

EDITOR'S CHOICE

Pract Neurol 2011; 11: 133

This month I shall allow myself to release a few bees from my bonnet, or – put another way – to have a rant:

First, how come a neurology journal such as this contains articles of no relevance to UK neurologists? For example, the Test yourself article on page 185 is to do with subarachnoid haemorrhage and the robust letter to the editor on page 202 is about head injury. Even though these patients very seldom require any surgical intervention, in the UK they are mostly looked after by surgeons. That would not happen in the Netherlands where the neurologists are the main players for both conditions. UK neurologists should start looking after acute and serious disorders of their favourite organ before they are marginalised by sharp-elbowed managers.

Second, how come so many neurologists in the UK are sequestered in academic centres and leave the care of acutely ill neurological patients in surrounding district general hospitals to neurologically untrained physicians? (yes, the neurologists may go out and do clinics in these hospitals, but how many tension headaches are worth a case of possible herpes encephalitis or intracranial venous thrombosis on the days when the neurologist is not around?). David Bateman's editorial (page 134) and the neurological letter from Gloucester (page 189) are attempting to redress the balance. Again UK neurologists had better watch out before they are made redundant.

Third, what are universities for? Teaching I believe, but no marks for UK university clinical academics who want to teach, but a big gold star for bringing in loads of money and publishing in high citation ratio (aka impact factor) journals, even if it means bypassing UK-based in favour of US journals. Luckily there are still some neurologists who are passionate about teaching, like Peter Gates from Australia – so look at his article on page 167 and read the book review on page 179. In the UK we have many excellent neurology teachers who are not clinical academics in universities, but hard

working jobbing neurologists in the National Health Service. Three cheers for them. I wonder when our academic neurologists will abandon clinical responsibilities as well as teaching, such is the pressure from their university masters.

Fourth, why is it that I have never been visited by a drug rep peddling either steroids or levodopa, arguably the two most effective drugs in our armamentarium? Could the levodopa lacune just possibly be because of all the razzmatazz and marketing of the dopamine agonists, and 'generous' industry sponsorship of neurologists and their meetings? Did this lead to levodopa phobia? Some calm arguments to dispel this phobia are presented on page 145. How up to our ears are we in conflicting interests I wonder? Does a free trip to South Africa help sell a particular drug in the UK? Or nudge a review article writer in the 'right' direction? UK neurologists should be distancing themselves more from industry before someone else does it for them.

Fifth, whatever happened to the wonderful educational opportunities of the postmortem, even just a limited examination of the brain? The clinicopathological conference on page 153 hinges on a biopsy but it might easily have hinged on a postmortem. There should be more of them. Patients may well be up for it if approached in the right way. UK neurologists could do something about this.

And finally, why do we all still so easily assume causation from association? For example, just because patients with the posterior reversible encephalopathy syndrome (page 136) are often hypertensive does not necessarily mean that rising blood pressure is the cause, an illogical jump so often made. Confusing reverse causality with causality is not of course confined to UK neurologists.

Time to close down the hive I think and wish all UK neurologists, and indeed neurologists in other countries whose foibles I am less aware of, a better future than past. Read on.

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