Neurology and Psychiatry

Mrs. Fields is wheeled into the auditorium. She stares at the ceiling. Dr. Nigel Browne, silver-haired, 6'3", the neurology chief in his long white coat takes his Queen's Square hammer in his right hand, smiles, and speaks to the patient. We are 70 medical students perched at wood desks that rise from the medical auditorium. Dr. Browne has studied neurology at Oxford and psychiatry at the Maudsley Hospital in London. He has an eagle's face on a giraffe's body. He sees and knows everything.

"Mrs. Fields," Dr. Browne says, "thank you for coming. What is your problem?"

"Doctor, I am unsteady on my feet."

"There." Like a maestro, Dr. Browne raises his hands to us; we are his orchestra. "We have the presenting complaint." He directs his hammer, asking the patient to walk. The patient lurches and almost falls. The chief resident catches her as she loses balance.

"I want to spend days exploring her feelings. My curiosity swells. I want to know everything about Miss Goodwin."

Dr. Browne writes on the blackboard "Astasia-abasia." He pivots to face us. "Who knows about astasia-abasia?"

There is a sound of pens on paper. We scrawl the patient's name and symptoms.

But no one speaks.

"Mrs. Fields, aged 48, gives a recent history of 1 month of unsteadiness, weakness, and incoordination," Dr. Browne continues. "She has paresthesiae in her extremities. There is reduced sensation to touch, position, and pin-prick." He produces two enormous needles from his lapel. He asks the patient to stand and close her eyes. She cannot. He simultaneously pricks legs, arms, face. He tests Mrs. Fields's muscle strength and deep tendon reflexes.

"What does paresthesiae mean?" I ask my lab partner, Peter.

"Sssh," Peter whispers. "Pins and needles."

Two students—Phillips, small, thin, and round-shouldered; Harris, so large and beefy that his lab coat puckers at each button—scurry like frightened white rats up the side aisle to the rear. They fall behind their desks in a sigh.

Like a shotgun Dr. Browne aims his hammer to the rear. "You sirs—the two miscreants who entered class? Would you step forward to interview Mrs. Fields?"

Phillips grows more round-shouldered, and Harris's beefy face is crimson. Together they walk to the stage as if facing a firing squad.

"And you—Rubens, the one muttering during my lecture," Browne turns his hammer at me. "You have the pleasure of interviewing the second patient."

I feel my meager breakfast rise up my throat. A few well-wishers greet me. "Fight the good fight," says one. "Don't let the bastard get you," says another as I limp forward. "Now, let us see how you approach diagnosis," Dr. Browne says.

Ten minutes later, after Phillips and Harris move Mrs. Fields's legs and arms, fingers and toes, look into her ears and eyes, examine her chest, measure muscles, then smash knees and elbows with reflex hammers, they have failed to advance their neurological knowledge of Mrs. Fields one inch.

"Do you Phillips, do you Harris, have a differential diagnosis?"

"We regret, we have only found generalized weakness," they reply in unison.

"Weakness?" Browne cocks his head. "Whose weakness? Yours? The patient?"

"The patient may have had a stroke," Harris says.

Browne nods. "But you *must* know."

I sit on the podium watching in horror as Harris and Phillips are reduced to medical incompetence. "Rubens, do you concur or have thoughts?" Dr. Browne asks.

"No sir."

Mrs. Fields exits. Harris and Phillips sit down, their heads hung in shame.

"The start of medical evaluation is history," Browne says in impeccable English. "Diagnoses are led by history. Was there a history taken?" He turns to me. "Rubens?"

"No, sir."

I look at my class. It is 8:45 a.m. and 15 minutes remain. All eyes are riveted on Browne. No one sleeps. A classmate gazes at me with pity and fear.

"Are you ready for the second patient?" Dr. Browne asks and his brow quivers.

"Absolutely, sir."

Secretly I hope my patient is lost in an elevator or has had an untimely death.

The second patient is wheeled forward. "Miss Goodwin is 20, a nursing student. She has been unsteady for 4 weeks. Carry on, Rubens."

I feel ill. My arms and mind are leaden.

"*Rubens. Carry on.*"

Miss Goodwin wears robin-blue pajamas and holds a teddy-bear. She smiles. I inhale faint jasmine perfume, which revives me. I introduce myself, mumble about weakness, and suggest we stroll across the podium. I hope she will support me. She rises from her wheelchair; I take her hand and release it. I see slim ankles, fine-shaped calves; all is symmetrical, perfect. She struggles back to her wheelchair. I find strength to assist her. I undertake a brief neurological examination. Minutes pass. I fail to find positive signs. I am lost.

"When were you last well?"

"A month ago."

"Did anything happen then?"

Her voice is a hesitant whisper. "No."

The inexplicable occurs. My fear dissolves. The room fades; Dr. Browne is gone. There are only the two of us. Instead of fear, I feel passion. I draw near to Miss Goodwin. I question her. Our knees almost touch. We dance with words. "Have you or your family had these symptoms before?"

"No."

"Have you had accidents or head injury?"

"No."

"Have you had changes to your life?"

"I left home for nursing school," she lingers a moment, smiles. "Then I got sick."

I want to spend days exploring her feelings. My curiosity swells. I want to know everything about Miss Goodwin. A loud voice cuts short my reverie.

"Rubens," Dr. Browne says.

"I have not finished, sir."

"Rubens. You are finished. You are out of time."

Miss Goodwin is pushed from the auditorium. I stagger to my seat and turn to my lab partner, Peter. "What happened up there? What did I say?"

Dr. Browne flicks his hammer at us. "Both patients complain of unsteadiness. Do they suffer from disease or functional disorder?" He pauses. "What do we need?"

Silence. A hand rises. "We need a history, sir," Peter says.

"Indeed. With history, we find Fields has a relapsing-remitting pattern of weakness, numbness, reduction in vibration and position sense; we suspect—?"

"A relapsing-remitting history makes us suspect multiple sclerosis," Peter says.

"Quite so," Browne says. "But what is the differential diagnosis?"

My lab partner, I suspect, has a photographic memory. He reads Harrison once and zing, it is memorized. He rattles off familial ataxias, encephalitis, vascular malforma-

tions, cerebral infarction, tumors, amyotrophic lateral sclerosis, pernicious anemia, systemic lupus erythematosus.

"But sir," I throw up my hand, "Miss Goodwin has no positive signs."

"Precisely," Browne says. "In the absence of pathology, her symptoms appear triggered by unconscious factors. We suspect hysterical conversion. A history is crucial."

It is over 20 years. I have not finished my history.

I see Miss Goodwin, ageless, in robin-blue pajamas, holding her teddy. Muse-like, she waits for questions. I am fascinated by mind and body. I ask Dr. Browne if I may interview Miss Goodwin with the chief resident. He agrees. That night I read in the medical library that multiple sclerosis and conversion mimic each other. I rehearse questions so I know more than Peter. Two days later, after lectures, I go to the ward and check her room. Her bed is empty.

Miss Goodwin has been discharged.

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