Fisher’s Rules
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C. Miller Fisher is a clinician whose
methods and style deserve the same
attention given his accomplishments. The
17 “rules” presented herein summarize
some of the basic principles he has fol-
lowed in the practice of medicine.
(Arch Neurol 1982;39:389-390)

The unique capabilities of C. Miller
Fisher as astute observer and describer of clinical phenomena,
pathologist, investigator, and physic-
ian were appropriately recognized by
his colleagues and students on Fisher
Day, Sept 7, 1980, during a celebration
marking his formal retirement. His
many accomplishments and publica-
tions, especially in the field of cere-
brovascular disease, were dealt with
by Adams and Richardson. As has
been true of clinicians in former eras,
the legacy of Dr Fisher’s methods and
style may prove just as important and
enduring as his scientific advances.

Change in medical and technical
knowledge is so rapid that we accept
constant flux as a fact of life. The
Queen of Chess in Lewis Carroll’s
Alice in Wonderland put it aptly,
“Now, here, you see, it takes all the
running you can do just to keep in the
same place.” This constant state of
change means that some of today’s
“brightest advances” may be labeled
tomorrow as yesterday’s mistakes. If
gains in knowledge are so fleeting,
how then do we make our mark on the
future? Dr Fisher, as a student and
teacher, conveys to colleagues, and
students, by his words and personal
example, a way of procedure, a meth-
odology. I have chosen to call his
method “Fisher’s Rules” because he is
fond of organizing clinical phenomena
into well-ordered patterns and will
frequently ask, “does this patient’s
findings fit the usual rules for a lesion
in this anatomical region?” These
rules are described herein for those
not fortunate enough to have worked
with this master, in hope that they
may serve as guides for the apprentice
clinician. Those who know C.M.F. well
will recognize that he did not actually
state many of these rules, they are
inferred from his behavior and his
example.

1. The bedside can be your laboratory.
Study the patient seriously.—Clinical
observation takes time and patience.
The method of clinical observation
should be just as rigorous as that of
the laboratory bench. Generate hy-
potheses from your history and obser-
vations, and then proceed to devise
tests applicable at the bedside that
will corroborate or disprove your
ideas.

2. Settle an issue as it arises at the
bedside.—Whenever possible, don’t
leave a “maybe.” The situation may be
quite different tomorrow, so that
the opportunity to answer an important
question will be lost. A loose, indef-
nite formulation of the clinical prob-
lem is usually not improved or clari-
fied by laboratory investigations.

3. Make a hypothesis and then try as
hard as you can to disprove it or find
the exception before accepting it as valid.—
C.M.F.’s publication or formal state-
ment of a concept often appeared
years after the idea was originally
generated. During that time, he would
test and retest the idea to uncover its
weaknesses and pitfalls, always try-
ing to “trip it up.” He was also wary of
stating ideas that had not stood the
test of time and inquiry.

4. Always be working on one or more
projects; it will make the daily routine
more meaningful.—Once a hypothesis
has bloomed, collection of data at the
bedside or in the clinic can begin.
Even patients whose problems do not
relate to the study at hand can some-
times serve as controls. Also, “nor-
mal” patients can teach how a task is
ordinarily approached, a story ana-
yzed, or a picture interpreted. One
can gain from any clinical encounter.

5. In arriving at a clinical diagnosis,
think of the five most common findings
(historical, physical findings, or labo-
atory) found in a given disorder. —At least
three of these five are not present in a
given patient, the diagnosis is likely to
be wrong.

6. Describe quantitatively and precise-
ly.—From a verbal or written account
of the findings in a given patient,
others will need to picture what has
been found. Furthermore, when the
patient is reexamined months or
years later, you will need to compare
the findings with your own prior
description. “The patient, while
supine, could lift his leg to a height of
6 in for 10 s,” gives a visual picture far
superior to a simple statement that the
leg had moderately severe weak-
ness.

7. The details of the case are impor-
tant; their analysis distinguishes the
expert from the journeyman.—For
example, an exacting account of the
pace of a stroke frequently helps sepa-
rerate hemorrhage from occlusive
disease.

8. Collect and categorize phenomena;
their mechanism and meaning may
become clearer after if enough cases are
gathered.—Scattered over, under, and

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on C.M.F.'s work area are untold manilla folders containing collections of unusual, historical accounts, or unique or poorly understood observations. The headings on these folders might read "patients who write off the paper," "intermittent interruption of behavior," "nonsense speech," "inconsistency," "mumbling," "ovipository," "unusual movements ipsilateral to a cerebral lesion," "laughs,"
"smiling while talking of feeling sad." If we have not collected our observations as we go along, they are often impossible to retrieve later.

9. Fully accept what you have heard or read only when you have verified it yourself.—Whenever possible, test the ideas of others before embracing them as valid or quoting them. The literature and dogma of medicine are filled with hearsay, half-truths, and imaginings. Misinformation is poorly tested "facts" are frequently passed along in rote fashion from one generation to the next.

10. Learn from your own past experience and that of others (literature and experienced colleagues).—C.M.F. knows and reveres the history of ideas and the contributions of others. As Osler had noted, "to study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all." C.M.F. can frequently be found in the evening among the stacks of one of another of the medical libraries in Boston. Each generation cannot relive the history of neurology. Take advantage of what has been already clarified in the past.

11. Didactic talks benefit most the lecturer. We teach others best by listening, questioning, and demonstrating.—C.M.F. would often casually question bright students months after they attended one of his lectures or after a particularly good talk they had heard together, attempting to gauge retention of the material presented. Often the cardinal points had been forgotten or never learned. We recall best facts and concepts that we ourselves have struggled to obtain.

12. Write often and carefully. Let others gain from your work and ideas.—C.M.F. set a goal of producing at least one major and two minor reports each year. This gave him time lines to aim for that he invariably surpassed but seldom lagged behind.

13. Pay particular attention to the specifics of the patient with a known diagnosis; it will be helpful later when similar phenomena occur in an unknown case.—Many clinicians stop acquiring information when the diagnosis becomes clear; for them, the object of the clinical encounter is simply to make a diagnosis. Listening to detailed descriptions, for example, of visual phenomena in known migraines may prove invaluable when confronted later with a patient with an unusual undiagnosed visual experience. Compare the unknown with the 100 prior migrainous visual accompaniments: does it fit the rules?

14. Be a good listener; even from the mouths of beginners may come wisdom.—C.M.F. frequently questioned students, fellows, and colleagues and patiently listened to their replies in hopes of gleaming new thought or insight.

15. Resist the temptation to prematurely place a case or disorder into a diagnostic cubbyhole that fits poorly.—Allowing it to remain an unknown stimulates continuing activity and thought. C.M.F. has an uncanny knack for recognizing the unusual patient or the facet of the case that did not quite conform to the rules. He is also keenly aware of the limitations of present medical knowledge. Identifying the unique case led to further analysis and frequently a report of a newly defined condition or variant.

16. The patient is always doing the best he can.—Be supportive. Never become angry with a patient or his family.

17. Maintain a lively interest in patients as people.—C.M.F. also collects people with unusual attributes, for example, a man strong enough to lift a small car, families with a history of impressive longevity, fat people who enjoy excellent health, people who succeed at unusual occupations. His interest in people also extends to his students, residents, fellows, and colleagues. He is never too busy to discuss a vexing clinical problem, share ideas about a new medical advance, or simply chat about the recent news of the day. Perhaps his success as a clinician partially reflects his more general interest in humanity and its trials, tribulations, successes, and sufferings.

**References**