Practical Neuro

an international

EDITORIAL

Correspondence to the Editor

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Practical Neurology aims to be international – full of practical advice, instructions even, for neurologists practising anywhere in the world, written by neurologists and others from anywhere in the world.

There are no international boundaries in medicine, neurology patients are much the same the world over. A first tonic-clonic seizure in Birmingham (England or Alabama) is no different to one in Porto, or in Nairobi. But the way we deal with it is, because of huge differences in our health care systems – different traditions, different organizations and different resources available to us. In Birmingham, England, the patient is taken to the Emergency Department and seen by a general internal physician, whereas in Porto there will be a neurologist on hand, because Portugal has far more neurologists than the UK. In 'old' Europe we all have easy access to the standard anti-epileptic drugs, and often the new and more expensive ones as well, but in Sub-Saharan Africa the patient will be lucky to get even phenobarbitone. By Birmingham, England, standards many patients in the USA are grossly over-investigated. By Birmingham, Alabama, standards patients in the UK are appallingly under-investigated, in part because there are more resources in the USA – and more lawyers, and in part because the USA has a fee for item of service system that encourages investigation, but the UK does not.

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Of course the frequency of some neurological disorders is very different in different parts of the world. Multiple sclerosis is hardly likely in Zambia, but very common in Glasgow. Leprosy will catch a European neurologist by surprise, but not a Sri Lankan. Japanese encephalitis is not a diagnosis that comes to mind in Frankfurt, but it would in Ho Chi Minh City. Swedish neurology patients are unlikely to be HIV-positive, quite unlike those in South Africa.

And referral patterns differ. In the UK, neurologists see very little 'infectious' neurology – meningitis is largely looked after by infectious disease specialists. Holland is unusual because the neurologists look after head injury and subarachnoid haemorrhage. The Mayo Clinic is perhaps unique in their policy of having almost all patients, except trauma cases, admitted under physicians first and only afterwards are those who require a surgical opinion referred to the surgeons. This ensures that surgeons spend their time doing what they are good at and enjoy – operating and perioperative care – and this is also the most cost-effective use of their time.

WHY SHOULD WE ATTEMPT TO BE INTERNATIONAL?

So how can we possibly produce a journal that will be helpful and relevant for neurologists, and indeed others practising neurology, in every country in the world? Will the African neurologist have any interest in advanced imaging for acute stroke? What do North Americans need to know about schistosomiasis? Is it even a sensible aspiration to be 'international'? Yes, we believe it is, for several reasons.

Firstly, international differences are – for better or worse – withering. Taking a history and doing the neurological examination is already more or less identical the world over. The *principles* of diagnosis are the same, and gradually with global development the investigative facilities should become more even, at least the basic ones like CT and EMG. Care is certainly the same – turning, feeding, toiletting – although sadly in some countries little attention is paid to this while expensive interventions for which there may be little evidence of efficacy are widely used. The advances in basic science – such as in molecular biology and imaging – must be put into the context of the sensible and cost-effective practice of neurology in developing as well as developed countries.

Secondly, neurologists move around and need to know what to expect in neurological practice the world over, and how to conduct it – just what do you do when there is no CT scanner for 100 miles and even basic blood tests are unavailable? In the UK there have long been doctors from the Indian subcontinent, and more and more they are now coming from Europe. London neurologists teach neurology in Palestine. The US is a magnet for trained neurologists from anywhere in the world. There is an increasing tendency, certainly in the UK, for young neurologists to do all their training in one place. But they need to get out and see the world, learn from other people in other cultures, appreciate that there are many ways of achieving the same ends, and maybe that their own place is not so bad after all.

Thirdly, we can undoubtedly learn from each other. The basic neurology nursing care widely available in the UK has been a revelation to colleagues in St Petersburg. The artemisinin derivatives – the most potent antimalarial drugs ever discovered – of the plant Artemisia annua were first described by Chinese traditional doctors and are now being used throughout South-East Asia, and soon perhaps in other countries too. Maybe multiple sclerosis is not quite so rare as we once thought in countries nearer the equator as their neurologists learn to recognize it. And how can we know whether different forms of what appears to be the same disease really are different in different countries unless we talk to each other?

Fourthly, we should all surely be interested in neurological disorders wherever they occur

– after all, one day they might arrive on our doorstep like the case of bat rabies in Dundee, Scotland last year. And we should be interested in the history of our subject, and how it has interacted with art and literature, although these are not exactly international issues.

And finally, perhaps not the best of reasons, a journal for a relatively small speciality has to have an economy of scale. It is difficult enough making a new review journal pay its way, it would be almost impossible if it was only marketed in one country.

ARE WE INTERNATIONAL ENOUGH?

Well, we do try, although inevitably for a journal that started in the UK, we tend to be able to persuade our local friends to write for us more easily than more distant colleagues. At present, to ensure the best possible balance for a review journal across the whole of 'neurology', almost all our articles are commissioned rather than submitted although we are open to good ideas. Our 'Neurological letter from …' column is clearly international, that is the whole idea – of the first 12 in our first two years, only one came from the UK. Although most editorials came from the UK (eight out of 12), nearly half the reviews came from outwith the UK (13 out of 31) as well as most of the articles describing how a paper or patient changed the author's practice (eight out of 10). That is not too bad but we would like to do better and as the journal becomes better known we will. And we have certainly had articles on diseases that are not much seen in the west – rabies, schistosomiasis, tuberculosis.

We make no excuse for writing in English. This has become the international language of medicine, a huge advantage for those whose first language is English (rather like being born into the English aristocracy, this is undoubtedly an unfair advantage, but speaking English is not really our fault anymore than it is the fault of aristocrats to be born with 'blue blood'). What we can try to do is write clear English that can be understood by those with a different first language. Indeed, it would be worth studying what it is about English that makes it difficult to read, or maybe that depends too much on the reader's own language for any useful generalizations. Latin-based English words such as compress rather than squash may make matters easier for an Italian, but what about for an Arabic reader?

ARE WE AFFORDABLE IN LOW-INCOME COUNTRIES?

There is not much point in writing for neurologists in low-income countries if the Journal is unaffordable for the neurologists who work there. To this end, it is extremely helpful that our publishers – Blackwell Publishing – work to provide free or reduced-rate online journal access to libraries in developing countries. For example in collaboration with WHO, online access has now been made free in countries with a Gross Domestic Product under $1000 per capita per annum. But that still leaves the next layer up of countries in some difficulty and all we can do is to make the journal as inexpensive as possible both to individual subscribers and institutions. If only we could give it away free, but that would require too much and probably over intrusive sponsorship. We would then be in danger of loosing our independence and whatever reputation we have managed to gain so far.

FINALLY, A HIDDEN AGENDA

Sadly, even nowadays after the end of the cold war, there are still international conflicts and tensions that are in themselves a far greater threat to world health than any neurological disorder, or even all neurological disorders put together. If we neurologists, and everyone else in their own 'subculture' of not just medicine but any human endeavour, talked more to each other, worked together, met together and became friends then it would become impossible for politicians and their armies to take us to war. Like Daniel Barenboim's West–Eastern Divan orchestra of young players from Israel and Arabic countries who play and perform music together, we in *Practical Neurology* in our own very small way, hope to be part of the slow process towards international understanding and so friendship.

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