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THE HEALTH OF THE PUBLIC FROM COS TO MAASTRICHT¹

The medical profession above all others has reason to be grateful that health has been and remains of vital importance to the individual and the public. Throughout history, health and hygiene have been recurrent topics in literature and philosophy, even featuring in early mythology: the Greek god Asclepius had a large family, most of whom had health and medical functions. One daughter, Hygeia, was the deity of health. Another daughter was Panacea who represented treatment. It is a tribute to their sagacity that the ancient Greeks separated the concepts of health and sickness, of prevention and cure.

My title gives notice of an historical perspective on public health, but not a systematic review of public health history. Rather, I shall look at three phases of history, the ancient world, the 19th century and the renaissance of the past 20 years. I have dubbed the first the Age of Ignorance, the second the Age of Enlightenment, and the third the New Public Health.

THE AGE OF IGNORANCE

The island of Cos is famous in some quarters for having given its name to a variety of lettuce but for the medical profession down the ages and throughout the world it has been famous as the birthplace of Hippocrates, and the home of an early school of medicine which represents above all an ethical ideal embracing commitment to the profession and to patients and encompassing compassion and discretion. Even today, the majority of practitioners recognise the Hippocratic Oath as the basis for their professional conduct.

The thinking of the school of Cos is transmitted down the years through the so-called Hippocratic Corpus or Hippocratic Collection. There are 60 treatises which vary widely in subject matter and in style and date. Not all of the writings could possibly have been by Hippocrates. They were probably

written between 430 and 330 BC when Hippocrates would have been aged between 30 and 130 years old! Some may even be later. The major preoccupation of those Greek doctors, not unlike that of their successors of today, was the curing of the sick. In 'The Science of Medicine' the author writes: "I would define medicine as the complete removal of the distress of the sick, the alleviation of the more violent diseases and the refusal to undertake to cure cases in which the disease has already won mastery, knowing that everything is not possible to medicine".

Although concentrating on sickness, there was a definite orientation towards what we would now describe as the prevention of disease and the promotion of health: "We must consider the patient's customs, mode of life, pursuits and age ... Are they heavy drinkers and eaters, and consequently unable to stand fatigue or, being fond of work and exercise, eat wisely but drink sparingly?" The 'Regimen for Health' provides some lasting advice on diet, exercise and hygiene. "In winter a man should walk quickly, in summer in a more leisurely fashion. Fat people who want to reduce ... should take only one meal a day ... Those who enjoy gymnastics should run and wrestle during the winter. Those who find that exercise causes diarrhoea and who pass undigested stools resembling food should have their exercise cut by at least a third while their food should be halved." (Is this the earliest recorded reference to joggers' trots?)

The early Greek doctors had an awareness of the influence of the environment, including weather and water supply, on the prevalence of disease. The author of 'Airs, Waters and Places' says: "The best water comes from high ground and hills covered with earth. This is sweet and clean and when taken with wine, little wine is needed to make a palatable drink. Moreover it is cool in summer and warm in winter because it comes from very deep springs".

Galen, born 129 AD, brought together the medical knowledge up to his time including that derived from Hippocrates. His writings dominated medical thinking for many centuries and held sway until science struggled through from the 17th century onwards. For Galen, bathing and food are important. So is exercise—walking, riding, gymnastics. The elderly require less exercise than the young. Sleep and sexual activity are to be controlled. Excrements are to be evacuated with great care and attention; exercises help in this.

¹ Ulster Medical Journal, 1993, v62, p68.

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Thus there was in very early days an awareness of the importance of hygiene and of what we now call lifestyle. Doctors were hampered by lack of knowledge: the arguments of the Hippocratic writings and of Galen are wearisome to read today, but their instincts served them well. Many even earlier civilisations had practical public health measures which seem correct even today. Among the most primitive peoples it is known that excrement was buried, a practice observed in the breach on the pavements of Belfast today. Tribes of Africa practised a type of protection against smallpox by variolation. The Chinese blew powdered smallpox scabs into the nostrils.

Water has been especially important since ancient times. Public health measures involving water are known to have been of concern to early Egyptians. The cleanliness of the Nile was in early times assured by religious requirements, but alas later deteriorated in Greek, Roman and Moslem times. Public baths and water systems were developed in ancient India. The culmination of the cult of water in the ancient world occurred at Rome.

During the reigns of the Tarquins (from the 7th to the 5th century BC), the Romans constructed underground drains including the Cloaca Maxima which is still in use today. They brought water by aqueduct from the Sabine hills. Their wonderfully elaborate baths were centres of leisure and culture—and if you go to Rome today the remains of the baths of Caracalla are still there to amaze you.

Public health measures in the ancient world displayed characteristics which remain relevant today: first, an innate acceptance of the importance of health, and an intuition that there are things which can and should be done to secure and improve health. Second, the recognition of the need for collective action by the body politic—what Acheson later describes as “the organised efforts of society”. It need hardly be said that the extent of public involvement has not been the subject of universal agreement throughout history. Nor is it today: witness the difficulty European Governments have in agreeing whether or not to ban tobacco advertising.

THE AGE OF ENLIGHTENMENT

For me, two men stand out as heralds of the age of enlightenment, one an Austrian, the other an Englishman. Johann Peter Frank was born in Austria in 1745. His first public health post was as District Medical Officer of Baden and he was appointed Director General of Public Health of Austrian Lombardy in 1786.

Frank perceived very clearly that poverty was the main cause of disease. He regarded health problems as one aspect of broader social and economic problems and he associated medical reforms with social and economic reforms. “Starvation and sickness are pictured on the face of the entire labouring class. You recognise it at first sight. And whoever has seen it will certainly not call any one of these people a free man.” His basic concept was that government can accomplish a great deal that would be beyond the power of the individual physician. He wrote of “medical policing” which he described as a defensive art. Its object was the promotion of the physical welfare of the people in such a way that they may put off death as long as possible. He complained that only recently had people considered the welfare of a population. He had very positive views of the responsibility of the state and of its capacity to improve the lot of the citizen so that “without suffering from an excess of physical evils, they may defer to the latest possible term the fate to which, in the end, they must all succumb.” Today the World Health Organisation talks of adding life to years and years to life.

Despite Frank's enlightenment he did not exert a great deal of influence beyond his death. This was largely because the paternalistic political framework which he took for granted did not persist long into the 19th century, which makes the timeless point that conditions must be right for change to occur. I find it saddening that such perspicacity somehow got lost because the ideas were sown on unreceptive soil.

An interesting comparator in England at that time was the great utilitarian Jeremy Bentham, born three years after Johann Frank. He was an enthusiastic proponent of the principle “the greatest happiness of the greatest number”. The study of legislation was the central preoccupation of his life and he wrote extensively on how he thought the law ought to be. He also wrote widely on the welfare of individuals. He presumed the existence of a state authority which was committed to the promotion of the greatest happiness. He discussed the difference between state intervention and individual autonomy. Bentham believed there was some degree of evil in all forms of government intervention but if the benefits outweighed the costs the measure would be good rather than bad. He recognised that the population would benefit from more state intervention than occurred in the latter part of the 18th century. Bentham was a major influence in creating an ethos in which it was possible on the heels of the Industrial Revolution for another revolution to occur in

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England—the great sanitary movement of the 19th century. He certainly influenced John Stewart Mill and Edwin Chadwick.

I need not recount in detail the well-known and fascinating story of public health in the 19th century in England nor dwell on the famous names which resonate in public health history—Chadwick, Thomas Southwood-Smith, John Snow and Sir John Simon, who became the first Chief Medical Officer of England in 1859. The sanitary revolution culminated in the great Public Health Act of 1875. This revolution was very largely about sanitation, about the provision of clean water, the disposal of sewage, the condition of dwellings, the adoption of measures to prevent epidemics, the burial of the dead, the registration of deaths and of infectious disease—all things now taken for granted in the west, but not yet achieved in the third world.

The pattern in Ireland in the 19th century followed a similar if not exactly identical course to that in England. The Act of Union came into effect in 1801 and in 1805 the Government provided grants for the medical attention of the poor. Boards of Health were established in 1918. Workhouses were established in 130 unions throughout the country. Official dispensary districts in the charge of Boards of Guardians were created under the Medical Charities Act 1851.

In 1864 the city of Dublin appointed a Medical Officer of Health. The first occupant was Edward Dillon Mapother who was Professor of Hygiene in the Royal College of Surgeons in Ireland. In 1870 Dublin University introduced a Diploma in State Medicine, the first of its kind in these islands. The Public Health Act of 1875 was followed by a Public Health (Ireland) Act of 1878 and in 1880 the first Medical Superintendent Officer of Health was appointed in Belfast, Dr Samuel Browne.

The history of public health in Ireland must be dominated by the famine, and by epidemic disease. There was of course widespread poverty. Sir William Wilde who conducted the Irish census of 1851 wrote of “the poverty, dirt, misery and destitution of our people”. I wonder had he read Frank? Many people lived just above subsistence level depending very heavily on the potato. As early as 1829 Dominic Corrigan in a paper published in the Lancet had warned the authorities that unless Irish peasants were made less dependent on the potato for survival there would eventually be a blight followed by famine and pestilence. Sadly his predictions were all too true. Blight destroyed potato crops in 1845, 1846 and 1847. The total mortality in the Irish population was

estimated to be about one-eighth of the population, or one million people, most of whom were probably killed by infectious disease. Typhus was endemic; typhoid, dysentery, smallpox and measles were rampant. Cholera caused thousands of deaths between 1847 and 1849. In Belfast, Malcolm recorded 13,600 hospital admissions in 1847, estimating that one in five of the population were attacked. In 1849 there were 2,000 cases of whom 600 died. Dr David Hadden wrote in Skibbereen in 1847: “This place is one mass of famine, disease and death; the poor creatures hitherto trying to exist on one meal per day are now sinking under fever and bowel complaints—unable to come for their soup, and this not fit for them: rice is what their whole cry is for; but we cannot manage this well, nor can we get food carried to the houses from dread of infection. I have got a coffin with moveable sides constructed to convey the bodies to the church yard in calico bags in which the remains are wrapped up. I have just sent this to bring the remains of a poor creature to the grave, who having been turned out of the only shelter she had—a miserable hut—perished the night before last in a quarry, she was found with some flax around her, lying dead”.

It would of course be wrong to get the impression that Ireland was the only country beset by epidemics at this time. The United States was attacked by cholera three times in the 19th century. Yellow Fever swept up through the States from the Gulf of Mexico with cases reaching a peak in the 1850s. A vast epidemic of cholera swept across India and came first to Europe in the south east of Russia in 1829, and soon reached Moscow. The first English case was recorded in Sunderland in 1831. In the succeeding years cholera caused major epidemics in most European countries. Belfast had epidemics in 1832/1834; 1836/7 and 1847/9. In 1854 in London there were reckoned to be 14,000 cases of cholera with over 600 deaths. Quarantine was the only precaution applied, which resulted in long delays and great expenditure because ships were immobilised. Their crews and their passengers were held up, and their cargoes were ruined. France tried to generate interest in holding international meetings in order to resolve the differences and stop the disruption of trade, but it was not until 1851 that the first International Sanitary Conference was held in Europe.

In the United States the National Quarantine and Sanitary Conventions of 1857 to 1860 had a very similar background. The first convention came about in 1857 out of the Philadelphia Board of Health and was the brain-child of Dr Wilson Jewell. The existing

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quarantine laws displeased merchants because of the restriction on trade. Health officers knew that the measures did not protect the public and there was no uniformity—for example, Baltimore and New Orleans operated entirely different systems. This led to the Americans moving in a very similar direction and not long after the movement in Europe.

There were 10 international sanitary conferences in the 19th century beginning in 1851 and continuing to 1897. The six held between 1851 and 1885 came to no useful conclusion, largely because of lack of scientific knowledge. However, the 7th international sanitary conference was held in 1892 and there was by then general agreement on the etiology of cholera, so the first international sanitary convention was adopted. Further conventions in respect of cholera were adopted in 1893 and 1894. The 10th conference held in 1897 adopted a convention referring to plague.

Lest anyone should think these changes took overlong, it might be a useful corrective to recall that in 1896 Belfast Corporation set up a special committee to consider “the present high death-rate of Belfast and the general unsatisfactory condition of the public health in the city”. There was no proper sewage system. People still threw their excrement into the streets and animals were kept in residential districts.

The pace of international change quickened after the turn of the century. The Americans got in first with the Pan American Sanitary Bureau established in 1902. In 1907 the Rome Arrangement led to the foundation of l'Office International d'Hygiène Publique (OIHP), which consisted of a permanent committee with delegates from all member states, a small permanent staff and provisional headquarters which it occupied for 40 years. After the first world war the Health Organisation of the League of Nations held an annual general conference. It had a secretariat in Geneva. It was assumed that the OIHP would be subsumed into the League's Health Organisation. However, the United States repudiated the League of Nations and for the 20 years between the wars two independent international health organisations operated, one from Paris and the other from Geneva. It was not until 1952 that the World Health Organisation finally put to rest the Rome Arrangement of 1907. This was the untidy background to the formation of the World Health Organisation as we now know it, an organisation which is doing enormously important public health work across the world and which remains a force in public health matters in Europe today.

Perhaps I should explain why I associate the horrors of the 19th century with enlightenment. Firstly, I think the term is well used to describe the people involved, whether forward thinkers like Frank and Bentham, or doers such as Chadwick, Sir John Simon, Dominic Corrigan, or the local Dr Samuel Browne, or his successors. They introduced new insights and energies and commitment.

Secondly, I applaud society for allowing itself to be propelled along an enlightened road—and Governments which responded on behalf of society, though perhaps too often as shepherds who led their flocks from behind. It was, after all, the initiative and foresight of our 19th century predecessors that got the international health movement going against all sorts of odds, including their own ignorance and the trials of international travelling 150 years ago.

Thirdly, I celebrate the explosion of scientific knowledge in the second half of the 19th century and especially the birth of microbiology. This provided a theoretical basis for the public health movement and created the atmosphere which allowed it to develop headlong into the 20th century. Who rank higher in the history of medicine than the early microbiologists: the brilliant Koch who discovered anthrax in 1876, tuberculosis in 1882 and the cholera vibrio in 1883; Eberth who discovered the causative organism of typhoid in 1880 and Widal of the agglutination reaction; the great Louis Pasteur and many others? If you mention together the two phrases '19th century' and 'public health' the Pavlovian response is 'infection'. It would be a great mistake ever to forget that the main subject of public health for two centuries has been communicable disease. It is still the case that the major gains in child survival are, if I may put it this way, the deaths from infection which we prevent.

If we look at the wider world, the persistent need is obvious. The public health fight is against poverty, hunger, over-population and communicable disease. Recent World Health Organisation figures are horrifying. There are annually 1·7 million deaths from measles, neo-natal tetanus and pertussis. There are 100,000 cases of poliomyelitis. Parasitic diseases are rampant. It is believed that there are 5·2 million cases of malaria. 200 million people have schistosomiasis. American trypanosomiasis (Chagas' disease) afflicts between 16 and 18 million people. Three million suffer from guinea worm infestation and 12 million have leishmaniasis. If there is any doubt about the public health problems of the world today we need only think of the famines of Ethiopia and Somalia. Is it not shaming that at the end of the sophisticated 20th

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century those countries are suffering the privations which people endured in Ireland in 1847? It is poor consolation that we have the knowledge to solve the problems if we lack the will to tackle them, or the generosity to commit a greater share of our western luxury to meeting the basic necessities of our neighbours worldwide.

If we foolishly believe that communicable disease is a third world problem, we need think only of AIDS which has provided a timely reminder of our continuing susceptibility. Meningococcal meningitis, hospital infection and resistant organisms still frighten us all. Easy air travel and a venturesome population introduce new hazards. If a medical student of my time had listed malaria in a differential diagnosis he would have risked being marked down for being esoteric and perhaps even impertinent: not so today. Infections old and new make complacency the major public health risk, a risk which the enlightened public health workers of the 19th century would have found unthinkable.

THE NEW PUBLIC HEALTH

One of the most important developments in the history of public health, nothing less than another revolution in which we are all privileged to play a part, is what has been called the New Public Health. I referred to figures such as Frank and Bentham as heralds of the Age of Enlightenment. The outstanding herald of the New Public Health must be Marc Lalonde, a Canadian lawyer who was Minister of National Health and Welfare. On May 1, 1974, he tabled in the Canadian House of Commons a Working Document which proceeded from a series of Canadian health reports emphasising social values in health, and the importance of environment and lifestyle.

The working document 'A New Perspective on the Health of Canadians' was a set of proposals based on these concepts. "The approach we have outlined", said Lalonde "I believe, offers great potential for the prevention of disease and the promotion of health on a much broader scale than has been previously considered. For many health problems the possibilities for prevention extend beyond the boundaries of the traditional health field." He pointed out that the five most important causes of death before the age of 70 were road accidents, cardiovascular disease, other accidents, respiratory disease (including lung cancer) and suicide. Changes in lifestyle and environment could obviously make major contributions to reducing these diseases. He strongly emphasised the need for a variety of agencies to contribute to health.

Other nations moved quickly. The ideas were soon taken up by the United States. A document 'Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention' was published in 1978. In a conference in Alma Ata in 1978 the nations of the world met to discuss health matters and emerged with the Declaration of Alma Ata to which the UK Government was a signatory. In 1984 the member states of the European Region of WHO adopted a common health policy and a common set of targets.

In Britain a Working Group on Inequalities in Health was set up and reported to the Department of Health in 1980. The Group had been chaired by Sir Douglas Black, then Chief Scientist to the Department and later President of the Royal College of Physicians, and the Report became known as the Black Report. I have avoided technicalities in this discourse, but allow me to mention one point of record from the report: the age-standardised death rates per 100,000 people living at the ages 15–64 showed a gradient between those of social class I and II and those of social class V in 1971. The ratio is a staggering 1½ : 1 in favour of the better-off. Poorer people had a 50% worse experience of premature death than the well-off. Sadly, the gap between the underprivileged poor and the well-off has widened since then. The working party emphasised that economic factors such as income, employment, environment, education, housing and lifestyles all affect health and all favour the better-off. Their recommendations strongly echoed Lalonde and Alma Ata.

The United Kingdom did not rush to implement the principles of the Declaration of Alma Ata, or the recommendations of the Black Report. Other pressures were required and two were of great significance. The first was the publication in 1988 of the Acheson Report: 'Public Health in England' commissioned by the Secretary of State for Health "to consider the future development of the public health function". The Committee which produced the report was chaired by Sir Donald Acheson. The remit to which the Committee worked was a wide one: "The science and art of preventing disease, prolonging life and promoting health through organised efforts of society".

The report was wide-ranging. The core recommendations concerned the public health responsibilities of District Health Authorities:

- 1 To review the health of the population. To define objectives and set targets to deal with the problems.

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- 2 To relate investment in health services to health problems.
- 3 To evaluate progress.
- 4 To deal with communicable diseases.
- 5 To advise and co-operate with other agencies in their locality to promote health.

The importance of the Report is nowhere more clear than in the NHS review 'Working for Patients'. In the foreword Margaret Thatcher wrote "Taken together the proposals represent the most far-reaching reform of the National Health Service in its 40 year history." This document created very significant pressures for change. Its echo of the Acheson Report is very clear in the section at which it sets out the functions of District Health Authorities: "District Health Authorities can concentrate on ensuring that the health needs of the population for which they are responsible are met; that there are effective services for the prevention and control of diseases and the promotion of health; that their population has access to a comprehensive range of high quality value for money services; and on setting targets for and monitoring the performance of those management units for which they continue to have responsibility. The Government will expect Authorities to provide themselves with the medical and nursing advice they will need if they are to undertake these tasks effectively".

We in Northern Ireland can claim to be the first of the four territories of the United Kingdom to have formally adopted the principles of what has come to be called the Health for All movement. We enshrined those principles in our Strategy 1987/92. Wales came later to the ideas and adopted them in an enviably systematic way through the Welsh Planning Forum, now recognised as a WHO collaborating centre. England has finally joined the movement with the recent publication of 'The Health of the Nation' and Scotland has also come aboard.

At national level, Government intervention is now readily accepted as essential on public health issues. The way, however, is rarely simple. Governments do not like to be thought patronising and show a proper reluctance to engage in anything that looks like over-legislation. Governments, like people, have identity problems and may be reluctant to take action because they are fearful of foreigners trenching on national sovereignty. Governments tend to have to reconcile differing interests within a country: the interests of farmers and the food industry may not, for example, coincide entirely with those of the public health. One good result of AIDS is that within the

United Kingdom a cabinet committee was formed. This not only provided a central forum for AIDS problems to the great benefit of the public health; it paved the way for a cabinet committee to drive forward the Health of the Nation. This is real progress in promoting public health and moves public health higher on the agenda than it has been for over a century.

In Northern Ireland several activities are contributing to a renewed drive to promote public health. Among them are the Regional Strategy of the Department of Health and Social Services which adopts health promotion as a major theme; the adoption by Government of the policy of Targeting Social Need to tackle areas of social and economic difference; the creation of an Interdepartmental Committee on Public Health, chaired by the Permanent Secretary of the DHSS; the establishment of the Health Promotion Agency for Northern Ireland; the reaffirmation of the central role of Directors of Public Health and the requirement that they produce an annual report; the important programmes in health promotion adopted by general practitioners; the growing realisation that health is an inter-sectoral matter, requiring the involvement of a wide array of contributors.

For doctors in public health medicine, the problems to be addressed become more and more complex and the decisions are less and less based on certainty and more and more on balancing probabilities—witness the difficulty in explaining that the young, the immunocompromised and pregnant women should beware of listeriosis while those in rude health should enjoy soft cheese; the difficulty in reassuring the Northern Ireland public that they may eat local eggs while advice in England was to be cautious; the difficulty in giving clear advice on folic acid supplements in pregnancy. Issues presenting nowadays are rarely clear and never simple.

I have sometimes been asked about the future of public health medicine. I am convinced that, because of the growing complexity of the evidence and the growing difficulty of its assessment, doctors have an increasing role in public health and an assured place for the future. I think we in Northern Ireland are especially fortunate in our public health practitioners. Training programmes began in the early seventies; we set high standards and we attracted good people. It is a young, vibrant speciality, substantially better in both quantity and quality than can be found anywhere else in these islands.

What of the profession outside public health medicine? Every doctor has a role in preventing

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disease and promoting health. Clinicians stand in a unique relationship to patients. The credibility of the profession with individuals is high and the influence of personal doctors is great. I believe clinicians should stand back and take a broad view: the value of immunisation relates to herd immunity as well as to personal protection. The greatest good of the greatest number is relevant to all our activities. This does not in any way oppose the role of the clinician in the important work of delivering care to individual patients. Lalonde emphasised "... the importance of basic, good health services. Preventive health measures and promotion of healthy lifestyles are not an alternative to the health care services needed by a person who is actually ill".

While emphasising that public health is not exclusively a medical function, it must be said that the medical profession does have a special role in informing, in inspiring, in driving, in energising, and in helping all the others from Government to the individual. It is not too much to say that the display of a positive attitude to public health is the most important collective function of the profession today. When data about the number of beds or of operations or of prescriptions written in the last decade of the 20th century are confined to dusty, unopened files or some forgotten floppy disc in the deepest Government depositories, history will ask rather what successes were recorded in this decade in eliminating the inequalities, in reducing the morbidity and in improving the health of the population of Northern Ireland.

MAASTRICHT

The Treaty of Rome did not feature health, though there have been European Community initiatives: manpower directions have cleared the way for exchange of health workers and the effects of this for doctors will be very profound; biomedical research including work in medical informatics is increasingly important; the single market affects topics as diverse as medicines and smoking; environmental directives are vital to health—the levels of water purity are much in the news. The draft Treaty of Maastricht signed on 7 February 1992 introduced for the first time a direct competence in health and, significantly, in the field of public health:

"The Community shall contribute towards ensuring a high level of human health protection

..."

"... action shall be directed towards the prevention of disease, in particular the major

health scourge....

"Health protection demands shall form a constituent part of the Community's other policies.

"The Community and Member States shall foster co-operation with third countries and the competent international organisations in the sphere of public health."

This last is vital. The entry of the European Community to health matters must mesh with the World Health Organisation and especially its European Region. We cannot have the repetition of the silly international overlap between the League of Nations Health Organisation and the International Office of Public Hygiene which existed in the inter-war years.

POSTSCRIPT

The fascination of history is more to do with insights into human behaviour than with any recitation of facts. The story of public health does not fail this test. A current perspective on public health in the light of history must proclaim that public health has a distinguished past and a certain future. Thirty years ago it would have been pronounced dead or at least dying, its practitioners unfashionable and near to extinction. Today, whether coping with the affluence of the west or the desolation of the third world, the importance of public health is growing. As an aspect of collective human endeavour it is a wakening giant clamouring for the attention of Government and citizen alike. As a medical speciality, it is enlivening, demanding and rewarding and nowhere in the world is it more determined to pull its weight or, in the persons of its young practitioners, better stocked with talent than here in Northern Ireland.