A cautionary tale about a global problem

Nitin K. Sethi, MD: Direct funduscopy vs nonmydriatic ocular fundus photography—which is more reliable in untrained hands? I read with interest the editorial on the dying (or rather already dead) ophthalmoscopic skills of neurologists and the advent and superiority of nonmydriatic ocular fundus photography over direct fundoscopic examination. There is a saying that “the eye cannot see what the mind does not know,” and the 2 cases cited by Kattah and Halmagyi¹ are examples of this rather than a failure of direct ophthalmoscopy itself. So while the advent of cheaper, portable, and more user-friendly nonmydriatic ocular fundus cameras is a welcome addition to the diagnostic armamentarium of a clinical neurologist and I agree with Mackay et al.² that this skill should be taught to physicians in training, more emphasis should be placed on knowledge of when to order the test in the first place.

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Disclosures: N. Sethi serves as Associate Editor for *The Eastern Journal of Medicine*.

Authors Respond: Jorge C. Kattah, MD, G. Michael Halmagyi, MD: We appreciate Dr. Sethi's response to our editorial.¹ In the best of all possible worlds, we agree with Dr. Sethi, as would Dr. Pangloss. But what should we do when an unknown neurology resident calls us at 2 AM about a patient with headache she wants to admit? She says there are no neurologic abnormalities, the CT is normal, and so is the CSF. We ask, “What about fundi?” She replies, “They are normal too.” Should we believe her? We can log in and check the CT and the CSF lab results, but we cannot check the fundi. Could the patient in fact have critical intracranial or even arterial hypertension? Do we have to get out of bed and go to the hospital to check the fundi for ourselves? No, *mirabile dictum*: “Doctor, please take fundus photos now and e-mail them to me.” “*Wir sehen nur das was wir wissen*” (we only see what we know). An old chestnut from Goethe, but then he was never on call.

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Disclosures: J.C. Kattah served as a consultant for Questcor Co. G.M. Halmagyi serves on the scientific advisory board for Brain Foundation of Australia; has served as a consultant for and received funding for travel from GN Otometrics; and serves on the editorial boards of *Acta Otolaryngologica*, *Otology*, *Neurotology*, *Audiology*, *Neuro-otology*, and *Italian Journal of Otolaryngology*.

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Autonomy and the “demanding encounter” in clinical neurology

Nitin K. Sethi, MD: As an epileptologist, I have frequently navigated a demanding encounter with a psychogenic nonepileptic seizure patient. While I do attempt to uncover what is driving my patient's desire to seek the diagnostic label of seizure disorder, this is easier said than done.¹ I often find myself ill-equipped for the time-consuming work involved in exploring and uncovering the family dynamics, relationship issues, and self-beliefs driving the patient's nonepileptic seizures. As a result, I usually transfer the care of these demanding patients to my

colleagues in psychiatry. Navigating the demanding encounter in neurology requires time and patience. Many of us in busy clinical practices either refer these patients to another physician or cave in to the demands of the patient, irrational though they might be.

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Author Responds: Joel Salinas, MD, MBA: We agree with Dr. Sethi that a physician's time is just one more scarce resource that can be found at the top of a demanding patient's list.¹ We extend a few practical suggestions that may seem ambitious but are worth some consideration in navigating these clinical encounters:

1. Plan accordingly. Some patients respond best to face time and may benefit from being scheduled for longer appointment times whenever feasible.
2. Adopt a piecemeal strategy. Not all problems can or must be solved in one sitting. Breaking up the discussion into a series of longitudinal visits at clearly defined intervals creates an opportunity to make steady progress with a patient's belief structure.
3. Create strategic multidisciplinary alliances. Tag-teaming with a psychiatrist or psychologist can be extremely helpful. The neurologist plays a pivotal ongoing role not only by helping providers understand which spells are concerning but also by serving as a point person who can address a patient's underlying beliefs about the etiology and appropriate treatment of the spells or any other neurologic symptoms.

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Disclosures: The author reports no disclosures.

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An electronic medical record just for neurologists: A daunting proposition

Marc A. Swerdloff, MD: Electronic medical record (EMR), daunting indeed.¹ The biggest challenge I have experienced from using EMR—and potentially the most dangerous to patient care—is the tendency for the record to bury important information. In that light I have spent excessive unreimbursed hours entering and then pasting data into the record so it is easily viewed. Allscripts has a prominent perch for diagnostic results; however, it does not automatically drop entered data into this logical category. It also doesn't drop it automatically into a printout for the patient to receive at check out.

I have served as a scut monkey slave to this promised time-saving EMR monster for the last 2 years, a role I relished more than 30 years ago when I was a chipper student/intern/resident. I am looking forward to the day when EMR may actually save me time and enhance my practice. I am not holding my breath.

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Disclosures: The author reports no disclosures.

Author Responds: Allison L. Weathers, MD: I thank Dr. Swerdloff for his comments on my editorial.¹ He raises an excellent point regarding the risk of “information overload” and of critical information being hidden within the record. This problem will almost certainly be magnified by the growing access that clinicians have to external records through their EMRs and through participation in Health Information Exchanges. Although Dr. Swerdloff

should be commended for his personal efforts to combat this risk and ensure the safety of his patients, his solution is not a tenable one for the reasons he outlines. I would encourage Dr. Swerdloff and others with similar concerns to reach out to their EMR vendors. The issue mentioned here is not specific to neurology and is one they are likely hearing from a number of clinicians. Customer input does factor into decisions regarding enhancements and future development, but we must voice our concerns for this change to occur. I anticipate that as the functionality recommended by McCarthy et al. becomes more widespread and the American Academy of Neurology and other professional medical societies continue to advocate for more physician-friendly, usable systems, we will start to more fully realize the potential of EMRs and some of the burden of their use will hopefully be lifted from clinicians.^{2,3}

Rush University Medical Center, Chicago.

Disclosures: A.L. Weathers has received funding for travel or speaker honoraria from the American Academy of Neurology, North Carolina Neurologic Society, and Los Angeles Neurologic Society.

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Multiple sclerosis in US minority populations: Clinical practice insights

Jagannadha Avasarala, MD, PhD: The article by Khan et al.¹ rightly points out that there are various reasons for underrepresentation of minorities in clinical trials for multiple sclerosis (MS). I had pointed out in my recent *JAMA* viewpoint article² that the enrollment of African Americans (AAs) has dropped from about 9%–10% in 1993 to a lowly 2% in more recent phase 3 clinical trials. This brings about a typical conundrum for physicians treating AA patients with MS since the data sets that are valid for Caucasian patient cohorts may not be applicable to the AA cohort, given poor enrollment numbers. The only way this malady would be addressed correctly would be for the US Food and Drug Administration (FDA) to set clear-cut guidelines for enrollment numbers. Without a set percentage number (as determined by statisticians) of patients enrolled, no study should be allowed to be filed for drug approval before the FDA. Without guidelines, data are likely to be doled out with no justice done to certain patient cohorts who may need the efficacy results the most. It is a well-known fact that AAs do poorly across all treatment regimen protocols in MS as well as likely have a more virulent or aggressive type of MS at onset.³ They also are more disabled earlier compared to Caucasians, as a group.⁴

As for minority enrollment in phase 3 clinical trials, it is also worth noting that the recently approved drug for MS, Plegridy, had Indians (from the subcontinent) as the second-highest cohort of patients with MS included in the phase 3 study, and AAs were not even mentioned as a group! So much for minority enrollment.

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Disclosures: The author reports no disclosures.

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Multiple sclerosis in US minority populations: Clinical practice insights

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