhile to staff on the ground.

For instance, spin-off projects at Northwick Park and North Middlesex hospitals have led not only to concerted partnering with local organisations to provide more joined up care for families in need, but even to successful bids to commissioners to
Social Determinants of Health Questionnaire

This questionnaire aims to identify areas of everyday living which can be missed during appointments but impact families and their healthcare. It will be given out to all families coming to our clinics. We hope to improve our services by picking up on these issues and worries so we can offer advice and support.

For each statement, please mark on the scale how relevant it is to you and your family i.e. how closely each statement fits with your situation.

1. Lack of access to affordable and reliable transport has made it difficult for me to get to this medical appointment or has caused me to miss medical appointments for my child/children in the past.

How relevant is this to you with 0 being not relevant at all and 5 being very relevant?

![Scale for relevance](0 1 2 3 4 5)

2. I worry about being able to pay for my housing and/or my electricity/heating bills.

How relevant is this to you with 0 being not relevant at all and 5 being very relevant?

![Scale for relevance](0 1 2 3 4 5)

3. I worry about where my family live due to one or more of the following problems:
   - Pests e.g. bugs, mice or rats
   - Mold, damp or leaks
   - Broken heating/oven
   - Missing smoke detectors
   - Difficulty accessing house/flat (e.g. due to a disability, too many stairs, poor lighting)
   - Not enough space

How relevant is this to you with 0 being not relevant at all and 5 being very relevant?

![Scale for relevance](0 1 2 3 4 5)

Figure 1 The Social Determinants of Health Questionnaire (SDH-Q), a social risk screening tool used as conversation opener in community setting. Reproduced from reference 1 with permission from BMJ Publishing Group Ltd.

change local services and argue for more resources. In this way, ordinary paediatricians have been able to translate what they see in their everyday practice into evidence that local leaders are forced to engage with, and bring about tangible change on the ground for how child health is practiced locally. In addition, these projects have successfully changed team cultures. In Newham, the multidisciplinary, egalitarian and collaborative approach led to improved team dynamics and morale. In Bristol, a trainee presented one of the projects above in a local journal club, setting in motion a chain of events which not only helped to change the conversation but enabled other trainees to develop the work in their own way. These are the kinds of broader
repercussions of applying a social lens that enable us as a service and a profession to do this work more often and more successfully.

**At the level of national policy and advocacy**

The RCPCH states that, “Paediatricians are committed to a policy of advocacy for a healthy lifestyle in children and young people and for the protection of their rights.”

When most paediatricians think of ‘advocacy’, they see it as a lofty venture that must be the preserve of the great and the good, leaving it to the College to take this mantle for the rest of us. This is a mistake for two reasons. First, there is only one Royal College and our patients are many. Their concerns, problems and struggles are unique and they far exceed what individuals in the College can deal with. Second, and more important, is that we, as ordinary clinicians, paradoxically have far more power than the College. By this I am referring to the limits placed on the College as a royal institution with charity status. These factors necessarily constrain what the College can say and the kinds of campaigns and debates it can freely engage in. By contrast, within the bounds of normal decency and patient confidentiality, ordinary paediatricians face no such restrictions.

What could advocacy for the ordinary paediatrician look like? The chief goal is to change the conversation and this can either be in the general public or within the profession itself. In the first instance, Dr Julie-Ann Maney, a Consultant Paediatrician in Belfast, was able to bring the shocking state of child poverty to the public in Ireland through writing about her experiences and following that up with TV and radio interviews. Through the medium of the creative arts, Dr Najette Ayadi O’Donnell, at the time a paediatric registrar in London, with colleagues combined video and poetry to communicate directly with the nation’s
Figure 2 Bespoke local child poverty leaflet with resources that increase income, provide essentials and improve participation used in conjunction with Table 1. Reproduced from reference 1. © G. Singh and H. Zhu 2020. Reproduced under CC BY-NC (http://creativecommons.org/licenses/by-nc/4.0/).
children during the worst of the Coronavirus pandemic in 2020, generating a vibrant and active discussion on social media. In the second category, trainees often have opportunities to direct the shape of their own training. The Royal Society of Medicine’s “Child Health Festival” in 2018 and 2019, and the “Child Health on Trial” session at the RCPCH annual conference in 2020 are examples where I with other paediatric trainees co-opted traditional venues for postgraduate learning to showcase and highlight novel topics or approaches to clinical practice. This creates the space for curious paediatricians to come together and set new agendas for where child health needs to go.

To properly lean into the advocacy role, paediatricians must first see their roles as extending beyond the limits of the clinic into the public sphere. This is an uncomfortable space for many clinicians, but as the above demonstrates, not all interventions necessitate personal exposure. Besides, this discomfort is something that we need to overcome, if we are to fully utilize the power of our profession to bring about change in the world. Paediatricians can bring the issue of the social determinants of health the pain, anguish and injustice faced by our patients every day - to the public in a way that capitalizes on our credibility. Doctors carry significant social and cultural capital; our messages are listened to. This is power and it should not go unused.

We all have a part to play. With whatever means you have open to you, I encourage you to engage with campaigning organisations in the further resources section to help get your patient’s voices heard.

Powering up: creating the social tool kit and social incubator

I hope the above demonstrates how, when focused on applying the social lens, the actions of ordinary paediatricians in training can bring about significant, impactful changes to clinical practice at the individual, local service and national level. These approaches explicitly make use of resources and tools that clinicians have available to them, rather than attempting to enact high-level, distant institutional or social change. Why? Because this is all about power.

Our patients reveal that it is axes of power and structural violence that connect us all in this messed up whole. Unfair rules prescribe that some of us can come out of this mess better than others. It should not be our job to pick up the pieces of a broken society, but if we’re doing it anyway, we should be asking why. Because this is all about power.

Our patients demonstrate that while most of what humans need ought to be plentiful, easy to access and free, many children today - even in rich countries - have to go without. You can’t
grow a happy, healthy human in times of austerity or when public commons have been privatized. Make no mistake: if we are to end the poverty that drives ill health, we need to fight for an alternative vision of the future.

But, when faced with growing numbers of children suffering the health impacts of social adversity in a health system under near constant pressure, it is easy to feel at a loss to know how to help them with the feeble tools at our disposal in clinic. How can we rebalance and reclaim power for both our patients and ourselves?

The title of this article references the seminal 1971 book "Rules for Radicals: A Pragmatic Primer for Realistic Radicals" by community activist and writer Saul D. Alinsky. It is about how to successfully run a movement for change. Though much less ambitious, this article is a first attempt at creating a guide for paediatric trainees with a social conscience to use in service of their patients who are in short supply of social, political, legal, and economic power.

But confronting the social determinants of health in clinical practice is hard. My own experience has been one of years of frustration, disheartening setbacks, and burnout as a result of misalignment between my personal values with those of the organisations I worked in. Should you follow orders or do what is right? Dealing with this question causes tension, and is stressful. It has largely been a lonely and unsupported path with huge amounts of emotional labour rendered for free. But, I am thankful; the work that is offered in these pages has been made possible through the collective actions and care of a group of equally committed trainees concerned about the same issues. Together we have been able to stimulate ideas, share concerns and commiserate as well as distribute the burdens that fall on already encumbered shoulders.

How can we make addressing the social determinants of health easier for ordinary clinicians? If we, as a profession, want to move beyond rhetoric and platitude toward action, then we must take the responsibility for developing the tools and approaches we need ourselves. More powerful still, is to create the necessary conditions for this to be a sustainable, longer-term endeavour. As such, I propose that we need a community of practice in which such ideas and ideals can be nurtured and held safe.

Hence the “Social Incubator”: a space where socially-conscious clinicians addressing the social determinants of health in clinical practice can learn from each other, refine each other’s ideas, and build solidarity across geographical and hierarchical lines. As part of this community of practice we might share insights from our own struggles and compile this collective practical wisdom in a creative, co-produced commons: the “social tool kit”. The idea would be that doctors and patients across the country could contribute to this repository, or living resource, which grows and evolves with time and through lived experience. The social incubator is the network that connects us all, and the social tool kit the weapons with which we can fight together.

This is a new idea and still in its inception, but plans are already afoot. I envisage a web-based platform to house this incubator and tool kit for now, in order to allow resources and ideas to evolve and mature easily and to be easily shared. We have called it the Wellbeing and Health Action Movement (WHAM). As the name suggests — and as powering up demands — we may be small, but we pack a punch. I invite you to take part in not only empowering yourself, but also contributing to help empower others.

Remember, Martin Luther King Jr. and Gandhi didn’t follow the rules. Nothing ever changed by following the rules. I am calling for disobedience, but you can keep it civil. Disobedience, after all, can look like innovation and invention. Through the social incubator, we can all come up with news ways of practicing, whether it’s how we conduct consultations, deciding who our pathways reach, or the kinds of questions we focus on in research. It’s our practice for our patients. We can make the changes now. Don’t wait for those in power to show the way, or we’ll be waiting forever.

In this way, it is my hope that, we, as ordinary paediatricians, from the ground up can tackle some of the most challenging problems faced at the doctor-patient interface and to help us do our jobs as they are meant to be done: wholeheartedly.

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FURTHER READING
Mitchell P, Cribb A, Entwistle V, Singh G. Pushing poverty off limits: quality improvement and the architecture of healthcare values. BMC Med Ethics 2021; 22: 1–13.

ONLINE RESOURCES
British Association for Child and Adolescent Public Health - Child poverty campaign: http://www.bacaph.org.uk/advocacy/child-poverty-introduction.

Dr Julie-Ann Maney’s blog: https://medium.com/rcp-ch insight/im-a-paedia trician-and-i-see-the-impact-of-poverty-and-childhood-hunger-486b5629b9fc.

Free Open Access Medical Education (FOAMed):
- Call to Arms: Fighting Child Poverty Together Part 1: https://www.paediatricfoam.com/2021/03/call-to-arms-fighting-child-poverty-together-part-1/.
- Call to Arms: Fighting Child Poverty Together Part 2: https://www.paediatricfoam.com/2021/03/call-to-arms-fighting-child-poverty-together-part-2/.

“Listen Up!” from Dr Najette Ayadi O’Donnell and company: https://www.youtube.com/watch?v=xnsUoSDeWsQ.

MedAct - Health professionals for a safer, fairer, better world: https://www.medact.org/.

Wellbeing and Health Action Movement (WHAM): A movement to unite, inform and inspire healthcare providers fighting inequality in child health. https://www.whamproject.co.uk/.
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