Looking Ahead of 1952

By PAUL Q. PETERSON, M.D.

Every health officer has two broad areas of responsibility. The first is primarily medical in nature and requires the diagnosis and treatment of the medical ills of the health officer's patient—that patient being the total community of people residing in the health district which the health department serves. The second responsibility is primarily administrative and requires the ability to organize and supervise personnel and facilities necessary to achieve the integrated health program which is planned for the health district.

In the practice of medicine an error in diagnosis and therapy by the physician jeopardizes the health and welfare of the individual patient. The health officer's mistake in diagnosis and therapy may jeopardize the health of hundreds of individuals and the welfare of an entire community. Therefore, from the standpoint of our first responsibility, we in public health must attempt to foresee the future public health needs of our patient and prepare programs that anticipate the changing disease problems facing our health district.

In the area of administration, the business executive who makes mistakes measures his failure in terms of reduced earnings. The public health officer's mistakes in the administrative field are measured in sickness. Therefore, the health officer must at regular intervals take stock of the abilities and efforts of the individuals engaged in the various programs. He should also attempt to anticipate changing social and economic problems.

Dr. Peterson, assistant director of health of the Ohio Department of Health, presented this paper before a meeting of the Ohio Public Health Association at Columbus, May 28.

This entire process represents what we in public health term as evaluation of the programs of our departments. For the most part the information, knowledge, and ability to achieve this objective rests within the hands of the local health officer. However, because of the complex nature of disease and of our social order, the local health administrator must draw upon sources of information which are broader than those available within his health district.

There are some significant trends which the Ohio Department of Health believes will create an impact on local health problems and therefore should be taken into consideration by the local health commissioners in planning services and programs for the protection of the public health in the years to follow.

Civil Defense

Probably no public health program has presented greater problems than civil defense. It is a situation in which none of us is really intimately familiar with the extent of the problems we will face. Although we have a broad background of experience in many of the areas, we are not completely sure of how the entire program should be developed to the best advantage. Also, we are faced with a public reaction which has been particularly frustrating. The attitude of many citizens ranges from complete indifference to hysteria, depending upon newspaper headlines and announcements which come from Washington. Because of indecision, there is also a state of confusion which has made it practically impossible to plan intelligently.

We feel, however, that the picture is clear enough at present for concrete action by community leaders who have true ability and honest

interest. State planning appears to be on a sounder basis, and for the first time real progress may be anticipated. This now places on the local health departments and health commissioners the responsibility of putting the program into effect.

Two important facets in the planning stage are of particular interest. The first is a plan for taking care of casualties that might be expected should an attack occur on one of the target areas in the State. This plan will specify what each community will be expected to do. It will make possible specific planning in the local community for a particular program without needless concern for problems which probably will not come to that locality. As this program is developed each local health department will be kept informed and the State department will depend upon it to provide this service.

The second program being completed is that of medical stockpiling of supplies and equipment. Ohio has participated with the Federal Civil Defense Administration in purchasing supplies which might be needed and has sent lists of those items to each health commissioner. The items are now being received and will be stored in strategic locations.

Drugs which require professional supervision will be located in hospitals surrounding the target areas and will be available for transportation to areas of need. Items which require only normal storage will be strategically located in the State, available for ready transportation to communities needing help. We recognize that there is an insufficient quantity of such equipment to satisfy the complete needs of the State. However, when it is remembered that this equipment will supplement supplies purchased by the local communities of Ohio and that local and State supplies will be complemented by Federal equipment, we may feel more secure that these essential items will be available when needed.

We would therefore alert the health commissioners of Ohio to the fact that the ensuing year will require of them a greater interest in problems of civil defense and that their medical administrative ability will be sorely needed if this program is to be successful.

Financing

The period of Federal support for basic local health and State health programs is ending. Within the past two fiscal years the total grants-in-aid allotted to Ohio for public health has been reduced by nearly one-half million dollars.

Fiscal year	*Grants-in-aid*
1950	$1,951,883
1951	1,944,361
1952	1,842,002
1953	1,561,324

This reduction has created serious fiscal problems for both the State and local health departments. However, it may represent a blessing in disguise. Without a sound method of financial support which comes primarily from State and local sources, it is impossible to build the type of public health service in this State which can develop according to its particular needs and have sufficient financial stability to encourage long-range planning.

Added to this reduction of income, local departments are faced by mounting costs of service and the necessity of competing for their share of the tax dollar. Under a difficult tax structure, which cannot possibly provide funds necessary for all local governmental operation, it becomes absolutely essential that public health administrators devise a more stable financial structure for public health and the most efficient basic organization that can be recommended to the citizens of the State to insure the greatest return in service for the tax dollar provided to the health department.

Personnel

Because of the expanding horizons of public health and scientific research, which are giving us new methods and greater knowledge, the public health worker must have high standards of professional qualifications. No longer is our service primarily a police action. It is founded upon an educational approach for the application of scientific principles which will reduce the health hazards of the communities we serve.

The inclusion of a wider range of scientific disciplines and individuals of varying abilities requires the health commissioner to engage in

more serious planning so that the varying abilities of staff members may be integrated to best advantage. Constant in-service staff training should be established, for unless the health commissioner makes available to his staff new knowledge and techniques the programs will certainly suffer.

A second major problem in this area of personnel is that of shortages. We are all painfully aware of this problem because of our inability to fill many positions which have been budgeted. From studies made in Ohio and the country as a whole, we may anticipate continued shortages in qualified medical, nursing, and sanitation personnel. It is therefore necessary that we use the qualified talent at our disposal to best advantage and seek out ancillary personnel who may be useful.

Programs

We have heard much in the past about new programs. Especially, we have been urged to develop programs in the chronic disease field. These requests are proper because a larger population group is living in the age span in which these diseases take their toll. Community resources need to be marshaled and applied to these problems.

My main concern has been that too often we hear the statement, "The acute communicable diseases are now whipped. Public health must look for new fields to conquer." Nothing could be further from the truth. We may state flatly that we are not doing as well as we can with our present knowledge. There is an absolute necessity for better application of existing programs which have proved of value. Diseases for which immunization and other protective measures are available may, by judicious application of these procedures, be eradicated. We should not be satisfied with a decrease in their incidence and prevalence but should continue to apply with ever-increasing effort our control procedures with the aim of complete eradication of these maladies.

It must also be remembered that when we create artificial controls, usual host parasite relationships are altered so that we must maintain constant vigilance and control efforts. Should we fail, we will have created a population susceptible to unprecedented rises in both incidence and prevalence. Diseases which fall in this category are: smallpox, typhoid, diphtheria, whooping cough, venereal disease, tetanus, and tuberculosis.

Another need in communicable disease control is for additional exploration in two areas:

1. We should investigate new control procedures for diseases about which we have amassed considerable knowledge but which are obviously not responding to present methods. For example, it may be that in brucellosis the emphasis on economic rather than on public health needs for control has been misplaced. Or in rabies our concern with the animal reservoir rather than the epidemiology of the disease in animals may be misdirected. Or in poliomyelitis our interest in the patient rather than the reservoir of infection may be a fallacy.

2. We must investigate public health hazards presented by diseases where these problems have not been clearly delineated in the past. For example, a recent epidemic of psittacosis among workers in poultry processing was traced to turkeys, a heretofore unknown reservoir of infection. Recent work has already shown that such diseases as histoplasmosis, toxoplasmosis, leptospirosis, and amebiasis may present dangers to public health which have not yet been appreciated and against which no adequate control programs have been formulated. Continued investigative effort and an open mind for the acceptance of new information and procedures by those actually administering programs is an essential need.

Two concurrent movements are making it necessary for the health commissioners of Ohio to enlarge their horizons:

1. It is apparent that Ohio is experiencing a ground swell of public interest in public health. More people on the street are becoming interested in public health programs and are willing to offer more support than ever before in the history of our commonwealth.

2. Public health as a field of official service is receiving ever-growing responsibilities. New programs are constantly being requested, and the talent of the health department is being

recognized because more and more legislative bodies are planning these programs under the administration of public health departments.

Thus, it is becoming evident that we may not permit our thinking to be stultified nor our programs to be stereotyped. We must adopt the philosophy that we are responsible for the total health needs of our communities and must be constantly planning to use the facilities within our districts in order that these community health problems may be brought under control.

I say quite sincerely that the local health departments hold the key to success of public health in Ohio. Either we are progressive, energetic, and intelligent enough to meet our problems in a scientific and efficient manner completely divorced from personal considerations or public health will fail to retain public respect.

The interest of the public and their desire for service is unquestionable. If we have vision, dedication to service, and the courage to move ahead, our profession will prosper and our rewards will be many. If, on the other hand, we fail to accept this challenge because of lack of vision, personal interest, or a lack of courage, then we may be assured that ahead of 1952 lies a dismal prospect with diminishing public respect, limited budgets, and ever-decreasing responsibilities.

Court Rules Against Hoxsey Clinic

The United States Court of Appeals for the Fifth Circuit, sitting at New Orleans, on July 31, 1952, ordered the district court to enjoin Harry M. Hoxsey and the Hoxsey Cancer Clinic of Dallas, Tex., from shipping from the State their two colored liquids intended for use in the treatment of cancer. This reverses the decision of the District Court of the United States, Northern District, Dallas Division (Dec. 21, 1950), which refused to grant an injunction.

After reviewing the testimony of 50 physicians and pathologists and 5 nationally known cancer specialists who had testified for the Government and about 25 defense witnesses, the appeals court in a unanimous opinion found that the conclusions of the lower court were not supported by the evidence and that these Hoxsey "remedies" do not cure cancer. The court made these two pertinent rulings:

". . . when the subject of investigation is the existence of cancer, the personal testimony of the lay sufferer is entitled to no weight, since the overwhelming preponderance of qualified opinion recognizes that not even the experts can assuredly diagnose this condition without the aid of biopsy and pathological examination."

". . . despite the vast and continuous research which has been conducted into the cause of, and possible cures for, cancer the aggregate of medical experience and qualified experts recognize in the treatment of internal cancer only the methods of surgery, X-ray, radium, and some of the radioactive by-products of atomic bomb production."

The drugs in question originated about 1840, it was testified. One contained a laxative and potassium iodide and extracts of prickly ash, red clover blossom, and alfalfa; the other was chiefly of lactated pepsin, a flavoring used to disguise the unpleasant taste of potassium.