

On “A Practice of Social Medicine” by Sidney and Emily Kark.

Jaime Gofin

In the first chapter of Kark and Steuart's *A Practice of Social Medicine*, published in 1962, (1) Sidney Kark and Emily Kark introduce the basic conceptual framework of Social Medicine. (2) They do this through a series of case discussions based on their own field experiences, which began in 1940.

A practice of social medicine

The chapter opens with this sentence: "Social Medicine may be regarded as a practice of medicine concerned with health and disease as a function of group living." In this initial sentence, they tell us that social medicine is a practice, not just a theory; it is an integral part of medical care; it addresses health and health promotion in addition to disease; and it is not limited to individuals, but is concerned with the family and community context in which we live.

The Karks' description of the communities in which they have practiced Social Medicine are colorful and rich, providing vivid examples of how this practice can benefit many aspects of community life. They begin with a discussion of a village community in the rural district of Kwazulu-Natal, Pholela. They show that knowledge of population characteristics - demographic, cultural, and social - provides basic information for an assessment of the determinants

of health and the available resources in the community.

One of the basic resources they describe is, of course, the type of health service available. The health services made available in Pholela by the Karks in those early years were pioneering. A team of doctors and nurses were responsible for health assessments at the individual, family and community levels. These assessments formed a community diagnosis on which health promotion and preventive services, as well as curative services, were based. These features are now in the frontline of proposals by international health organizations for integrating clinical care and public health. (3)

An essential component of social medicine practice was a team that included, in addition to physicians and nurses, a health educator and a health recorder. The role of the health educator extended beyond the provision of health information; the educator played a key role in encouraging communication. In those days, the distinction between health promotion and health education had not yet been made. (4) The health recorder was trained to measure progress and change in the community's state of health and to evaluate the health programs.

The process for promoting health at the community—or public health—level should resemble the process of providing clinical care at the individual level. It starts with a diagnosis. Just as the knowledge of physiology and pathology are necessary for individual patient diagnosis, "epidemiology is the foundation science for social medicine".

The family is emphasized in the practice of Social Medicine. As described by the Karks, the

From the School of Public Health and Community Medicine, Hadassah and Hebrew University Jerusalem and the School of Public Health and Health Services, George Washington University
Conflict of Interest: none declared
Corresponding author: Dr. Jaime Gofin,
Ben Zeev 13/3 Jerusalem 97281, Israel
Email: jaime@md.huji.ac.il

family is the “primary group”, which has "intimate and enduring qualities" that health practitioners should strive to know through face-to-face relationships, especially with regard to their habits, feelings, and beliefs.

Individual care was conducted within the “family diagnosis”, which required epidemiological, as well as clinical skills. A contemporary of the Karks, John Rodman Paul defined clinical epidemiology as "a marriage between quantitative concepts used by epidemiologists to study disease in populations and decision-making in the individual case which is the daily fare of clinical medicine". (5) Integrating epidemiology into the work of a family physician was an innovative and important professional shift at the time.

The chapter provides a case illustration of these methods in industrial Durban, a mixed ethnic community. This begins with a detailed and precise analysis of children with nutritional failure. Through a meticulous, detailed but

relatively simple, study of 600 families, randomly selected and conducted by nurses, they were able to identify and characterize the elements of an abnormal family-life-situation, described as social pathology, which were considered as determinants of their health status. The health of the child is assessed within his/her family-life-situation. Without an understanding of the family, it would not be possible to reach an adequate diagnosis.

Conducting research is an important part of health services, and was a distinctive mark of the Karks' work. Research includes collecting and analyzing demographic data, information about the health status of community members and data about their cultural, social and behavioral characteristics. Information about the habitat and environment was an integral part of the diagnosis. Thus, measurement of meteorological variables, such as rainfall, temperatures and humidity was performed. In fact, the authors tell us that an observation unit for meteorological measurements was installed in Pholela, and was considered



Pholela, South Africa; Photo courtesy of Dr. Jeremy Kark

a part of the primary health care services. This was quite an innovative approach forty years before the Alma Ata Declaration on Primary Care!

The initial community assessment was followed by ongoing surveys that revealed deficiencies in sanitary conditions and in the consumption of meat, milk and green vegetables. Consequently a demonstration unit was established at the health center to deal with these two urgent health problems. Two pioneering intervention programs were established: an inexpensive model latrine to improve sanitary conditions and a vegetable garden in which the staff and members of the community, including patients and school children, were involved. The vegetable garden program included nutritional education and also aspects of community development, such as agricultural techniques, a farmer association and a local market for home produce. (6) Not all these activities were successful, and while the evaluation showed that the home gardening was accepted, it also showed that the sanitary programs were much less successful. Studies of these issues found that cultural and belief systems were discordant with these interventions and explained the low response to these new health programs.

Finally, teaching was an integral part of the Karks' vision of health services. Teaching carried out in the "community laboratory" was a comprehensive program based on health and disease, as they were expressed at the primary care level. Students of various health professions participated in clinical and in community health studies in family practice and were thus involved in all aspects of social medicine including the care of individuals, family and community. Student involvement was crucial in the design of community health education projects. These education projects linked epidemiological studies to the "social and cultural changes". In this way students recognized the "importance of associating *what* people do with the *why* of their so doing".

In summary, this pioneer practice of Social Medicine in the 1940's and 1950's integrated clinical care and public health through:

1. Consideration of the community as a whole;
2. Recognition that behavioral, cultural and social characteristics were crucial components of assessment of health and of planning of care;
3. Provision of health care by a team;
4. Use of epidemiology as a tool for the assessment of health determinants and evaluation of care;
5. Use of teaching and research as integral parts of health services.

The genesis of the Kark and Stuart book lay in their 20 years of field experience of Primary Care with community-orientation, in the framework of the particular socio-economic-political context of South Africa. Through this work Sidney and Emily Kark demonstrated their commitment to the health of the African population.

Who were Sidney and Emily Kark?

Sidney Kark's broad view of the social, cultural, economic and political determinants of health found expression in many publications, such as "The economic factor in the health of Bantu in South Africa", (7) and "Problems of national health", both of which were written while Kark was a medical student. (8) Together with Emily Kark, he founded the Society for the Study of Medical Conditions Among the Bantu. (9)

Based on their work and activities as medical students in Witwatersrand University Medical School, Sidney and Emily Kark were recruited in 1940 by the Secretary of Health of the Governmental Health Department of South Africa to create a Pholela Health Unit in the rural area of what is today Kwazulu-Natal. (10) Services offered at the Pholela Health Unit went beyond what was offered at a typical clinic setting. This Unit embraced a new concept of health care service - the community health center. It integrated individual-based treatment with community health activities. The model of health care created in Pholela was eventually adopted throughout the country in a nationwide network of 44 community health centers. The Pholela Unit itself later became part of the Institute of Family

and Community Health in Durban. (9,10) In 1946, Sidney Kark was named as Director of this Institute, and later, became the Chair of Social, Preventive and Family Medicine of Natal University Medical School in Durban.

Over 200 health centers were planned for South Africa along the lines proposed by Kark. Unfortunately, changes in the government of South Africa--which introduced the apartheid policy--initially interrupted the development of new health centers, and ultimately forced the closure of all centers. Sidney Kark was compelled to leave the country at this time, as these closures were emblematic of the apartheid regimen's efforts to negate his ideas and dismantle his achievements. (11)

In 1958, Sidney Kark became founding chairman of the Department of Epidemiology in the School of Public Health at the University of North Carolina in Chapel Hill. As planned, a year later he and Emily Kark left North Carolina for Jerusalem, where, together with a multidisciplinary team of their colleagues from Durban, they established the Department of Social Medicine of the Hebrew University (9) and the Hadassah Medical Organization. In 1960 the Department established a Master in Public Health (MPH) program for Israeli health workers and in 1970, an International MPH Program was created. Together these programs have some 1200 graduates from 85 countries.

It was at the Pholela Health Center and in Durban that the Karks developed the "seeds" of what Kark later named the "community oriented primary care" (COPC) approach. They introduced these COPC concepts in Jerusalem at the Kiryat Hayovel Community Health Center. This health center became the base of the Department of Social Medicine in which COPC was practiced, developed, demonstrated, evaluated and taught to students of health sciences in Jerusalem. (6) Throughout his professional life, Sidney Kark integrated clinical knowledge, rigorous research methodologies and social justice into his practice of medicine and public health. Kark's keen oral and written communication skills enabled him to

reach varied cultures and diverse professions in introducing the COPC approach and causing change in how medicine and public health are practiced worldwide. (12) Sidney was a prolific writer, and published a number of books. In 1962, his first book described his concepts of social medicine. (2) His second book *Epidemiology and Community Medicine*, (13) emphasized the essential role of epidemiology in this branch of medicine. Later he merged his ideas into what is now known as Community Oriented Primary Care, and published a book, which firmly established this approach as a science: *The Practice of Community Oriented Primary Health Care*. (14) In 1994, the publication of a book on COPC in Spanish, which was prepared and edited by SL Kark and his team, (15) is a clear indication of the support that Kark gave to the work on community orientation initiated by us in Spain in 1986. (16)

Sidney and Emily Kark's latest book



Dr. Emily Kark, Photo courtesy of Dr. Jeremy Kark

Promoting Community Health: From Pholela to Jerusalem (6) contains an overview of their work in Social Medicine throughout their professional life.

Among the many articles published about the Karks and their work, one of particular note is the article "What is Social Medicine" from the January 2005 Monthly Review. This article analyses the relationship between Social Medicine and social concerns in the twentieth century and makes reference to three "physician activists", including Sidney Kark, Salvador Allende, and Che Guevara. This is the first time that Kark has been mentioned together with Allende and Che. Although each of these men took very different life paths, all three embraced elements of Social Medicine as a means toward social justice. While Salvador Allende and Che Guevara opted for political engagement as expression for their ideology, Sidney Kark chose the field of public health. Keeping in mind the diversity of their paths it is worthwhile to emphasize the common influence for social justice that they brought to the diverse groups of people interested in their life and actions.

I was introduced to the work of these three men in different ways. While working in medical student and professional associations in Uruguay and Latin America, in the 1960's and 1970's, I became familiar with Salvador Allende's social medicine ideology and his involvement in academic and political life. Che Guevara's political involvement was, of course, well known, and I had the opportunity to meet him in the beginning of 1965. Our conversation led me to a deeper study of his written works in Social Medicine. One of Che's writings that was never finished, "The Doctor's Role in Latin America", was planned as "...a long essay in fourteen chapters covering not only public health problems, clinical problems, and the economy of disease and its geopolitics, but also projections for the "socialist future" of social medicine in the continent". (17)

My relationship with Sidney Kark began in 1972, when I studied public health under him, later



Sidney & Emily Kark, Photo courtesy of Dr. Jeremy Kark

I worked with him. Eventually, I became Director of the Hadassah Community Health Center. Throughout the years, even after his retirement in 1981, he and I shared our international activities in community medicine and COPC.

The greatly differing public life of these three physicians should not prevent us from identifying their central agreement on the social determinants of health, and hence of the main elements of Social Medicine.

Sidney Kark passed away in April 1998.

Current relevance of this text

Kark's article on the "Social pathology of syphilis in Africans" published in 1949, identified social dislocation, migrant labor, living conditions and lack of psychological support as responsible for the spread of STI; this paper was recently republished in the *International Journal of Epidemiology*. (18) It was accompanied by several articles that emphasized the relevance of Kark's 1949 paper for understanding the HIV/AIDS epidemic of today. (11,19-21)

The publication in this issue of *Social Medicine* of the chapter "A Practice of Social Medicine" written in 1962 is relevant today from diverse points of view:

a) There is increasing interest and consideration of the Social Medicine dimension in the policy and organization of health care. The launching of this Journal (*Social Medicine*) in early 2005 is one evidence of this. So is the growing availability of data from Latin America

on the development and experiences of Social Medicine. (22) And Social Medicine has been incorporated as the predominant public health course in a survey of 16 medical schools in six southeastern European countries. (23)

b) Countries in which family physicians are key components of the health team in primary care are places where the dimension of Social Medicine has a strong potential to be fully expressed. There are two distinctly different groups of family physicians: those physicians who give emphasis to the development of clinical skills and of communication skills in the patient-doctor relationship as the core of this specialty in primary care, and those physicians who argue that family medicine should naturally merge with community medicine. The attitudes of World Organization of Family Doctors (WONCA: World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians) have become more favorable toward social medicine. The Durban Declaration (24), signed by WONCA, affirms the need for family physicians to extend their field of action from the individual and the family into the community. The WONCA Guidebook on "Improving Health Systems: the Contribution of Family Medicine" analyzes the different roles of Family Medicine in the implementation of Primary Health Care based on Kark's approach and experience in COPC. (25) The experience in the last fifteen years in the training of Spanish family physicians in COPC shows that the interest for an extension of clinical activities and identification with the community component of the specialty (in Spain the specialty is called Family and Community Medicine) is present in the physicians as well as in the residents and nurses. (26)

c) In order to deal with the negative results of fragmentation of health services, international health organizations are recommending the integration of medicine and public health. (27) The integration requires that both disciplines are seen as equal even complementary; this, in turn, implies a change of attitudes by professionals involved in each of the disciplines. Social Medicine could play

an important role in this integration through its emphasis on the importance of the social determinants of health in the assessment of health, and intervention in both individual health care and in population care. This integration could deal with inequalities in health by taking into account the importance of human rights for health. The implementation of this integration requires study of the fundamentals and methods such as those clearly described and analyzed in Kark's Chapter I reproduced here.

d) COPC exemplifies the programmatic aspects of Social Medicine that can serve as a bridge between primary care and public health. The elements of COPC that constitute the bridge are (28):

As part of *Primary Care* functions:

- Demographic and health surveillance
- Screening and treatment in clinical care
- Counseling individual, familial, community
- Team responsibility for identifying health needs and addressing the prioritized health conditions

As part of *Public Health* functions:

- Health care for a defined total population
- Use of epidemiology, behavioral & social sciences
- Identification/ promotion of community involvement
- Promotion of inter-sectorial coordination

e) COPC has an important role to play in the renewal of primary health care (PHC). As a result of an extensive study on the performance of the Primary Health Care approach in the American Region carried out by PAHO, the Ministers of Public Health approved a Declaration for Renewing of Primary Health Care. (29) The principles of Community Oriented Primary Care (COPC) were considered as one of the approaches to primary health care. At the same time, an historical analysis published in the American Journal of Public Health on the origin and development of the Primary Health Care (PHC) approach promoted by WHO since the Alma Ata Conference, traced PHC to the pioneer work of Kark in South Africa. (30;31)

Some recollections of Sidney Kark

Re-reading Kark's Chapter brings back memories and thoughts about my first experience of his teaching in 1972-74 when I was a student in the International MPH Program. Kark described to us his work in the 40's and 50's in South Africa. Those very same principles and similar methods constituted the practice carried out by Kark and his team at the Hadassah

Community Health Center in Jerusalem from the early 60's. It is the same framework and content of principles that we teach varied audiences in different countries today. It is this consistency of the concepts and approach, in COPC as an expression of Social Medicine that continues to stimulate interest in the learning, teaching and practice of this type of delivery of health care at the community level.

In 1972, in his Course of Epidemiology and Social Medicine, Kark described Social Medicine in very simple terms as "the social in medicine"; he taught that "the social" should always be considered when referring to assessment or diagnosis and regarding intervention or care.

Since 1974 I worked with Professor Kark in the practice, teaching and research of COPC in the Department of Social Medicine. On his retirement I had the privilege of taking on the responsibility of the COPC teaching in the

Jerusalem School of Public Health and Community Medicine. Now we have the privilege and the responsibility of continuing his practice, through the critical application of the community orientation toward maintaining and improving the health of the public.

Post-script

While preparing this paper in December 2005, I was in touch with Emily Kark, life-long companion and colleague of SL Kark with whom I shared reflections and data. Sadly, Emily Kark passed away on January 8th, 2006.

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- Jaime Gofin

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Pictured in front of the Hadassah Community Health Center in Jerusalem, is the 1988 class of the Community Oriented Primary Care Workshop of the International MPH Program. Seated left to right are some of the teachers: A Ifrah, R Gofin, SL Kark, JH Abramson, J Gofin; Photo courtesy of Dr. Jaime Gofin.

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