



Commentaries

Specialty Care

ALL DOCTORS BELIEVE THEMSELVES, LIKE THE children in Lake Wobegone, to be above average. Certainly specialists consider themselves even more so, at least with respect to non-specialists, but we don't often have data to prove it. A recent article in *Neurology*, in support of this assertion (*Neurology* 2011;77:851) made me recall some comments I heard regarding neurologists and Parkinson's specialists.

At a large primary care meeting that a colleague, another movement disorders specialist, lectured at, the panel of speakers was asked, "When should someone with PD be referred to a neurologist?" A prominent family care doctor on the panel answered, "Never." I suspect that the response emanated from experience that the specialists concentrated on the motor aspects of PD and failed to view the patient as a whole human being, addressing the manifold concerns that accompany disabling diseases in general and the non-motor problems of PD in particular. A few years later, a different prominent primary care professor, a colleague at Brown, told me that neurology training for medical students was generally a waste of time so that it didn't matter that Brown didn't require it for graduation. "How much useful information would a student learn in an MS clinic or a PD clinic?"

The article that triggered this commentary simply examined a gigantic cohort of patients in the Medicare data base for the whole United States and surveyed out-patient claims to determine how many people diagnosed with PD had seen a neurologist, and whether there were differences in outcome between those who did and those who didn't. Women and minorities were less likely to see a neurologist. PD patients who had seen a neurologist lived longer, had fewer hip fractures and were less likely to end up in nursing homes. There were no overall benefits seen in those who were not referred to a neurologist.

I would like to extrapolate that PD patients who saw PD-specialists (ie like myself) do even better but that would

be speculative. This is not to say that every patient needs referral to a specialist. Many patients are a lot better off *not* seeing one.

All doctors see their role as guardians of their patients' health and well being. Some do this by limiting testing as much as possible, with the notion that excessive testing leads to excessive costs, excessive worry, and sometimes unintended consequences. Some, on the other hand, believe that it is crucial not to miss anything, and testing provides a written, objective report stating that something was looked for and not found. Just as PCP's have different thresholds for ordering tests, they have different thresholds for referrals to specialists.

Specialists are just like PCP's with regards to referrals and testing. Some count on their expertise and clinical judgment and simply reassure their patient, "This headache is really bothersome, but another MRI isn't going to make it better," and others may say, "Well, I'm pretty sure there's nothing abnormal, and it's probably migraine, but let's get another MRI just to be sure." A friend complained of chest pain after she took her alendronate. Esophageal irritation is a well known side effect, which is why patients are instructed to not bend over or swallow anything for 30 minutes after taking it. So the gastroenterologist opined that the symptom was likely due to the alendronate, but, since the patient was 60 years old and her father had an MI, it would be a good idea to get an echocardiogram and a stress test, despite the absence of any other cardiac symptoms or ECG changes. And, of course, the echocardiogram had a minor anomaly, which led to a cardiology consultation, which, luckily, stopped the ball from rolling further downhill when he said her heart was fine.

Some specialists feel, with justification, that "the buck stops here." It's their job to provide the highest degree of certainty that something is either not wrong, or at least not diagnosable with current technology, or to define, as well as possible, what is wrong. A patient I

evaluated for a movement disorder was then seen at an even more specialized center, which focused only on one particular type of movement disorder. I had ordered the usual "mundane" tests, MRI, a few routine blood tests and a genetic test for the most common disorder that might explain the problem, despite the absence of a family history. When that came up negative, as is often the case, I explained that I was not going to be able to diagnose the problem, that it was likely one of a group of very similar diseases, thought to be hereditary, none of which had any treatment. The patient desired further evaluation. At the quaternary referral center, there are, apparently, no barriers to testing, other than those imposed by the insurers. Eighteen thousand dollars of testing later, no identifiable cause for the disorder had been found, but, as the super-specialist noted, even, had a cause been found, there would have been no treatment for any of them anyway.

I like to think I'm on the conservative end of test ordering, but I'm certain there are colleagues who think I order too many, and others who think I order too few. I try to find guidance from my patients. Do they want to pursue expensive testing to find a cause that will have no treatment or are they content to know they have a type of disorder, say a spinocerebellar ataxia, rather than knowing they have spinocerebellar ataxia type 23? I don't think there's a "right" answer to the problem of how much to test. Each case is different. The only thing I do know is that the functionary at the other end of the telephone in an insurance company office probably is less capable of making these decisions than I am.

— JOSEPH H. FRIEDMAN, MD

Disclosure of Financial Interests

Lectures: Teva, Ingelheim Boehringer; General Electric

Consulting: United Biosource; Bupa-loo, Halsted, Reitman LLC; EMD Serono; Genzyme; Teva; Acadia; Addex Pharm; Schwarz Pharma

Research: MJFox; NIH: Cephalon; EMD Serono; Teva; Acadia

Royalties: Demos Press

CORRESPONDENCE

e-mail: joseph_friedman@brown.edu