Highlights from this issue

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What are the most important skills for a neurologist? The fact that neurologists often discuss this kind of question amongst themselves, over a drink at meetings—and not just at meetings to develop training—suggests reflection and self-criticism are probably key skills. What other suggestions are put forward? There is often a lot of support for the seemingly simple skill of information gathering (taking the history). This no doubt reflects the large number of neurological diagnoses that entirely or predominantly depend upon the history—primary headache disorders being perhaps the most common and pure example. The point of dissecting the history of headaches is to make a diagnosis, most importantly to guide how best to use the wide range of available treatments. Alex Sinclair and colleagues (***see page 411***) provide a practical update on pharmacological treatment of headache.

Thoughtfulness, critical thinking, analysing clinical problems: these are some of the terms used to try to describe the way neurologists try to make sense of their patients' problems. This contrasts with the formulaic approach engendered by using patient pathways or by adhering too tightly to clinical guidelines. Guidelines might help, but what is wrong with my patient? Where is the lesion? What level of the nervous system is involved? What type of disease process is going on? This approach is essential if neurologists are to pick up unusual versions of common diseases. Mitochondrial disorders can hide behind lots of common presentations—stroke, epilepsy, weakness—and only by thinking critically and recognising what is atypical can we make the appropriate diagnoses and management decisions. Patrick Chinnery provides a very useful review of mitochondrial mimics and chameleons (***see page 424***). Functional neurological disorders provide a similar challenge and manifest across the spectrum of neurology: Catherine Pennington and colleagues (***see page 436***) explore functional cognitive syndromes and how to recognise them, and suggest an approach to treatment.

The discussion (in our imaginary bar) then often turns to how these skills are taught and learnt. As a rule, almost everyone when asked how these skills should be taught goes on to describe their own training. We lack evidence on the best approach to teaching these essential critical thinking skills; however, there is usually a consensus that a period of research training is very valuable. This can provide perspective on the limitations of our current understanding of neurology, a critical approach to problem solving. Getting into research is a big step for neurological trainees and they need to master a whole range of skills before they even start, the first being how to apply for a grant: Masud Husain provides the guide on how to do just that (***see page 474***).

What else does our practical neurologist need? Most would agree that neurology is learnt case by case, albeit with the proviso that the learning favours the prepared and thoughtful mind, and that experience—involving seeing, thinking about and following up enough patients—is essential. *Practical Neurology* can help a bit by sharing others' experiences—neurological rarities such as Fahmida Chowdhury *et al*'s case of focal inhibitory seizures causing recurrent weakness (***see page 479***), striking images such as Sashank Prasad's report of positional visual symptoms in Marfan's syndrome (***see page 484***), or a Test Yourself such as Viswas Dayal and colleagues' case of confusion, hearing loss and visual symptoms (***see page 466***). Or your practice might change on learning from patient experiences—reading Stanley Fink's story of his neurological illness (***see page 488***) may prompt additional essential advice to patients whom you refer to neurosurgical colleagues.

Of course, what neurologists really need is an intense interest in neurology; which is probably why they find themselves talking about this sort of thing in bars—especially when the rugby is on…(or maybe because the rugby is on).