HOW MUCH DO WE CONTROL COMMUNICABLE DISEASE?

# EDITORIAL SECTION



## HOW MUCH DO WE CONTROL COMMUNICABLE DISEASE?

AT the annual meeting of the Ontario Health Officers Association in 1928 the late Dr. Wade Frost, Professor of Epidemiology, School of Hygiene and Public Health, Johns Hopkins University, discussed the control of communicable diseases. He directed attention to the fact that many high hopes of effectual control had not been realized; he pointed out the necessity for recognizing our failures, for casting off those methods which had proved to be of little or no value and for adopting, when possible, new methods based on adequately controlled observations and experience. He emphasized that public health work, including control of communicable disease, should be re-assayed in order to determine the current value of methods which might have been established and evaluated under other conditions. In short, he made a plea that health officials of all grades should keep an eye open to both success and failure and that practice should be based on previous results.

The fact that now, over ten years later, nearly one whole general session of the recent annual meeting was given over to presentation and very lively discussion of current practice in control of communicable disease is evidence at least that we are cognizant of our imperfections, if not failures. Some progress has been made since Dr. Frost indicated the serious limitations in our practices. Diphtheria is to a large extent controlled through active immunization with toxoid; the misconception of the "irreducible minimum" in typhoid fever has largely disappeared and the sporadic residual typhoid that still persists is receiving attention as well as the epidemic outbreaks; tuberculosis is treated, not merely spoken of, as a communicable disease and sources of infection are recognized and where possible, and as soon as possible, segregated or otherwise controlled. Gratifying results have been obtained, too, in other fields. Therein is encouragement.

But some features are less encouraging—especially the lack of factual information in regard to the value of current practice. Is it true, for instance, that whooping cough mortality in the United States has decreased very decidedly while in Ontario the level of thirty years ago is, for practical purposes, maintained? Has control been achieved south of the border and not achieved north of it? Have control measures been applied in the United States so much more effectually than here in Ontario? Or is the difference in the apparent decline

purely artificial and merely a difference in bookkeeping? This is the most feasible explanation of the difference in the rates of decline. We are confronted then with two alternatives: Either our methods have not been successful; then why continue them? Or our bookkeeping leads us astray; then why continue it? Why not insist that our bookkeeping reflect the truth and not fallacy? Whooping-cough mortality is only one example of a problem, factual information in regard to the control of which by notification, isolation, placarding, and quarantine, is lacking. Even diphtheria, until active immunization achieved control, might have served equally well. So might the morbidity and mortality from measles, from scarlet fever, from poliomyelitis, etc. If we are in earnest and willing to face reality, we will not be satisfied or greatly encouraged by this state of affairs. We should be spurred to some more effectual action, or, at least, to look facts in the face. In order to preserve respectability or, more important, self respect, public health practice must be based on fact; fancy, untested, is little better than fallacy. Practice must have purpose and unless the objective is attained, continuation of the practice is not warranted. If the annual meeting provided an opportunity for taking stock of ourselves in this regard, the benefits to be derived from such stock-taking should not be lost by any relapse to complacency. Stock-taking, measuring our failures and our successes, should be part of every day's routine.

## THE ANNUAL MEETING OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

CANADIAN public health workers will be interested in the sixty-eighth annual meeting of the American Public Health Association, which will be held in Pittsburgh on October 17th to 20th. The Association has served the whole North American continent, sharing with members in Canada, Cuba and Mexico its meetings and services. It would indeed be difficult to measure the extent of the assistance which has been rendered to public health in Canada by the American Public Health Association since its establishment in 1872. Among the Presidents of the Association have been leaders in the health field in Canada, and it is interesting to recall that the Laboratory Section was established on the occasion of the Association's first meeting in Montreal.

The annual meeting of the American Public Health Association affords Canadian workers a comprehensive review of the methods adopted by their American confrères in the major problems facing public health on this continent and it is expected that the Canadian attendance will be large this year in view of the central location of the meeting. One of the features will be the provision of a Health Education Institute, the sessions of which will precede the meeting proper. Under the chairmanship of Dr. Ira V. Hiscock, the Institute will provide practical help, guidance and stimulation for those responsible for health education programs.