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ART. I.—PROPOSITIONS ON THE "FALLACIES OF PHYSICAL DIAGNOSIS IN DISEASES OF THE CHEST." By THOMAS ADDISON, M.D.

Critically Examined by ROBERT L. MACDONNELL, M.D, *Lecturer on the Institutes of Medicine, McGill College, Physician to the Montreal General Hospital, Consulting Physician, Montreal Eye Institution.*

In the last number of "Ranking's Half-Yearly Abstract," the reader will find a series of propositions from the pen of Dr. Addison, Physician to Guy's Hospital, London, purporting to point out numerous errors in diagnosis, which those who practise auscultation and percussion are liable to commit, if too exclusive reliance be placed on physical signs.

We do not deny, that the science of auscultation is imperfect, but we do maintain, that without its assistance, we cannot have accuracy in diagnosis, and consequently success in the treatment of thoracic diseases. We have always insisted upon the necessity of comparing the general symptoms, the history of the case, and the mode of succession of the physical phenomena, with the signs actually existing, as indispensable to accuracy of diagnosis, and in this, we have but followed the example of the many distinguished writers who have devoted attention to this subject.

But, in reading the aphorisms of Dr. Addison, one would suppose that auscultators invariably made a diagnosis from physical signs *alone*, and not from a comparison and combination of these signs, with every other particular, capable of elucidating the nature of the malady. Auscultators do not make a diagnosis because they *hear* certain abnormal sounds, but because they *reason* on the physical changes which have produced these sounds. If an observer be perfectly ignorant of the necessity of studying the modifications and combinations of physical signs; the importance of comparing the sounds heard in diseased parts, with those produced in a healthy or less diseased portion of the lung; the value to be attached to a particular sound occurring at a certain stage of the disease; and, above all, if he be as ignorant of pathology as Dr. Addison takes it for granted that auscultators usually are, then, but only then, are the alleged errors he has pointed out likely to be made.

In the observations we are about to offer, we feel it our duty to expose the many fallacies put forward by Dr. A., and in doing so we shall follow him through each proposition, and as briefly as possible, reply to his alleged objections to physical diagnosis. We would, however, observe, *in limine*, that Dr. A. commences with objections to the stethoscope, as if auscultators never employed percussion; and he then objects to percussion, as if those who practise it, never use the stethoscope. His object is but too apparent. He has proposed to himself the task of underrating the stethoscope, and, where the attempt can be made, he neglects not the opportunity—seemingly not aware, that in his efforts, he displays remarkable ignorance of the actual state of our knowledge as regards physical diagnosis. The truth of what we now state, we hope to be able, satisfactorily to prove, and we at once proceed to our task.

A few of the propositions have been so glaringly absurd, that Dr. Ranking has himself pointed out their refutation. We regret he did not criticise more closely the remaining ones; for doubtless, many an inexperienced physician has already been deceived by Dr. A.'s plausible sophistry.

1. It is well known that many persons while under examination entirely fail to perform the respiratory act efficiently, either from nervousness, or from mistaking the manner of accomplishing it. This may lead to an erroneous belief, that the respiratory murmur is deficient, or even absent, while the lungs are perfectly healthy.

This source of fallacy is avoided, says Dr. Ranking, by desiring the patient to cough, and to inspire deeply, so as to cough a second time. This done on both sides of the chest, the actual state of either lung may be ascertained with tolerable precision.

It could hardly have occurred to any writer, except one whose object was to undervalue the stethoscope to urge such an objection. It is, in fact, tantamount to this, that an objection to the use of the stethoscope consists in the *necessity of learning* how to employ it; for if this preliminary step be taken, the above objection falls to the ground.

2. Whatever lessens the freedom, mobility, or elasticity of the ribs, renders the sound on percussion more dull. Hence it is that in rickety persons, where deformity of the chest has taken place subsequent to birth, the signs furnished by percussion are often extremely unsatisfactory; and, indeed, under such circumstances, neither percussion, nor in many instances auscultation, can be much relied upon.

Admitting the truth of this proposition, the rarity of the cases to which it applies, weakens its value; and,