# The Beauty of Reflex Hammering

*Jacob L. Freedman*

To the untrained eye, Neurology can appear to be a sadistic profession. Many of our patients are comatose and our daily exams consist of pinching their fingers and toes as hard as we can and documenting that for the ninth straight day there is no reaction to painful stimuli. As I lament this to Duncan, my fellow psychiatric resident who has also been rented out to the Neurology Consult Service, he completes a physical by hollering into a patient's left ear. It is obvious that our patient is unresponsive to verbal commands and when I tell Duncan to keep it down, he tells me that his wife screams at him every night and why can't he have a turn to yell at some people. Especially since they aren't able to hear him.

As we walk to see our next patient, I tell Duncan that I am discouraged with my experience on the Neurology service. We always seem to be called to evaluate horrendous cases after it's too late for any curative interventions. We then poke and prod our patients repetitively and pour cold water into their ears to see if their eyes spin around. We stick Q-Tips into their noses and observe whether their grimaces are symmetrical. We have them memorize nonsensical lists of words like "Physicist-Prism-Amphibian" and then we call the Psychiatry Team when they kick us out of the room because we need someone to make a professional comment on our patients' "affective dysregulation as evidenced by opposition to thorough medical evaluation."

Somewhere in between the physical torture of crushing people's toenails with a reflex hammer and the psychological stressors of making them count backwards from two hundred sixty two in increments of thirteen, I wonder if we'll get more information out of our patients by waterboarding them. Duncan suggests that we might use therapeutic lashings to help our patients who suffer from tremors. He suggests that maybe this will condition them to stop shaking when we tell them to touch their index fingers to their noses and when I give him a quizzical look, he reminds me that it worked for Pavlov's dogs.



Our next patient is Mr. Stevens, a seventy-eight-year-old veteran admitted to the hospital for a heart attack which required bypass surgery which subsequently caused a stroke. This in turn landed him on our list this morning. We were consulted for "pathological crying" and when Duncan reads this, he suggests that they probably should have consulted the patient's mother instead. I remind him that the patient is in his seventies and that the patient's mother is probably deceased. Duncan notes that the patient's mother probably died from embarrassment that her son was still crying like a baby even in his old age. I concur that the patient is likely yellow-bellied and we knock on the door and enter.

Mr. Stevens smiles at us and then barks, "Who the hell are you?" I smile back and show him my ID badge, forgetting that it rats me out as a psychiatrist and he tells me, "I don't need any damn psychiatrists, I'm not crazy, the other doctors already told me that." I apologize and explain to him that Duncan and I have been exiled to the Neurology Consult Service as part of our training and that while we are in fact psychiatrists most of the time, today we're wearing our Neurology hats even if we forgot to take off our Psychiatrist ID cards. Mr. Stevens remarks that I also forgot to take off my psychiatrist beard and reemphasizes, "I don't need any psychiatrists, I'm *not* crazy, I *told* you already." He immediately begins sobbing hysterically and I hand him a tissue from the box on the table next to him. He takes it and dabs at his cheeks and tells me a third time that he's not crazy, "It's just that something in my brain is broken and I cry like a girl scout for no damn reason!"

Duncan and I sit down and Mr. Stevens proceeds to tell us the story of how he was diagnosed with a small stroke after his bypass surgery a few days ago and has since experienced at least six episodes of bizarre crying every day. The only other neurological symptom he's experienced is numbness in his right

leg but otherwise the stroke left him in pretty good shape. When Duncan and I pull out our reflex hammers he shakes his head and starts crying. "This is exactly what I mean, I just start crying for no damn reason. I'm not sad, I just start crying. It's ridiculous."

I reach to hand him another tissue but he waves it away as he's already stopped his tears and seems back to his cantankerous self. I ask him if we can examine him and he starts crying again. "I don't need to be examined anyways. You idiots poked me just about everywhere last time I was here after my first stroke and you didn't find anything then and you ain't gonna find anything now! Why don't you go poke each other instead, you perverts!" Duncan and I nod to Mr. Stevens and bid him good day. We tell him that we'll discuss the case with our Boss and that we'll make the appropriate recommendations to his primary medical team. Mr. Stevens smiles and waves us goodbye.

Duncan and I page our Boss who happens to be the world's expert on epilepsy in pregnant women. This means she has about twenty-three seconds to discuss any case that is unrelated to either pregnancy or epilepsy. She calls us back in exactly nine seconds and explains that we'll have to present the case quickly because she has four patients waiting in clinic, a lecture to give at the medical school later this afternoon, and is consulting with a pharmacology corporation on the other line to make some extra pocket money to pay for her step-daughter's Suzuki violin lessons.

She then explains that she really doesn't need to hear anything more about the case because she already reviewed the chart online and that the patient clearly has Pseudobulbar Affect. She tells us we can treat it with a standard antidepressant like Zoloft or whatever else we want to do but just to make the recommendations and move on because she also needs to edit a review article on post-partum seizure evaluation for the *American Journal of Neurology* before it hits the press tomorrow.

Duncan wonders out loud if our Boss might have put some extra thought into Mr. Stevens if we had told her that he was thirty-six weeks pregnant with an epileptic fetus. He asks me what



I know about Pseudobulbar Affect because all he knows is that it's abbreviated PBA. I know even less so we decide to look it up online and figure out what the heck we'll recommend as a treatment.

As we sit down and log onto a computer to search for "Pseudobulbar Affect," I ask Duncan if he thinks that the *New York Times* would run a front page article if they knew that the Neurology Consultants at the most prestigious teaching hospital in Boston were getting all of their moves from Google. Duncan remarks that they'd only care if we were Tea Party-ers protesting our socialist government's takeover of health care.

Wikipedia says Pseudobulbar Affect is characterized by "pathological crying." Duncan says maybe we should try getting Mr. Stevens some medical marijuana to induce "pathological laughing-and-nacho-eating," which might even things out. I remind him that we aren't practicing medicine in California, and we continue our search online. After stops at eHow.com, Twitter Health, then finally WebMD, I find the first-line medication for management of Pseudobulbar Affect and send a page to Mr. Stevens' primary medical team telling them to start the drug. I ask Duncan if he finds Neurology to be too reductionist. He hands me a tissue and asks if I am going to pathologically cry.

Duncan tells me that he misses psychiatry's taboo on touching patients, but that he finds it fascinating to pore over MRI scans and correlate anatomy with sensory, motor, and mood-related symptoms. Duncan is excited by the possibility of mapping the brain and finding the exact location where he can have an electrode planted to fire every time his wife yells at him. He is confident that, set properly, the electrode can convert "You haven't taken the trash out for two weeks" into "How about a margarita and a back rub." He is convinced that this technology will work even better than cocaine and without the risks of addiction and losing your medical license.

I ask him if, as a psychiatrist, he is concerned by the prospect of breaking human emotions down to electrical currents, and of reducing paranoia, love, and creativity to ions that drift through

protein channels. Duncan tells me that he is more concerned by the unchecked proliferation of nuclear technology in unstable Middle Eastern regimes, the subsequent risk of dirty bombs coming onto American soil through Canada, and the recent unavailability of organic buffalo milk yogurt at Trader Joe's. I agree. He asks me if it's really any worse than psychiatric medications that would take away Mr. Stevens' tears but neuter his personality. Duncan asks me why I shouldn't be more frustrated that Psychiatry can't ever fix our patients' unemployment, traumatic childhoods, catastrophic love-interests, and architecturally-uninspired government housing, and that instead we just dole out pills that castrate their mood.

I ask Duncan why he used "neutering" and "castrate" in the same paragraph and he responds that he watched a *Price is Right* re-run yesterday on his day off and Bob Barker had reminded him "to have your pets spayed or neutered." Duncan adds that "neutering" is a technically appropriate term because most pills we prescribe in Psychiatry double as libido-killers, orgasm-inhibitors, and erection-impairers.

I momentarily consider these grave problems within the field of Psychiatry and then smile because I don't have to think up any solutions until I finish my eight-week contract with the Neurology Consult Service. Duncan says we should try to appreciate these last precious weeks of caring for unconscious patients before we resume our careers as psychiatrists. I agree and we walk down the hall to see our next comatose patient. Neurology can be a reductionist and somewhat sadistic profession but at least we get a chance to whack people with reflex hammers. ☙