



Commentaries

Rat Doctors

A world renowned expert, chair of a neurology department at a prestigious university, gave an invited talk at an international congress, talking about his field of expertise, pathophysiology of brainstem function in animal models of a behavior seen in **Parkinson's disease (PD)**. He was asked a question about the actual human condition: If the region of the brain he discussed was so impaired in every PD patient, why wasn't that clinical problem seen more? The expert noted that if one was clever enough to ask the correct questions and delve into the issue adequately, it was far more common than the literature would suggest and was virtually ubiquitous.

That comment provoked this column. I have been interested in the behavior under discussion and have, in fact, delved into the question. I am familiar with the clinical literature, which clearly shows that the problem affects under 30% of PD patients, whether one uses intensive questionnaires or laboratory testing, one of which is the "gold standard" depending on who you are. I have probably seen over 100 times as many PD patients as the expert, and the 30% estimate is probably correct. And since I've contributed a few papers to the clinical literature, including data from first hand observation, I think I have a reasonable handle on the problem.

As they say in the trade, "If you don't know the answer, then baffle them with baloney."

I worry about the impact observations by such researchers make on people who are not experts in the field. I understand why the expert feels the need to extend his aura from the laboratory to the clinic. He wants to be perceived as the omni-competent, omniscient ubermensch who deserves his distinguished position. He needs to show that he is not simply a lab expert. He *understands* the disorder based on animal and

human experience. It is hard to understand, however, how one can be a clinical expert when one sees patients one half day each week (when not traveling to a conference or too busy to attend the clinic). This isn't to say there aren't such people. I have met them and stand in awe of them. There aren't too many of them. However, and far fewer than they think.

I am familiar with prestigious institutions which have a myriad of experts in my field of movement disorders who each see patients one half day per week. For some reason there is a feeling that laboratory experts have expertise in clinical medicine whereas clinical experts never think their competence extends into the laboratory. The latter is understandable; the former, less so.

The danger lies in the impact an "expert" may make on an unwitting listener who cannot distinguish between the "rat doctor's*" expertise and the clinician expert. The "rat doctor," who may be world famous, is famous for his laboratory observations. He should limit his expert comments to this area in which he is, in fact, expert. He should speculate on what his observations mean in "the real world," meaning, the world of human patients. His basic research work is always focused on this, the ultimate goal of all medical research. This work is the beginning of the translational research road. The problem arises when the doctor confuses his white coat, medical degree and animal research contributions with clinical knowledge.

I heard a wonderful joke from a neurosurgeon. When a doctor has seen one case, he talks about his experience. When he's seen two cases he describes his "series." When he's seen three cases, it becomes, "In case after case after case..." So when the rat doctor reports that a problem affects 75% of his cases whereas studies report less than 30%, one wonders if this represents three of four cases

or 75 out of a 100; how did he interview these patients; how did these patients get to see him in the first place?

Another neurology chair asked his movement disorders chief, an internationally recognized figure, whom he would see if he had PD and lived in a city where there was a world renowned researcher and a locally well known PD clinician who had written books for patients. When the PD expert said there was no question that he'd see the clinical expert the chair was astounded. "But so and so is a first rate scientist and very famous! The other guy doesn't even publish."

At a meeting of one of the state PD support associations a motivational speaker taught patients that the abbreviation, MD, stands for medical doctor not "medical deity." She said, "Listen to your doctor, but he's not god, no matter what he thinks." An RN told me that at a lecture she gave to PD nurses she tried to make the point over and over that the RNs had to worry less about what their physician supervisors think about them and do more to support their patients, even if it meant a confrontation with the MD. I responded that it was too bad that more doctors didn't worry about what people thought about them, less about being paragons of knowledge and competence.

Who knows what we look like to our patients, staff, colleagues or students? Gazing at ourselves in the mirror isn't enough. After all, look what happened to Narcissus.

—JOSEPH H. FRIEDMAN, MD

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