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Focus On Health Or Illness?

Promotion and Prophylaxis Reports with Diagnostics and Measurement

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The two "kingdoms" of medicine are **community medicine (or public health or preventive medicine**) and **clinical medicine**. While in **clinical medicine** the actor is the clinician and his client is an individual-patient, in the community medicine, he is an epidemiologist and his client is the community, that is - the population, *understood not as a numerator of only individuals-patients, but as the plural of all individuals community or population components*.

Clinical and community medicine differ essentially between them. While clinical medicine decides the diagnosis through anamnesis and physical examination of the individual, community medicine determines the diagnosis through estimation of population patterns. On the other hand, while clinical medicine treats (cures) the individual, community medicine uses programs for the treatment of specific population groups. These differences dictate the undertaking of efforts to achieve the equiliber (balance) between the community and the individual.

The basic question "The focus should be on health or the disease?" of this talk is a question, the answer to which would essentially embody questions such as "What is health and what does healthy mean " and "what is the disease and what does 'sick' mean related to the 'natural history of the disease'? "; "What is community medicine (or public health) and clinical medicine, and what is the relationship between them: controversy or interaction?"; "What is the 'gnosis' process in public health (community medicine) and clinical medicine related to etiology or causality ('diagnosis'), and prognosis?"; as well as "What is the prevention of the" natural history of the disease "and what is its relation to public health (community medicine) and clinical medicine?". These questions, which actually express the reports of health promotion and prophylaxis of community medicine, i.e public health, diagnosis and treatment (cure, treatment) of clinical medicine, and vice versa.

And it is precisely the concept of the term "disease" in the sense of '*sickness*', '*disease*' and '*illness*' (a single term in Albanian and in Neolithic languages versus three meaningful Anglo-Saxon terms), the concept of 'natural history of the disease ', the concept of' *continuum* 'of' '*disease*' 'disease in nature, and the concept of epidemiology and epidemiology ', those that would constitute the scientific foundation of the response to the baseline question and the underlying questions above.

Based on the **'natural history of the disease', disease '*sickness*'** represents the widest time span in my timing axis, which includes **'predicament or preface'** of 'sickness' plus '**disease**', which in turn includes **illness'**. "Disease" are anatomical (morphological), biochemical, physiological, and / or psychological disorders that are installed and developed in the human organism as a result of the action of the respective cause, i.e the ensemble of the respective risk factors (determinants) at a time $\mathbf{t_0}$ of 'natural disease history' in the time progression **t**, the realization of which was enabled by the 'social, psychological and economic predication' of placing the individual-patient in his or her surrounding environment. It is precisely 'disease' or 'marked targeting' (the most accurate term), which, in relation to etiology, pathogenesis, clinical picture or presentation, therapeutic management and prognosis, is included in the textbooks in clear-cut way. Meanwhile, disease '**illness**', a constituent part of 'disease' **t1** in the 'natural history of disease' is nothing but a clinical manifestation of the anatomic-biochemical-physiological-psychological "*marked disorder*" 'disease' at a time $\mathbf{t_1}$, with the cluster of clinical symptoms and clinical signs that, together with the relevant laboratory tests, reflect the 'case definition' of 'disease', on which is based the clinical '*diagnosis*', namely ' 'the modus operandi of the clinician.

But, we must always have in mind that, in nature, there is no 'sick' / 'not sick' division associated with every *'disease'*. **In nature, '*disease*' is displayed with a continuum of its severity**. The categorical dichotomic (binomial) division of the 'sick' and 'not sick' with the '*disease*' of interest has been done with convention (agreement) precisely by clinical medicine because without such division it could not operate. And, consequently, **'case definition'**, that is, the set of symptoms and clinical signs and relevant diagnostic tests for any 'disease' of the [*International Classification of Diseases* - **ICD**] is totally conventional. Without the **definition of a case**, **the diagnosis** at the $\mathbf{t_1}$ stage of the natural history of the disease can not be realized (= disease *'illness*' is clinically manifested). It is a crucial moment in clinical medicine, but of the same importance in the epidemiological perspective, because its quantitative deficiencies and its quality shortcomings directly affect the epidemiological surveillance data.

The most prominent illustration can be found **in the field of infectious diseases**, where the postulated "infection is different from the disease" i.e. "not

every infected gets sick". Specifically, the infection/disease ratio for any *'disease'* is never 1/1 (with the exception of measles only), but at least 2/1, to reach 5/1 or 20 / 1 (eg rubella), 100/1 (e.g cholera) or 1000/1 (e.g, paralytic polio), which means that for clinical medicine, an individual with the *'disease'* but without disease '*illness*' is not [ill], while for nature he is sick with the '*disease*'.

The situation is the same in chronic non-infectious diseases, neoplasmic diseases, mental illnesses, i.e. in all *'disease'*. Myocardial infarction has coronary heart disease on its substrate, but coronary heart disease itself does not necessarily end with myocardial infarction. Neoplasmic diseases (cancer) have on their substrate initial changes at the subcirculation level, but only in a proportion of cases these changes escalate at the cellular level. At each individual there is a dose of psychopathy, but he can never be labeled as a mentally ill person.

We emphasize that the most accurate term from scientific and generalization prespective would be **'health events'** (including 'health status') versus the **'disease'**. Accident, trauma or poisoning is a 'health event' and not a 'disease'. Death is absolutely a 'health event'. Which means that any 'disease' is essentially a 'health event', but not all 'health events' are 'diseases'. However, it is the term 'disease' that has virtually acquired the ownership use of "scientific divulgation".

'Gnosis' (= recognition) is essential in both the kingdoms of medicine, clinical medicine and community medicine or public health. It is **a category of probability** because it is based on an incomplete set of facts. And, when we talk about '*gnosis*', we mean all three of them - **'etiognosis', 'diagnosis', and 'prognosis'.** 'Diagnosis' is precisely the diagnosis (based on the definition of the case) of 'disease' at the moment of its 'disease' clinical manifestation at the moment t1 of the 'natural history of the disease'.We repeat the importance of its accuracy at the same moment for clinical medicine (accurate diagnosis for the individual who is a patient) and for community medicine (accurate epidemiological determination of the specific importance of the disease in interest of the population). **'Prognosis'** relates to the advancement of the disease from t1 to its end (recovery as the best option and death as the worst) at the right next moment so-called t2 of the 'natural history of the disease'. In clinical medicine, prognosis (prognosis) relates to treatment (ie medication), ie the quality of medical care, while in community medicine or public health, the spectrum of prognosis extends much more, because it implies the future advancement of the disease of interest in the community / population , a prediction that epidemiological research achieves. Meanwhile, **'etiognosis'** is almost the "property" of community medicine: one of the main directions of epidemiology is the study of causality, *the determination of the connection between cause and the interest about the disease, with the ultimate goal of intervention for control and prevention.*

The individual lives and develops his/ her own life activity in the micro, and macro-physical, chemical, biological, and social environment that surrounds him/her. This environment carries a vast and varied range of physical, chemical, biological, and social factors that act upon the individual by defining (determining) the risk of the installation of sickness (illness) in him/her. Meanwhile, even the individual carries his/her own specifics in the way of behaving, acting and living in the surrounding environment, which can also act as a determinant risk of the disease. We have the environmental or individual **risk factors or determinants,** as well as the person on which they operate. We also have the **medical implication** of this action, which is characterized by relevant organic (pat-morphologic), physiological (physical-pathological) and / or psychological (psychological) damages that at one time (hours, days, months or years) then become or are not (apparently) apparent, accessible through relevant clinical signs and symptoms.

Epidemiology, (biostatistics is implied as its inherent component), is the basic science of public health. Consequently, **as a community medicine science, epidemiology focuses precisely on the group-community-population** ignoring the peculiarities of the individual. It is based firstly on the fact that population sickness does not happen by chance, and secondly, that the disease has causal factors and preventive factors (precautionary) that can and should be identified through systematic research of different populations or groups of individuals within a population in different countries or at different times. Focused on the population and based on these two concepts, **epidemiology studies the disease (overall health outcomes) in the population regarding distribution, frequency and its risk determinants, and applies this study to control and prevent the disease.**

It is totally understandable the crucial role of epidemiology in community medicine, i.e. in the public health process, where it constitutes the scientific axis. But what is the role of epidemiology in clinical medicine?

In his clinical practice, the clinician faces the diagnosis and tries to manage the patient, and he historically thought that he basically practices **"the art and science of clinical medicine"**; ("Art" is based on such elements as our conviction, judgment, and intuition, which are unexplainable to us, while "science" in knowledge [*'gnosis'*], our logic and experience, as explainable elements). However, events and requirements in clinical practice, encountered at different times and in different situations, made the clinician aware of the need to apply in clinical practice of "**clinical oriented epidemiology"** or "**clinical epidemiology**", as a scientific basis for the interpretation of clinical phenomena, until the necessity of combining the clinical medicine with clinical epidemiology was finally fully understood. The recognition by the clinicians of the principles of epidemiology and the application of their beliefs, judgments and intuitions that make up the "art" of medicine, helps

the clinician realise in his clinical practice with the individual who is a patient essential improvement of the accuracy and efficiency of diagnosis and prognosis, as well as effectiveness of management. **The thesis that epidemiology constitutes the basic science of medical prevention was also extended to clinical medicine (curative) by arguing conclusively that epidemiology is "the art of medicine".**

Our natural condition is good health. But, "sickness" is felt, while good health is not felt at all", says an ancient Chinese proverb**.** Consequently, health has received less philosophical attention than the disease**.** The conceptual terrain in the case of health is a bit more complex than that of the disease. It is with this field that the current definition of health is related. **The World Health Organization** defines health as **"a state of complete physical, mental and social wellbeing, and not just a lack of disease, being a fundamental right of everyone (health equity)".** Although this WHO definition has been criticized because of the difficulty in defining and measuring the "full" quality of the "welfare", it essentially implies that **"health is a condition characterized by anatomical, physiological and psychological integrity of the individual; the ability of the individual to perform (to act in practice) values, moral norms and the role of family, community and society; the ability of the individual to cope with physical, biological, psychological and social stress; a sense of well-being; and, lastly, the freedom from the risk of the '*disease*' and premature death. "**

So health is a complex concept. It means that the same complexity represents the field of Public Health: Public Health is combined with various disciplines such as *biology, sociology, psychology, economy, agriculture and veterinary, education, culture, environmental protection,* etc., having as a basic method of operation *epidemiology* (where biostatistics is understood as an integral part of epidemiology). It means that the **medical model of health** cannot be understood disconnected from **the social model of health**: they intertwine rather than contrast.

Specifically, **the medical model of health** consists in: (i) the focus is that '*disease*' is considered the opposite of health; (ii) clinical medicine or the diagnosis and treatment of the sick individual is what implies tertiary prevention, ie quality of health care; and (iii) public health or community medicine is the one that carries out the community diagnosis and primary and secondary prevention, having in its essence the study of the cause (cause and effect connection) on the basis of cause (ensemble of factors or risk determinants) proximal in the sense of connection due to proximal-related disease. Whereas **the social model of health** consists in: (i) health is the result of the effects of all factors affecting the individual, the family or the community, through different ways; (ii) ie the study of causation extends to the the concept of causality chain ' - or in general a chain of causes now distal (each cause always considered as an ensemble of factors or risk determinants), where the outcome is the proximal cause directly related to illness or ill health.

The basic purposes of medicine are (i) to promot health, (ii) to maintain health, (iii) to restore (renewing) health when it is impaired, and (iv) to minimize bodily and/or mental suffering. These basic purposes are embedded (included) in the **term 'prevention'**. Prevention represents the essential moment of medical philosophy, synthetically expressed in the "**better prevent than treat**" postulate. The breadth of the concept of 'prevention' and directions of intervention for its realization, explains the variety of models, approaches and strategies of this process. Except that his scientific understanding requires as a condition *sine qua non:* (i) the founding of the prevention in the concept of 'natural disease history'; (ii) the founding of prevention in the broad concept of *causation*; and (iii) the founding of prevention in the concept of inclusiveness (individual-community-and the whole society as actors), guided by the philosophical dostojevskian principle "We are all responsible for everything" (Dostoyevsky).

Prevention would be defined as the actions/interventions undertaken to eradicate, eliminate or minimize the disease`s impact and disability, or if none of these would be possible, then the aim would be to delay the progress of the disease and disability. The concept of prevention is defined or best defined in the context of its traditional, primary, secondary, tertiary (and / or four-level) levels, as well as their predecessors - primordial prevention.

Primordial prevention consists on interventions, actions, measures taken to stop the appearance or development of risk factors (determinants), component of the consequential ensemble, these environmental (biological, physical, chemical) factors, economic, social, behaviour and lifestyle, etc. So, it is to be undertaken before the installation of the 'predicament' or 'preamble' phase (the initial part of the disease in the 'natural history of the disease'), represented by individual and community education and **is the sole object of public health or community medicine operation.**

Primary prevention would be defined as the action or intervention that is undertaken before the outbreak of the disease, ie prior to the onset of specific morphological, biological, physiological or psychological changes associated with the linked disease, and implies intervention in the stage of its pre-pathogenesis, with the aim of preventing the disease totally or to prevent the onset of the disease. **This operation is primarily a public health or community medicine operation, but does not exclude, in certain cases, clinical medicine,** and consists in "health promotion", namely in the health education, environmental modification, nutrition or nutrition interventions, changes of behaviour and lifestyle, as well as in "specific protection", namely, vaccination , chemoprophylaxis, use of nutrients and specific supplements, protection against occupational injuries, food safety, environmental pest control (air pollution, etc.).

Secondary prevention is defined as the action/intervention undertaken to stop the progression of disease to its development in clinical manifestation (= 'disease') with relevant clinical signs and symptoms and the relevant laboratory tests / tests (= 'random definition '). It consists on early diagnosis (screening tests) and adequate treatment and **is a operation subject to both public health or community medicine and clinical medicine interaction, in interaction between them.**

Tertiary prevention is carried out at that stage of the 'disease history' of the 'disease' when it has already become clinically manifest (= 'illness') and consists precisely in the quality of medical care to cure and to avoid or minimize disability, **by being presented only as a operation for clinical medicine.**

Regarding the **causality**, it's a complex matter that should always be considered: (i) biological and behaviour factors, (ii) environmental factors; (iii) immunological factors, (iv) nutritional factors (nutrition), (v) genetic factors, (vi) social, economic, and spiritual factors, and (vi) factors related to health and /or social services (availability, access, quality, etc.). Or, according to another kind of classification: (i) predisposing factors (such as age, gender, previous disease), (ii) enabling factors (such as income, nutrition, housing, availability of medical care), (iii) precipitating factors (such as exposure to a particular disease or to a certain toxic agent), and (iv) amplifier factors (such as repeated exposure, type of work, deprivation). Detailed elaboration on causality shows that: (i) it is never a single cause (= single causal component, determinant/risk factor alone) that, even if necessary, be capable of causing it alone the effect of the interest; (ii) the necessary cause is part of sufficient cause; (iii) sufficient cause is **a mist of causal necessary and unnecessary components,, that act together in the ensemble (= as a whole) and in interaction with one another.** But it's not just interaction. **Interaction is just a form.** While **the content is the concept of causation chain** mentioned above.

Public health or community medicine and clinical medicine are often seen as two completely different disciplinary frameworks, a misconception because the individual's health and community health are interrelated and interdependent. Which implies that these two different disciplinary frameworks are such only in a first and superficial view, while fundamentally they are but two compartments of the same disciplinary framework - the kingdom of medicine, which are interrelated between them and mutually interdependent . Public health and clinical approach prove this statement.

The public health approach, in its ideal concept, deals with communities - community health. This approach emphasizes primordial, primary, and secondary prevention. At community level, the difference between prevention and treatment may not be clear. The scope of public health is much broader than that of a clinical approach, because it involves the research of 'etiognosis/aetiology', the research

of causality, which is unlikely to be accomplished at the level of an independent patient in clinical medicine.

Meanwhile, **clinical approach** deals with individuals, families. The service provider's mission (= clinician) is to do the best for the patient. Although criticized for an insufficient attention to prevention, clinical medicine is not only inherently related to the treatment (treatment, cure) of the patient, but also to the prevention. In fact, in recent decades, time and resources devoted to prevention of the 'disease' have been significantly increased, especially in the area of secondary prevention (screening). At times, clinicians have emphasise the importance of the primary prevention. On the other hand, it is true that the inner, intrinsic of clinical approach is the focus on the individual, or sometimes even the family, regarding the diagnosis and therapeutic intervention, with the aim of realizing tertiary prevention, ie healing (though essentially without restitutio ad integrum) but meanwhile, education and health promotion to the patient and also to his/her family environment remains the other side of the medal of modus operandi of every clinician.

In conclusion, let's hope that all of the above elaboration, with the emphasis in the last part of it, has answered the basic question of this paper "Focus on health or illness?".

Diagnoses and Surgical Management. (Personal Case)

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Congenital posterior urethral-perinal fistula is a rare anomaly of which there have been reported only one case to date. This report outline the simple clinical presentation, diagnosis and simple technique surgical management. Congenital posterior urethral-perineal fistula is a rare anomaly. This is a rare case in the world literature. There are reported only six cases since 1964. Dr. William C. Brown, Dillon, Heusele has reported one case (diagnosis and new surgical technique). Other authors have reported rare cases: Le Duc has reported one instance ofan urethral-rectal fistula in the absence of any anorectal abnormality. Out of the 7 cases previously reported one is actually an urethral scrotal fistula but it is included since it has a similar embrylogic origin to the rest of the series.

The embrylogic basis for these anomalies is unclear. However two main theories have been proposed. Olbourne believes that if delay occurs in the descent of the anorectal septum at four weeks of gestation, then a fistula could result between the inferioraspect of the rectum and the primitive urogenital sinus. This may occur along the distance between entrance of the mesonephricduct which is the area of the prostatic urethrea and the urogenital ostium which will be the future area of the bulbons urethrae. Later dissolution of the anal membrane leaves the fistula at the site of the anal rectal junction. If the urethral folds start their fusion too far forward then a fistula may result.

In contrast to this I believe that the lateral ridges of the urorectal septum grow. into the cloaca and divide it as they meet in the midline. A defect in this midline joining would certainly account for fistula.

The anal plate which forms separately forces the opening to develop outside the anal sphincter and anus. This is important for surgical management. Woodhead