DIAGNOSTIC AND STATISTICAL MANUAL OF

MENTAL DISORDERS

SECOND EDITION (DSM-II)

AMERICAN PSYCHIATRIC ASSOCIATION

DSM-II

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

(Second Edition)

Prepared by

THE COMMITTEE ON NOMENCLATURE AND STATISTICS
OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Published by

AMERICAN PSYCHIATRIC ASSOCIATION
1700 18th Street, N. W.
Washington, D. C. 20009

968

Copyright 1968
American Psychiatric Association
1700 Eighteenth Street, N.W.
Washington, D. C. 20009

Library of Congress Catalogue Number: 68-26515

This Manual may be ordered at $3.50 per copy from Publications Office, American Psychiatric Association, 1700 18th Street, N.W., Washington, D. C., 20009. There is a 10% discount for 10 copies or more, and 20% for 50 or more. Also, a special library bound edition is available at $5.00 per copy.

First Printing, 50,000 copies, May 1968
Second Printing, 50,000 copies, October 1968
Third Printing, 50,000 copies, July 1970
Fourth Printing, 20,000 copies, August 1972

Committee on Nomenclature and Statistics, 1967

ERNEST M. GRUENBERG, *Chairman*
RICHARD L. JENKINS
LOTHAR B. KALINOWSKY
HENRIETTE KLEIN
BENJAMIN PASAMANICK
W. R. SLENGER
MORTON KRAMER, *Consultant*
ROBERT L. SPITZER, *Consultant*
LAWRENCE C. KOLB, *Co-ordinating Chairman*
EDWARD STAINBROOK, *Representative of Council*

Other Members of the Committee, 1946-1963

FRANZ ALEXANDER, 1947-1949
JOHN M. BAIRD, 1948-1951
ABRAM E. BENNETT, 1941-1946
GEORGE F. BREWSTER, 1946-1948
HENRY BRILL, 1958-1965
Chairman, 1960-1965
NORMAN Q. BRILL, 1946-1948
WALTER L. BRUETSCH, 1944-1949
JOHN M. CALDWELL, 1948-1951
J. P. S. CATHCART, 1941-1946
SIDNEY G. CHALK, 1947-1950
CLARENCE O. CHENEY, 1942-1947
NEIL A. DAYTON, 1936-1950
LEON EISENBERG, 1960-1966
JACOB H. FRIEDMAN, 1947-1949
MOSES M. FROHLICH, 1948-1960
Chairman, 1956-1960
ERNEST S. GODDARD, 1950-1966
RICHARD L. JENKINS, 1959-1962
JACOB KASANIN, 1944-1946
BALDWIN L. KEYES, 1947-1952
LAWRENCE KOLB, 1947-1950
LAWRENCE C. KOLB, 1954-1960
NOLAN D. C. LEWIS, 1946-1948
Chairman, 1946-1948
JAMES V. MAY, 1937-1948
H. HOUSTON MERRITT, 1946-1948
GEORGE N. RAINES, 1948-1959
Chairman, 1948-1949
and 1951-1954
J. DAVIS REICHARD, 1946-1949
MABEL ROSS, 1951-1957
ROBERT S. SCHWAB, 1949-1952
GEORGE S. SPRAGUE, 1945-1948
EDWARD A. STRECKER, 1948-1951
HARVEY J. TOMPKINS, 1950-1955
PAUL L. WHITE, 1946-1950

ACKNOWLEDGEMENT

The undersigned, at the request of the President of the American Psychiatric Association, served as consultants to the APA Medical Director and approved the final form of this Manual before publication. Dr. Paul T. Wilson of the APA staff undertook extensive editorial revision of the original manuscript and was notably successful in clarifying and adding precision to the definitions of terms. He was assisted by Mr. Robert L. Robinson. We are deeply grateful to both.

Bernard C. Glueck, M. D.
Chairman
Robert L. Spitzer, M. D.
Morton Kramer, Sc. D.

试读结束：需要全本请在线购买： www.ertongbook.com

FOREWORD

Ernest M. Gruenberg, M.D., Dr. P.H.
Chairman, Committee on Nomenclature and Statistics
American Psychiatric Association

This second edition of the **Diagnostic and Statistical Manual of Mental Disorders** (DSM-II) reflects the growth of the concept that the people of all nations live in one world. With the increasing success of the World Health Organization in promoting its uniform **International Classification of Diseases,** already used in many countries, the time came for psychiatrists of the United States to collaborate in preparing and using the new Eighth Revision of that classification (ICD-8) as approved by the WHO in 1966, to become effective in 1968. The rapid integration of psychiatry with the rest of medicine also helped create a need to have psychiatric nomenclature and classifications closely integrated with those of other medical practitioners. In the United States such classification has for some years followed closely the **International Classification of Diseases.**

With this objective in view, the Council of the American Psychiatric Association authorized its APA Committee on Nomenclature and Statistics to work closely with the Subcommittee on Classification of Mental Disorders of the U. S. National Committee on Vital and Health Statistics. The latter committee is advisory to the Surgeon General of the Public Health Service and was entrusted with responsibility for developing U. S. revision proposals for ICD-8, including the Section on Mental Disorders. Dr. Henry Brill, who was chairman of the APA Committee from 1960-1965, served as a member of the U. S. Subcommittee on Classification of Mental Disorders.

Dr. Brill also, it should be noted, served as Temporary Adviser to the Subcommittee on the Classification of Diseases of the Expert Committee on Health Statistics of the World Health Organization which made the final recommendations on the form and content of the various sections of the ICD. The final version of ICD-8 was adopted unanimously by the Nineteenth World Health Assembly in May, 1966, to become effective in all member states in 1968. Thus, from the beginning the United States representatives helped to formulate the Section on Mental Disorders in ICD-8 on which this Manual is based.

The WHO Nomenclature Regulations governing the use of the ICD recognizes that countries may, under exceptional circumstances, modify

inclusions within a major diagnostic category, provided the basic content of that category is not changed. In preparing this Manual the Committee had to make adjustments within a few of the ICD categories to make them conform better to U.S. usage. Decisions were also made regarding certain diagnoses which have not been generally accepted in U. S. psychiatry. Some of these diagnoses have been omitted here; others have been included and qualified as controversial. The diagnoses at issue are: **Psychosis with childbirth, Involutional melancholia,** and **Depersonalization syndrome.** Also this Manual suggests omitting certain specific categories and makes subdivisions in other categories, assigning unused numbers in ICD-8 to the new subcategories.

In publishing the Manual the Association provides a service to the psychiatrists of the United States and presents a nomenclature that is usable in mental hospitals, psychiatric clinics, and in office practice. It has, in fact, a wider usage because of the growth of psychiatric work in general hospitals, both on psychiatric wards and in consultation services to the patients in other hospital departments, and in comprehensive community mental health centers. It will also be used in consultations to courts and industrial health services.

No list of diagnostic terms could be completely adequate for use in all those situations and in every country and for all time. Nor can it incorporate all the accumulated new knowledge of psychiatry at any one point in time. The Committee has attempted to put down what it judges to be generally agreed upon by well-informed psychiatrists today.

In selecting suitable diagnostic terms for each rubric, the Committee has chosen terms which it thought would facilitate maximum communication within the profession and reduce confusion and ambiguity to a minimum. Rationalists may be prone to believe the old saying that "a rose by any other name would smell as sweet"; but psychiatrists know full well that irrational factors belie its validity and that labels of themselves condition our perceptions. The Committee accepted the fact that different names for the same thing imply different attitudes and concepts. It has, however, tried to avoid terms which carry with them *implications* regarding either the nature of a disorder or its causes and has been explicit about causal assumptions when they are integral to a diagnostic concept.

In the case of diagnostic categories about which there is current controversy concerning the disorder's nature or cause, the Committee has attempted to select terms which it thought would least bind the judgment of the user. The Committee itself included representatives

of many views. It did not try to reconcile those views but rather to find terms which could be used to label the disorders about which they wished to be able to debate. Inevitably some users of this Manual will read into it some general view of the nature of mental disorders. The Committee can only aver that such interpretations are, in fact, unjustified.

Consider, for example, the mental disorder labeled in this Manual as "schizophrenia," which, in the first edition, was labeled "schizophrenic reaction." The change of label has not changed the nature of the disorder, nor will it discourage continuing debate about its nature or causes. Even if it had tried, the Committee could not establish agreement about what this disorder is; it could only agree on what to call it. In general, the terms arrived at by representatives of many countries in the deliberations held under WHO auspices have been retained preferentially, unless they seemed to carry unacceptable implications or ambiguities.

The first edition of this Manual (1952) made an important contribution to U. S. and, indeed, world psychiatry. It was reprinted twenty times through 1967 and distributed widely in the U. S. and other countries. Until recently, no other country had provided itself with an equivalent official manual of approved diagnostic terms. DSM-I was also extensively, though not universally, used in the U. S. for statistical coding of psychiatric case records. In preparing this new edition, the Committee has been particularly conscious of its usefulness in helping to stabilize nomenclature in textbooks and professional literature.

A draft of this Manual, DSM-II, was circulated to 120 psychiatrists in February 1967, with a request for specific suggestions to eliminate errors and to improve the quality of the statements indicating the proper usage of terms which the Manual describes. Many extremely valuable replies were received. These were collated and studied by the members of the Committee prior to its meeting in May 1967, at which time the Committee formulated the present manuscript and submitted it to the APA Executive Committee for approval. In December 1967 the APA Council gave it final approval for publication.

Throughout, the Committee has had the good fortune to have as consultants Dr. Morton Kramer and Dr. Robert L. Spitzer. Dr. Kramer, Chief of the Biometry Branch of the National Institute of Mental Health, played a similarly vital role in the formulation of DSM-I. His intelligent and sustained concern with the problems encountered has assured that

the preservation of statistical continuity has been considered at every stage in the development of this Manual. He is specifically responsible for the preparation of the Introduction following and Sections 4, and 5 of this Manual. Dr. Robert L. Spitzer, Director, Evaluation Unit, Biometrics Research, New York State Psychiatric Institute, served as Technical Consultant to the Committee and contributed importantly to the articulation of Committee consensus as it proceeded from one draft formulation to the next.

The present members of the Committee on Nomenclature and Statistics owe a deep debt to former chairmen and members of the Committee who provided the foundation upon which the second edition was prepared. In the Foreword to DSM-I will be found an extensive description of those who contributed to the first edition. Because this second edition is, in fact, the product of the continuing endeavors of the Committee's changing members, all members of the Committee since 1946 are listed as authors.

As Chairman since 1965, the writer wishes to express his personal deep appreciation to the hard-working members of the Committee and its two consultants, all of whom participated vigorously and thoughtfully in the Committee's deliberations and the formulation of the many draft revisions that were required.

New York, N.Y.
March, 1968

INTRODUCTION: THE HISTORICAL BACKGROUND OF ICD-8

MORTON KRAMER, SC.D.
Chief, Biometry Branch, National Institute of Mental Health

The Classification of Mental Disorders in the Sixth Revision of the **International Classification of Diseases** (ICD-6) was quite unsatisfactory for classifying many of the diagnostic terms that were introduced in the first edition of this manual (DSM-I, 1952). For example, with certain exceptions, ICD-6 did not provide rubrics for coding chronic brain syndromes (associated with various diseases or conditions) with neurotic or behavioral reactions or without qualifying phrases, nor did it provide for the transient situational personality disorders. The exceptions were post-encephalitic personality and character disorders among the chronic brain syndromes, alcoholic delirium among the acute brain syndromes, and gross stress reaction among the transient disorders.

Accordingly, in 1951, the U. S. Public Health Service established a working party comprising the late Dr. George Raines, representing the American Psychiatric Association, and three others from the Public Health Service, Dr. Selwyn Collins, Mrs. Louise Bollo, and the author, to develop a series of categories for mental disorders that could be introduced into appropriate places in ICD-6 to adapt it for use in the United States.[1]

The shortcomings of ICD-6 (and of a seventh edition in 1955 which did not revise the section on mental disorders), pointed up the unsuitability of its use in the United States for compiling statistics on the diagnostic characteristics of patients with mental disorders or for indexing medical records in psychiatric treatment facilities. Moreover, the section on mental disorders was not self-contained. Certain mental disorders occurred in other sections of the ICD. General paralysis was classified under syphilis, and post-encephalitic psychosis under the late effects of acute infectious encephalitis, for example. Also, many of the psychoses associated with organic factors were grouped in a catch-all category of psychoses with other demonstrable etiology.

---

[1] See Appendix A, DSM-I. It reveals the extensive adjustments that had to be introduced into ICD-6 to make it usable in the U. S. for coding the diagnostic terms contained in DSM-I.

The United States, however, was not the only country which found the section on mental disorders in ICD-6 unsatisfactory. In 1959, Professor E. Stengel, under the auspices of the World Health Organization, published a study revealing general dissatisfaction in all WHO member countries.[1] This finding, combined with the growing recognition of mental disorders as a major international health concern, led WHO to urge its member states to collaborate in developing a classification of these disorders that would overcome the ICD's shortcomings and gain general international acceptance. Such a classification was recognized as indispensable for international communication and data collection.

To initiate the work of revising the ICD, the U. S. Public Health Service then established a series of subcommittees of its National Committee on Vital and Health Statistics, including a Subcommittee on Classification of Mental Disorders. The National Committee is advisory to the Surgeon General on technical matters and developments in the field of vital and health statistics. The goal of all subcommittees was to complete their recommendations in time for consideration by the International Revision Conference, which WHO had scheduled for July 1965.

The Subcommittee on Classification of Mental Disorders, appointed by the National Committee on Vital and Health Statistics, comprised Dr. Benjamin Pasamanick, Chairman, Dr. Moses M. Frohlich (then chairman of the APA Committee on Nomenclature and Statistics), Dr. Joseph Zubin, and the author. Later, Dr. Henry Brill was made Chairman of the APA Committee and replaced Dr. Frohlich on the Subcommittee. Dr. Leon Eisenberg, a child psychiatrist, was also added to the Subcommittee.

Throughout, the Subcommittee worked very closely with Dr. Brill in the latter's capacity as chairman of the APA Committee, and he actively participated in developing the Draft Classification that was submitted by the U. S. to the first meeting of the Subcommittee on Classification of Diseases of the WHO Expert Committee on Health Statistics in Geneva, Switzerland in November 1961. Dr. Brill was present at the meeting as an adviser.

Following this meeting, the possibility and desirability occurred to the U. S. Subcommittee of working with colleagues in the United Kingdom to develop and agree upon a single classification of mental

[1] Stengel, E. (1960), "Classification of Mental Diseases", Bull. of Wld. Hlth. Org., **21**, 601

试读结束：需要全本请在线购买： www.ertongbook.com

disorders. The counterpart committee in the U. K. readily agreed, and a joint meeting with them was held in September 1962. Again, Dr. Brill played a most constructive role in achieving agreement on a single classification.

By April of 1963 it was possible to report this achievement to mental health and hospital authorities in the United States and to solicit their comments on the U. S.-U. K. draft which were uniformly constructive and for the most part favorable.

Thus reinforced, the joint U. S.-U. K. proposal for a classification of mental disorders was submitted to WHO in midsummer of 1963. By this time, WHO had received seven other proposals, from Australia, Czechoslovakia, the Federal Republic of Germany, France, Norway, Poland, and the Soviet Union. WHO called a meeting in Geneva in September 1963 to attempt the formulation of a single proposal. Dr. Benjamin Pasamanick and the author came from the U. S. to attend the meeting, which was attended by several European psychiatrists. It was quite gratifying that the meeting elicited very considerable agreement on the classification of schizophrenia; paranoid states; the psychoses associated with infections, organic, and physical conditions; non-psychotic conditions associated with infections, organic, and physical conditions; mental retardation; physical disorders of presumably psychogenic origin; special symptom reactions; addictions; and transient situational disturbances. The areas that still remained in disagreement were the affective disorders, neurotic depressive reaction, several of the personality disorders (paranoid, antisocial reaction, and sexual deviation), and mental retardation with psychosocial deprivation. Although all differences still were not resolved, the general arrangement and content of the classification that resulted from this meeting were in accord with the U. S.-U. K. proposal.

The WHO Expert Subcommittee on Classification of Diseases then met in October and November 1963 to consider the results of the September meeting. At this point, the U. S. submitted a revised proposal. It had become quite clear by now, for example, that there would be little support for the U. S. terminology "Brain syndrome associated with (a specific organic or physical disorder) with psychotic reaction." Nevertheless, the classification of organic psychoses proposed by the U. S. and the U. K. was acceptable to others if the phrase "Brain syndrome" was dropped. The term "non-psychotic conditions associated

with organic or physical conditions" was acceptable, whereas "Brain syndrome with organic or physical condition" was not. Accordingly, some modifications of this order were proposed.

Two psychiatrists who acted as advisers at this Expert Committee meeting were Dr. Henry Brill for the U. S. and Professor A. V. Snezhnevsky, Director of the Institute of Psychiatry of the Academy of Medical Sciences, for the U.S.S.R. They were invited to resolve some controversial issues centering around three proposed diagnoses: antisocial personality, reactive psychosis, and mental retardation with psycho-social deprivation.

The report of this meeting and the proposed classification that resulted from it were then submitted to the Expert Committee on Health Statistics which met in Geneva in October 1964. Based on the report of this meeting and further evaluation of specific needs within different countries, the Secretariat of WHO drafted a final revision proposal which included rubrics for the diagnoses antisocial personality, mental retardation with psychosocial deprivation, and a separate category for the various reactive psychoses. This draft was submitted to and approved unanimously by the International Revision Conference in July 1965. The recommendations of this conference were approved unanimously by the 19th World Health Assembly in May 1966.

Shortly after the International Revision Conference, Dr. Ernest Gruenberg, who became Chairman of the APA Committee on Nomenclature and Statistics in 1965, prepared a special supplement for the eighteenth printing of DSM-I (November 1965) in which he described the plan for revision and reproduced the section on mental disorders of the **International Classification of Diseases** as approved by the Conference.

There is yet another important action to be cited. The WHO Expert Subcommittee on Classification of Diseases, at its first meeting in November 1961, recommended that WHO establish for international use a glossary of operational definitions of the terms that would be included in the revised classification ICD-8. This was viewed as an essential step in solving practical problems related to the classification of those disorders for international purposes. Two years later, in November 1963, the same committee further underscored its concern by urging all participating countries to develop national glossaries as

a first step toward achieving a single international glossary. Operational definitions applicable in the U. S. appear in Section 3 in this Manual. The United Kingdom has also prepared a set of operational definitions[1] and several other countries have them in progress. The WHO has initiated plans to develop the international glossary.

In sum, the classification of mental disorders in ICD-8 on which this Manual is based is clearly the product of an international collaborative effort that started in 1957 and culminated in the International Revision Conference of July 1965.

The U. S. recommendations presented by Dr. Henry Brill in Geneva had considerable impact on the form and content of the final classification. Those recommendations included the incorporation into the ICD of a single section providing a comprehensive classification of mental disorders and one that relates mental disorders associated with organic and physical factors to other disease categories in the ICD. Also, a series of categories that did not appear in ICD-6 were added, namely, mental disorders not specified as psychotic associated with organic and physical disorders, physical disorders of presumably psychogenic origin, and transient situational disturbances. Finally, a much more complete classification of mental retardation, based on recommendations of the American Association on Mental Deficiency, was accepted.

The new classification may be considered an achievement of the first order in international professional collaboration. It takes into account established knowledge of etiology, and where such knowledge is not available, it attempts to provide a middle ground to satisfy the needs of psychiatrists of different schools of theoretical orientation. It also is, manifestly, a compromise which will fully satisfy psychiatrists neither in the U. S. nor in any other country. The WHO is fully aware of this and already has programs under way looking to a still more satisfactory classification in the ninth revision.[2] The achievement of ICD-8 and the experience underlying it augurs well for ICD-9.

[1] *A Glossary of Mental Disorders*, (1968), Prepared by the Subcommittee on Classification of Mental Disorders of the Register General's Advisory Committee on Medical Nomenclature and Statistics. General Register Office, Studies on Medical and Population Subjects No. 22, Her Majesty's Stationery Office, London

[2] Lin, T., (1967), "The Epidemiological Study of Mental Disorders by WHO", Soc. Psychiat. 1, 204

TABLE OF CONTENTS

Foreword by Ernest M. Gruenberg, M. D., Dr. P. H. vii

Introduction: The Historical Background of ICD-8
by Morton Kramer, Sc. D. xi

Section 1 The Use of This Manual: Special Instructions 1

Section 2 The Diagnostic Nomenclature: List of Mental Disorders and Their Code Numbers 5

Section 3 The Definitions of Terms 14

I. Mental Retardation 14

II. Organic Brain Syndromes 22

A. Psychoses Associated with Organic Brain Syndromes 24

B. Non-psychotic Organic Brain Syndromes 31

III. Psychoses not Attributed to Physical Conditions Listed Previously 32

IV. Neuroses 39

V. Personality Disorders and Certain Other Non-psychotic Mental Disorders 41

VI. Psychophysiologic Disorders 46

VII. Special Symptoms 47

VIII. Transient Situational Distrubances 48

IX. Behavior Disorders of Childhood and Adolescence 49

X. Conditions Without Manifest Psychiatric Disorder and Non-specific Conditions 51

XI. Non-diagnostic Terms for Administrative Use 52

Section 4 Statistical Tabulations 53

Section 5 Comparative Listing of Titles and Codes 64

Section 6 Detailed List of Major Disease Categories in ICD-8 83

Section 7 A Guide to the New Nomenclature, by Robert L. Spitzer, M.D., and Paul T. Wilson, M.D. 120

Section 1

THE USE OF THIS MANUAL: SPECIAL INSTRUCTIONS

Abbreviations and Special Symbols

The following abbreviations and special symbols are used throughout this Manual:

WHO —The World Health Organization

ICD-8 —The **International Classification of Diseases, Eighth Revision,** World Health Organization, 1968. For use in the United States see: **Eighth Revision International Classification of Diseases Adapted for Use in the United States,** Public Health Service Publication No. 1693, U. S. Government Printing Office, Washington, D. C. 20402.

DSM-I —**Diagnostic and Statistical Manual, Mental Disorders,** American Psychiatric Association, Washington, D. C., 1952 (out of print).

DSM-II —This Manual: **Diagnostic and Statistical Manual of Mental Disorders,** Second Edition, American Psychiatric Association, Washington, D. C., 1968.

[ ] —The brackets indicate ICD-8 categories to be avoided in the United States or used by record librarians only.

* —Asterisk indicates categories added to ICD-8 for use in the United States only.

(( )) —Double parentheses indicate ICD-8 terms equivalent to U. S. terms.

OBS —Organic Brain Syndrome(s), i.e. mental disorders caused by or associated with impairment of brain tissue function.

The Organization of the Diagnostic Nomenclature

While this Manual generally uses the same diagnostic code numbers as ICD-8, two groups of disorders are out of sequence: *Mental retardation* and the *Non-psychotic organic brain syndromes. Mental retardation* is placed first to emphasize that it is to be diagnosed whenever present, even if due to some other disorder. The *Non-psychotic or-*

ganic brain syndromes are grouped with the other organic brain syndromes in keeping with psychiatric thinking in this country, which views the organic brain syndromes, whether psychotic or not, as one group. Furthermore, the diagnostic nomenclature is divided into ten major subdivisions, indicated with Roman numerals, to emphasize the way mental disorders are often grouped in the United States.

The Recording of Diagnoses

Every attempt has been made to express the diagnoses in the clearest and simplest terms possible within the framework of modern usage. Clinicians will significantly improve communication and research by recording their diagnoses in the same terms.

Multiple Psychiatric Diagnoses

Individuals may have more than one mental disorder. For example, a patient with anxiety neurosis may also develop morphine addiction. In DSM-I, drug addiction was classified as a secondary diagnosis, but addiction to alcohol, for example, could not be diagnosed in the presence of a recognizable underlying disorder. This manual, by contrast, encourages the recording of the diagnosis of alcoholism separately even when it begins as a symptomatic expression of another disorder. Likewise mental retardation is a separate diagnosis. For example, there are children whose disorders could be diagnosed as "Schizophrenia, childhood type" and "Mental retardation following major psychiatric disorder."

The diagnostician, however, should not lose sight of the rule of parsimony and diagnose more conditions than are necessary to account for the clinical picture. The opportunity to make multiple diagnoses does not lessen the physician's responsibility to make a careful differential diagnosis.

Which of several diagnoses the physician places first is a matter of his own judgment, but two principles may be helpful in making his decision:

1. The condition which most urgently requires treatment should be listed first. For example, if a patient with simple schizophrenia was presented to the diagnostician because of pathological alcohol intoxication, then the order of diagnoses would be first, *Pathological intoxication,* and second, *Schizophrenia, simple type.*

2. When there is no issue of disposition or treatment priority, the more serious condition should be listed first.

试读结束：需要全本请在线购买： www.ertongbook.com