An Address

ON

THE DIAGNOSIS AND NOMENCLATURE
OF DISEASE.DELIVERED ON MARCH 25TH BEFORE THE MEDICAL SOCIETY
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BY

R. D. RUDOLF, C.B.E., M.D., F.R.C.P.,
COLONEL C.A.M.C.,

CONSULTING PHYSICIAN TO THE CANADIAN FORCES IN ENGLAND.

SOME of us heard at the Royal Society of Medicine the other evening a delightful address by Dr. Henry Head upon disease and diagnosis.¹ This is a subject upon which we all must have thought a great deal, and when your secretary asked me to give something at this meeting, I felt that it might be useful, certainly to me, if we could discuss the matter a little.

When a practitioner is called to see a patient, he is sent for in order that he may cure the disease or relieve the suffering of the afflicted one. In order to do this efficiently his first step is naturally to try and find out what the trouble is—in what way the sufferer is deviating from the normal line, called health. In other words, he must make a diagnosis.

Now the word "diagnose" means to perceive, or to know through, or thoroughly, and medical diagnosis is defined in Murray's *Dictionary* as "the determination of the nature of a diseased condition," also "the identification of a disease by careful investigation of its symptoms and history; also the opinion (formally stated) resulting from such investigation." In the *Spectator* of October 1st, 1892, we read: "Swindlers seem to possess in an extraordinarily high degree the power of moral diagnosis—of telling what are the weak spots in the mind of the ordinary man," and Murray uses this as an example of the correct use of the word. In the same way (except that he is not a swindler) the medical diagnostician looks through his patient with his mental eye, aided by every possible clinical and laboratory method, and tries to unravel the whole condition of the man.

His aim is to unravel completely the whole of the puzzle before him, and *post-mortem* revelations tend to keep the most self-satisfied clinician humble, for when does one ever see a complete diagnosis? If the patient recovers, then you never know what really was the matter with him, and when he dies and the cadaver is opened, the pathologist points out to us, generally without remark, the effusion that we missed, the normal endocardium that gave rise to such a characteristic murmur, and so on.

But even *post-mortem* examinations do not always clear up diagnoses, and many of you will remember how Mr. I. H. Cameron used to say, in his quaintly humorous way, that he never yet saw a *sectio cadaveris* show exactly why the patient died. The difference between a body fit for the soul to dwell in and one just not fit is so slight that the most careful macroscopic and microscopic examination of the dead tissues may fail to show just why to-day the man is dead and yet yesterday he was alive.

Diagnosis must usually pass through the three stages of possibility, probability, and certainty. At the first visit the doctor thinks of a number of possible conditions from which his patient may be suffering. For example, he has continued fever, and the case may be one of typhoid, paratyphoid, influenza, malaria, military tuberculosis, trench fever, etc. In a day or two it becomes likely that the condition is either typhoid fever or one of the paratyphoid infections, and finally it is certain that the man has, say, enteric fever. In many instances the diagnosis never gets beyond the stage of probabilities—and even then may be wrong!

When a man, in previously perfect health, is taken with some acute disease, the diagnosis under a single name may be fairly correct. The patient is like a new motor-car that suddenly breaks down. In all probability here there is only one lesion, and when that is corrected the car will be as good as ever again. Most of our military medical work is among high category men, and the seeds of disease are thus sown in virgin soil; but in civil practice we are only too often dealing with people who are not originally healthy, and when these are taken ill with even the

simplest of conditions they are like C.A.M.C. "Jitneys," which, when they break down at last, are found to have many weak spots besides the final lesion. In patients like these many systems are involved, and this fact should be expressed in the diagnosis.

We do not, or should not, diagnose a disease, but rather the condition of a diseased person, which is quite a different thing. Two men may suffer from a pneumonia due to the same infection; but one may be otherwise sound, while the second may be like the old "Jitney" car, unsound in every part, and, although for simplicity of classification we put them both under the one heading of "pneumonia," the cases are quite different, as are also the prognoses and the methods of treatment.

Two ships are out in the same storm off the same lee-shore; one is sound in engines, spars, and crew, while the other is weak in all these essentials. The first will probably weather the storm and will reach port safely, while the other may founder, or else struggle into the haven a mere wreck. So it is with different individuals who are fighting against the same disease.

In endeavouring to diagnose the condition of a patient, a general view should first be taken of him, including the history and all the surrounding circumstances of the case. Next we concentrate on any abnormalities found, bringing to bear on such all the methods of precision that are at our command. Finally, in summing up the case, a general view should once more be taken, and then any abnormalities that our precise examination has revealed may be gauged in proper proportion to the whole "make-up" of the man.

All watertight compartment diagnoses must be avoided, under which heading we may put many so-called "specialists' findings. Sir James Mackenzie, in a humorous speech at Chicago last year, said to his audience that he had told Professor Welch and Sir Almoth Wright to their faces that they had had a most pernicious influence on medicine. Of course he did not mean it, but the lesson that he was hinting at is that too great concentration on laboratory findings may divert our attention from the condition of the patient as a whole.

All special methods of examination have their place in clinical medicine, and a constantly growing place, but they must be kept in their place and not called upon to settle complete diagnoses. A patient may show a positive Widal reaction and the typhoid bacillus may be found in the blood, but the statement that he has enteric fever may not be a complete diagnosis. He may have pneumonia or nephritis or any other condition as well, and the typhoid may really be the least important part of his condition. I came across a man the other day who was suffering from nephritis, with a very high blood pressure, and yet, because he had been found to have a one plus Wassermann reaction, without any history of venereal infection, he had been sent to a special hospital for venereal disease for a full course of salvarsan.

Many of you will remember when the von Pirquet test for tuberculosis was introduced. In time it was found to have a limited place in the diagnosis of this infection, but how many people were condemned to much mental and financial distress before that place was defined! Albumin in the urine does not necessarily mean nephritis; nor sugar necessarily denote diabetes, and yet every day one sees such unwarranted assumptions made upon such insufficient foundations.

All that I have been saying leads to the same point, and that is to the great value of team work. Probably one of the chief lessons that we have learned in military practice has been the appreciation of this matter. The staff of each military hospital is a team, and we have all got into the way of consulting together in the wards, in the laboratory, and in the x-ray room. It is one of the most hopeful signs of future good progress in medicine that this idea of team work is being discussed everywhere, and in many places is already being put into practice in civil life. As Dr. Head said the other night, of course such co-ordinated work is not everywhere possible. In country districts the general practitioner must often embody the whole team in his own person, but wherever possible such sharing of work and responsibility should be undertaken. The result will be that not only will the patients so studied benefit, but bodies of keen workers will, from the data that they collect, evolve certain simple rules of diagnosis

which the general practitioner may then apply, and so detect conditions that would otherwise be far beyond his ken.

Such team work in no way minimizes the importance of individual efforts at investigation. The most isolated practitioner can, and often does, contribute to the general knowledge, if he will but get into the habit of noting down what he sees. The best example of what can thus be done that occurs to me is that of Sir James Mackenzie, who, while a family doctor in a Yorkshire town, laid the foundation, and indeed accumulated most of a knowledge, of heart conditions, which knowledge has revolutionized our whole ideas of cardiology.

When a conclusion has been reached as regards the condition of a patient it usually has to be expressed in words. As Murray puts it, one meaning of the word "diagnosis" is "the opinion (formally expressed) resulting from investigation." And often this is a very difficult thing to do. The skilled old sailor, after he has glanced at the sky and consulted his instruments, usually has a very good idea of what the weather is going to be, but ask him to put his findings in words and you will seldom get much satisfaction. So it is with many a skilled practitioner. Fortunately the public often think the more of a man because he says little. Years ago, while on a walking tour in this country, I came across a country doctor whose chief claim to great cleverness, as far as I could make out, lay in his silence. According to one of his admirers, "He was such a clever man; that he would come into the house and look at you and write a prescription and go away without saying a word." I wonder if this man is now in the army, and, if so, how he likes always having to put his diagnosis in writing, and that within twenty-four hours of the patient's admission to hospital.

Often at a consultation the doctors very well understand the condition of a patient, and the first difficulty comes when the question arises, "What are we to say to the friends?" "What shall we call the trouble?" An old surgical teacher in Edinburgh, Professor John Chiene, used to advise us, when we were thus pressed for a name, to tell the patient that he had a sacro-iliac synchondrosis. As he said, this was true and did not commit you, and yet the name often gave the greatest satisfaction, and the patient went away feeling that he had got the value of his money. As we all know, many a patient fairly hugs such a satisfactory name as "V.D.H." or even "N.Y.D."

A diagnosis, in order to be correct, should be a complete description of the whole condition of the patient, and, as this is manifestly impossible, we must resort to names or labels of some sort, which, in a word or a phrase, will express what otherwise might require many lines. The danger of thus summing up a condition in a word is that we are all too apt to think that a final diagnosis has been reached when such a name has been appended. These names should not be considered as goals, but merely resting places on the road to a more detailed diagnosis. Labels or names, then, we must have, but what a chaos the whole of medical nomenclature is in! The names therein, often in bastard Greek or Latin, are apparently not founded on any basis of classification. They arise, for example, sometimes from the name of the supposed discoverer of the condition, again from the supposed cause of it or from a prominent symptom, or from the organ supposed to be chiefly affected, or again from the supposed pathology, or the geographical distribution of the disease, and so on. And yet there is often much doubt as to who first described a disease; uncertainty as to the exact cause of the trouble, and of the exact pathological nature of the condition.

Very often, the more we know of a disease the less satisfactory is the name under which it exists. I need only mention rheumatic gout (which is probably neither rheumatism nor gout, and we do not know what either of them are) and typho-malaria (which is either typhoid or malaria, but not both) to illustrate the truth of this.

Numbers or letters of the alphabet would often do as well as names for labelling diseases, and would not commit us in the same way. Indeed, in the official *Nomenclature of Diseases* supplied for use in the army, numbers are used in addition to names. Thus a man may suffer from "No. 9," as well as take it! This official list of diseases was prepared for the R.A.M.C. by a Commission of the Royal Colleges, and is indeed a wonderful production. Diseases are classified largely according to systems affected. It would scarcely do at present to criticize it, but it is hard

to understand why such symptoms as "dry mouth (482)," "eructations (501)," and "loss of appetite (512)," should be dignified with the rank of disease, while on the other hand such common and definite things as haemothorax and auricular fibrillation do not appear. "Ureteritis and perireteritis (669)" again seems an unnecessary name. I wonder how many cases have been returned under this diagnosis during the war. "N.A.D." and "P.U.O." are much used terms, although they do not mean "no authorized disease" and "put under observation" respectively, as I have heard them translated.

"V.D.H." and "D.A.H." are useful classes (merely as first resting stations), and "debility" and "myalgia" help many a man to the base and do not commit the hard-worked medical officer too much; but, as I said before, all these names are delusions and snares if they are treated as complete and final conclusions as to disease.

Conclusions.

1. Examine a patient generally, in detail, and then generally again.
2. In expressing the condition of the patient in a name, choose one that goes no further than the findings of the case permit. Often a generic name, which is probably right, as far as it goes, is better than a specific one which may be wrong.

REFERENCE.

¹ BRITISH MEDICAL JOURNAL, March 29th, 1919, p. 265.

SOME PRACTICAL SUGGESTIONS FOR THE WORKING OF A VENEREAL CLINIC.

BY

E. F. SKINNER, M.A., M.B., M.R.C.P.,

MEDICAL OFFICER IN CHARGE, VENEREAL DEPARTMENT,
SHEFFIELD ROYAL HOSPITAL.

The following notes make no pretence at setting out anything new in the way of treatment, but are simply the results of experience in carrying on a civil venereal centre. A short statement of this experience may be of value to other workers who have started, or are about to start, similar clinics.

The staff consists of two medical officers, one of whom takes charge of the syphilis, the other of the gonorrhoea cases; besides these there is an assistant medical officer who is paid, an orderly man who assists in the irrigation department, and a permanent sister in charge of the nursing arrangements, who also does the necessary clerking work.

All the patients are treated as out-patients, though two beds, one male and one female, are set aside in the wards for the use of the department if necessary, but these beds have not been called upon during the last six months, and it is now felt that the need of beds is not so imperative as was formerly considered. I propose to describe the arrangements as carried out for syphilis. The section on gonorrhoea has been omitted from consideration of space.

It has been found most convenient to divide the work into new cases and old cases, and to admit new cases on one day, carrying out the treatment on some subsequent date. One morning is set aside for the examination of new cases of syphilis, male and female, at which time they are examined, and instructions are given as to attendance for treatment, etc.; and one evening clinic is arranged for men only, to meet the convenience of working hours. Treatment is carried out on a subsequent day, one day being reserved for men and one for women.

ROUTINE FOR CASES OF SYPHILIS.

In dealing with a large number of people all suffering from the same condition it is essential that a routine should be followed; and, whilst admitting the dangers and disadvantages of routine methods, it may be pointed out that these dangers vary inversely with the interest shown by the medical officer. I will describe briefly the method of examining patients carried out in the clinic; it is rapid and sufficiently exhaustive to ensure that any lesion will be found, and to disclose the necessity or otherwise of any special examination.