



## Commentaries

# How Can You Be Two Places At Once When You're Not Anywhere At All?

### THIS TITLE IS A QUOTE FROM THE FIRESIGN

Theater, a comedy group in the 60's that appealed to the drug culture of baby boomers. It came to mind when I reviewed a couple of evaluations of patients I had seen, who had gone, at my suggestion, to another center for another opinion, from people who subspecialized within my own field of movement disorders. The notes on both patients seemed to have missed the mark. The neurological exam in movement disorders, as is true in much of neurology, is the crucial bedrock on which all else depends. Unlike other areas of medicine, or even in much of neurology, the history is less important than the exam. Like dermatology, what you see is what you get. After all, dizziness, clumsiness, imbalance are words so imprecise that they should not be used in medical presentations except when quoting the patient.

My two patients, who walk like they're drunk, are described as having a narrow based gait, mildly unsteady. Their limb ataxia is minimized to the point where it can be overlooked. The importance of various findings are given, to my mind, the wrong set of weights. Ataxia is minimized, akinesia exaggerated, instead of vice versa. In the area of movement disorders classification is everything. It's like classifying a murmur prior to the era of echocardiography, when findings on the physical exam had some meaning, and might even determine treatment.

So, what am I to make of a super-specialty clinic where the role of the quaternary consultation appears to be ordering as many tests as possible? Why do we refer to specialists? In some cases it is pro forma, perhaps even legal in its underpinnings, making sure that there isn't an incorrect diagnosis, that the management is acceptable, that in case of error there won't be recriminations. But most referrals are made for the patient's benefit. Someone who specializes should know more about

a disorder than the person who does not specialize. But what if the specialist really specializes in the basic science aspects of the illness rather than the human form? What if the referring doctor actually sees more patients with the disorder than the super-specialist who spends one half day/week in clinic during the weeks he's not travelling?

Can you be a clinical specialist if you spend only a half a day a week seeing patients? I am coming to think not. And I say this as a sub-specialist, not excluding myself from criticism. Of course, I also say this as a clinician who spends almost all day, every day seeing patients.

Many years ago, when I still saw general neurology patients and did in-patient consultations every other month, I gave a talk at a fairly distinguished medical center. After the talk a case was presented that centered on the neurological complications of bacterial endocarditis. Since this was a topic I dealt with frequently, at least as a possibility on the differential diagnosis list, I was fairly well educated on the topic. I was amazed though by how many of these distinguished, well known authorities in other neurological fields, were not. While there is an expected trade off between being a jack of all trades and being a master of one, one hopes that the "master" would restrict his authority in discussions to the discipline mastered, and not the ones left fallow. Every university medical center is run by subspecialists. They are, hopefully specialists, like cardiologists, who subspecialize in rhythm disturbances, or congestive failure, ischemia, or transplantation, but are also knowledgeable about cardiology problems in general. But what would an internist, or a cardiologist, think of the cardiologist who specializes in right heart failure and who sees patients only one half day/week? A busy academic cardiologist may see more of these patients in a typical week than the subspecialist. Can one be a clinical expert with limited experience?

The answer is yes but it makes me uneasy. Those of us who see a lot of patients "learn" from experience. We develop a clinical sensibility, we think, try constantly to revise this clinical sense, sharpen it, re-think it when we see cases that don't fit. But when the cases are few, we lose the strop that sharpens the razor. Especially so when we see a patient once or twice and send them back whence they came, losing the long term follow up.

I once invited a distinguished, justifiably famous, colleague to give neurology grand rounds. I think he's one of the best clinicians in my field in the world. I presented cases in which I was unable to make a diagnosis. He quickly diagnosed the first two cases as having progressive supranuclear palsy (PSP), which made my jaw drop (along, I think, with my reputation). I probably had seen more cases of this than him and I had not overlooked this diagnosis, but he had been convinced by a paper he read that a particular type of dysarthria was virtually diagnostic of PSP. Of course, his job was to make a diagnosis, if he could, and I got to follow the patients, neither of whom blossomed into typical PSP. Had my friend followed these patients he would have altered his diagnosis, I believe, but he was visiting, and rendering a teaching exercise. The specialist who has only limited clinical experience cannot learn from mistakes. They don't happen when you don't have time for follow ups. And even one's examination, the soul of neurology, apparently deteriorates.

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