Section Editor

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The other day I was listening to a senior cardiologist musing about the parlous state of clinical cardiology. This may seem an unduly jaundiced view given the specialty's success in treating the faint-hearted. His point, though, was that none of the recent graduates knew how to listen to the heart. The stethoscope had become more ornament than useful tool. It was the echocardiogram, the scan, and, to a lesser extent, the angiogram that answered the physician's and, consequently, the patient's concerns. My friend sensed a divide between those of his generation, to whom the heart's music spoke eloquently, and a new generation who were technically superb but, as it were, tone deaf. I believe his chief regret was that the technical wizardry at their disposal resulted in a more accurate diagnosis and that his beliefs about auscultation were nostalgic, as if remembering one's first love or the aroma of a childhood kitchen.

The comment that caught my attention was the existence of a "divide." We are used to thinking about such divides in terms of physical characteristics and it has always been thus. Those of us who had to pore over Caesar in Latin class remember the separation of Cis-Alpine Gaul and Trans-Alpine Gaul. It was however more than a physical barrier. Civilization, as seen by the Romans, definitely lay on their side of the Alps and the pesky inferior Barbarians were on the other side, or at least until they started to stray over with rather drastic consequences.

Another range of hills ran down the center of the north of England to separate the medieval House of York from the House of Lancaster. Both regarded the other side with disfavor, a dislike that persisted in vestigial form, at least, until the late 20th century in that arcane game of cricket. The match between Lancashire and Yorkshire still bore the title of the War of the Roses, neither side being eager to win but both with fierce determination not to lose. This resulted in glorious inactivity for days on end to the dour satisfaction of the silent spectators (one of whom, on the famous occasion of a car backfiring outside the cricket ground, announced loudly, "T" scorer's shot his-

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self"). There are many examples of such divides, the Pyrenees, the Sahara, among others, in which the presence of a physical barrier has lent itself to the development of people with different beliefs, lifestyles, and prejudices, depending whether they were cis- or trans-barrier.

This concept of a physical divide associated with differences in attitude extends to the New World as firmly as the Old. One may argue whether the Rockies or the Mississippi represents the divide that separates East from West, but there is a general belief that the West mirrors the youth-oriented, informal, and free-spirited way of life as opposed to the more traditional, conservative, and ordered patterns of the East. The West is Silicon Valley and dot.com, Hollywood and the Beach. The East is Wall Street and Insurance, Broadway and Pennsylvania Avenue.

The last point to make before turning to Neurology is that all of these stereotypes are inaccurate. One's belief as to what lies on the other side of the mountain is bigoted unless one has actually experienced it. Some of the Romans' diversions were barbaric. Art was flourishing in Celtic Gaul. Richard III may not have been the villain portrayed by the victorious Tudors led by their CEO, Henry VII. There are splendid beaches on the East Coast.

The first rumblings that heralded the appearance of the Neurology Divide were sensed in the 1970s with the arrival of the EMIScan (does anyone still remember the name?). The upthrust continued with the further development of computer tomography and the mountain chain became permanent with the ready availability of MRI and its associated techniques. I think of this divide as the Range of Imaging. All of my training and early experience was in the cis-Imaging territory and it is obvious that Neurology is now firmly planted in the trans-Imaging area.

We can now see lesions and where they lie in the nervous system instead of having to infer their presence after a series of academic gymnastics. Nobody in their right minds would recommend returning to the plains of cis-Imaging. My senior colleagues and I have crossed the Range of Imag-

ing with conviction if not always with an emotional commitment. We now live in a trans-Imaging world. That does not prevent us from looking back over the mountains with some fondness.

In that lost world, we lived with the ambiguous shadows of the pneumoencephalogram, the serpentine tracks of the eight-lead EEG and the Transylvanian carotid stick. We were serious about all of these but our real love, our staple, was the neurologic examination.

Our examination of the patient was intricate and mysterious; pulling on the patient's fingers and watching for the inward drift of the thumb, carrying balanced weights in our bag for testing barognosis, testing two point discrimination over the back, producing vials of cloves, sugar, salt, vinegar, and ammonia. Colleagues in lesser specialties were baffled at how often we were shown to be correct—usually at autopsy, such being the nature of neurology at the time. We were the virtuosi of the medical orchestra. When there was a patient whose symptoms were inexplicable, the cry went up “Get the neurologist!” (a little ahead of “Get the priest!”). If you read this paragraph with a knowing smile, you probably grew up cis-Imaging, especially if you know the eponymous tags for any of the signs.

I used the word arcane in relation to cricket. The neurologic examination was equally arcane. There were many similarities. You almost had to grow up with the sport to be able to understand it. Both were full of seemingly meaningless rituals and incomprehensible names. Both took an interminable time and often it was difficult to tell whether anything was being accomplished. Both have changed. Cricket has modernized and players now wear colored uniforms and games are rushed through in a day. Neurology is definitely trans-Imaging.

It is easy to look back at that cis-imaging world and shake one's head at its quaintness. Is there anything in it that is really worth preserving? Of course, knowledge of the rudiments of the neurologic examination is still essential. It is important to know which patients do not need to be sent to the imaging suite. It would be disastrous to miss a brain herniation. Medicine is still practiced outside the reach of the MRI. Most neurologists will tell you, if asked, that there is still a vital need for a good neurologic examination, which causes me to puzzle over the residents' amazement when they are actually shown one.

There was one by-product of the neurologic examination in those cis-Imaging days. It is rarely

discussed, but I believe it to be as important as the examination itself. The cis-Imaging neurologic examination was seldom less than an hour. It was the bane of the business manager and would be intolerable in today's economic climate. One was forced into contact with the patient for a long period of time.

Between starting the history and testing the sacral roots, one learned of the patient's hobbies, of the reasons for the failure of the first marriage and of who was to blame, one chuckled together at the indignity of hospital gowns and lamented the traffic conditions in town. A certain rapport was necessary before testing the anal wink without discomfort to both parties and the neurologic examination gave you time to establish it. It was, in short, a good way to get to know the patients and their families.

Which brings me back to cardiology. The day after my conversation with the cardiologist I happened to sit next to a retired nurse at a luncheon. Her husband had recently been in the hospital for the investigation of dementia. For some reason, he was on IV fluids and she noticed that they were running in at a rate that she thought excessive. He was increasingly unwell. She did not announce that she was a nurse since she felt it might annoy the hospital staff. She called the intern in to ask his advice, since she noticed that her husband's neck veins were up to his ears. The intern called the resident and they were both observed “twittering away,” to use her words, at the desk outside. They returned to explain that her husband was just having a temporary reaction to the IV fluids and it would pass. Fortunately, the attending, an elderly physician with low tolerance for absurdities, made rounds shortly thereafter. The Bowdlerized version of what he exclaimed as he entered the room is “Good God, how long has this patient been in failure!” The moral of the story is not that the intern was inexperienced. It is that nobody on the medical team knew the patient's family well enough to realize that they were dealing with an experienced nurse whose observations might be valid.

You may think that similar examples would be rare in Neurology. I believe to the contrary. Within the last few weeks I have heard two stories that bother me. In one instance the patient learned that he had amyotrophic lateral sclerosis because it was casually mentioned when he happened to encounter the physician in the parking lot on the way home. In the other, the family of an 85-year-old woman with severe speech difficulty and a right hemiplegia was given to understand

that a gyrus was missing but that it might grow back. They were not too sure what a gyrus was but assumed it had something to do with the brain and were encouraged that it would grow back. Yes, I fully realize that the patients may have misinterpreted what they were actually told, but that is the point. If you know people well, then you know whether they have grasped what you are saying or not.

The ramblings of a cis-Imaging neurologist in a trans-Imaging world are probably irrelevant and worthy of no more than a moment's diversion. The technical knowledge of the trans-Imaging neurologists is impressive and far superior to the norm of their cis-Imaging forebears. I am reminded of La

Fontaine's comment "Il connait l'univers et ne se connait pas." I would amend it slightly to read "He knows everything but not the patient" and caution the trans-Imaging neurologist never to be the object of such a tag.

Whose side are you on? I would like to be trans-Imaging but fear that I may be stuck on the other side of the mountain; a relic out of place. I have consolation, however, because, whether they like it or not, all of my trans-Imaging colleagues are actually dwelling in the cis-RNA/DNA side of the next looming divide and I happily abandoned any pretense at keeping up with that when the names of genes began to show up in my alphabet soup.

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