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Short Commentary

Rounds with Derek Denny-Brown at Boston City Hospital in 1965

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Commentary

This is a personal memoir of the experience of bedside rounds at the old Boston City Hospital when Derek Denny-Brown was the director of the Harvard Neurological Unit. This was pre-imaging neurology at a time when the life of residents and the diseases and treatments were markedly different from today.

Professor Derek Ernest Denny-Brown O.B.E. M.D. DPhil, FRCP was the Director of the Boston City Hospital Neurological Unit at the Boston City Hospital and the James Jackson Putnam Harvard Professor of Neurology from 1941 -1967. He was born in New Zealand but obtained a doctoral degree with Nobelist Sir Charles Sherrington and trained in neurology at the zenith days of clinical neurology at the National Hospital at Queen Square [1]. Students seeking residency training in neurology flocked to the Neurological Unit because Dr. Denny-Brown offered new physiological insights into clinical neurology and was moving neurology practice away from the psychiatric model into the model of internal medicine.

Taking care of the needy patients at Boston City Hospital with no worry about length of stay or other financial matters was a wonderful privilege. The residents also had the opportunity to perform all neurological testing such as perimetry, tangent screen visual fields, urodynamics, iophendylate myelograms, ophthalmodynamometry, pneumoencephalography, carotid “stick” angiograms and even EEGs. They also were expected to present these data on rounds. Trainees also had to accept that Boston City Hospital was a tough place to work. After advancing through the required training in internal medicine, starting over on the lowest rung as a junior “nerve” resident required lots of scut work such as doing the admission lab work, drawing bloods starting IV’s and even transporting patients. No time was spent gazing at computer screens. The resident’s white jackets appeared tie-dyed with the bright colors of Gram, Wright and acid fast stains. The Hospital was a scruffy, poorly maintained institution sprawling among a dozen buildings; connected by a maze of dark dank subterranean

tunnels. Many employees were the special needs relatives of Boston politicians and liked proving their unshakable job security was greater than the professional staff.

Tuesdays were special because Dr. Denny-Brown saw every patient on the Service. The other weekly major events included Thursday “brain cutting” where the neuropathologist would demonstrate the abnormalities in the brain after case discussions starting with a junior assistant resident on up to Dr. Denny-Brown. If the pathologist failed to demonstrate the Professor’s diagnosis, he was asked to make thinner cuts and sometimes we jested that the brain must be wrong! The third highlight was a 2.5 hour Saturday conference where two challenging cases would be examined and discussed in detail by Dr. Denny-Brown.

Tuesday rounds started in the small departmental library. Everyone stood when the Professor entered. A contingent of residents had been moving beds about in order to place the most interesting patient in the first position. The group included the monthly Visit who was a senior member of the Boston neurological community. Distinguished foreign neurologists were also frequently in attendance. The redolence that suffused the wards was that of the paraldehyde used to treat alcohol withdrawal.

The senior resident knew exactly where to stand and hand Dr. Denny-Brown the right instrument at just the right time. The junior resident presented new patients in the precise manner that he had been rehearsed by the senior. I had the good fortune to have Martin Pollock as my senior and his New Zealand accent seemed to have a mollifying effect on Dr. Denny-Brown. If any of the strict protocol was breached the junior resident might be “excused” from rounds and “someone who knows the case” i.e. the senior, would be asked to continue the presentations.

Forbidden acts included using terms like chorea or athetosis which would evoke “That is a diagnosis; describe the abnormal movements that you see.” This seemed peevish at the time but later I realized that this discipline did enhance one’s powers of

observation. If a patient had any sensory findings the resident was to display a carefully drawn map of each modality. One medical house officer who ultimately became a distinguished professor of medicine rotated through neurology and enjoyed tweaking the neurology residents about being too timid and obsequious with Dr. Denny-Brown. When it came time to present his patient who had sensory findings the requisite map had not been done. We anticipated an angry outburst and possible dismissal from rounds but instead we heard a quiet, calm plea indicating that a sensory map would be required for a neurology patient just as his medical visit would expect the result of an EKG in a patient admitted to the medical service for chest pain.

No questions were allowed during Dr. Denny-Brown's rounds; the discussion was unilateral and directed at the presenter. Psychiatric, especially Freudian, terminology was to be avoided. The only behavioral diagnosis I heard from Dr. Denny-Brown was "inadequate character development". If you admitted a patient with functional paraplegia you were not to leave the Hospital until you had the patient walking again by promoting their "confidence". Dependence on EEGs was also a peril. I once tried to convince Dr. Denny-Brown of a spike discharge only to be asked "Did someone slam the lab door?" I wondered whether this might be part of the reason why the epilepsy and EEG workers, Fred and Erna Gibbs and William Lennox, moved on.

Dr. Denny-Brown was not devoid of humor and there were certain stock lines he could not resist using repeatedly. If the resident began a presentation with "We have an interesting case" he would retort, "Tell me about it and I will tell you if it is interesting". When the resident indicated that "The ankle jerks were trace to 1+", Dr. Denny-Brown, on finding no reflex would comment "You must have gotten the last one". If the resident was carrying a Queen Square style reflex hammer he would enjoy calling it a "pessary on a pole."

The diagnoses on these rounds were very different from what you would find on present-day neurology services. Jakob-Creutzfeld was considered a degenerative disease and autism was due to "cold" mothering. There were still some cases of general paralysis of the insane and tabes dorsalis. Antihypertensives were not so effective and our patient population was disinclined or unable to take daily medications. Thus, *etat lacunaire* or advanced Binswanger encephalopathy with pseudobulbar palsy, frontal dementia and gait disorder was common even on the general medical wards. Hypertensive intracerebral hemorrhage was also much more common than today. Sydenham's chorea and tuberculous meningitis were not rare. Wernicke-Korsakoff patients were very frequent because community centers had not yet begun to dole out thiamine to all comers. Porta-caval shunts were a common surgery to prevent bleeding from esophageal varices in

the alcoholic cirrhotics and this made chronic hepatic encephalopathy extremely common.

When a senior resident (Dennis Thoen) once had the temerity to apologize for not having an interesting case, Dr. Denny-Brown made an effort to produce a special discussion and even sent Sid Gilman upstairs to retrieve a recently operated monkey to illustrate his discourse.

Personal Characteristics

Dr. Denny-Brown could tear into people but there were occasions when he was on the receiving end of the exchange. He was humorously rebuked in writing by some of his old Queen Square colleagues for certain of his inventions which never made it into mainstream neurology. These included the avoidance reflex of parietal origin and term amorphosynthesis which he coined to describe an overall behavior in patients with the parietal syndromes. The incomprehensiveness of some of his written works was also frequently noted. I once introduced Dr. Denny-Brown as having the singular honor of writing a book on motor control which was translated into the same language, [2] as the title of Othello Langworthy's book "The Sensory Control of Posture and Movement: A review of the Studies of Derek Denny-Brown" reveals [3].

After his retirement Dr. Denny-Brown made a comment to me that revealed much of his difficult behavior was a bit of a bluff. "Sylvia (his wife) and I have joined a Cambridge neighborhood group that puts on informal plays and of course they always cast me in the Iago parts". His scientific and clinical achievements and his personal characteristics made Denny a role model for a generation of neurologists. Dr. Denny-Brown had an incredible work ethic and even younger men had a hard time keeping up with him. He was also known for his uncompromising sense of honesty; he actually returned any unspent funds to NIH annually. Dr. Denny-Brown had great physical and mental toughness. The facial flushing and nasal discharge of his cluster headaches occurred but rounds continued on. When he rubbed the neuroma at the site of his amputated finger the residents feared this was an ominous "rattle" which might be followed by a "strike". He also endured catheterization to study bladder physiology. When I expressed my sadness at learning about his slowly advancing fatal myeloma, he said it was "not a bad deal" at his age and "dying of uremia was a good way of going". At that moment I could better understand his bluntness with patients and residents.

In the end, while we who trained with Dr. Denny-Brown enjoy the tales of awed terror, stress and bemusement, the Unit was an incredible opportunity to apprentice in neurology with a leader of colorful brilliance, superb clinical insights and a singular physiological perspective. We are forever proud to trace our neurologic lineage through him.

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