C. Miller Fisher: An Appreciation

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In an era when almost anyone of note is called a star, superstar, or legend, the death of Dr Fisher in April 2012 at 98 years was the loss of a true once-in-a-generation figure. A brief outline of the bulleted dates in the biography of Dr Fisher shows his birth in Waterloo, Ontario, in December 1913, receipt of medical degree from University of Toronto in 1938, service in the Canadian Navy with transfer on loan to the British Royal Navy, and 3.5-year internment in a German prisoner of war camp from 1940 to 1944, training in neurology and neuro-pathology at the Montreal Neurological Institute and Boston City Hospital to 1949, faculty position at Montreal General Hospital to 1954, and subsequent move to Massachusetts General Hospital under the leadership of Dr Raymond D. Adams. I have been unable to ascertain a date when Dr Fisher officially left Massachusetts General Hospital, an event many at this institution would say has not occurred.

As chair of the International Stroke Conference Program Committee, I was exceedingly privileged to deliver In Memoriam remarks at the conference in February 2013 summarized in the current article. These represent personal reflections on a legendary investigator, healer, and teacher from a tremendous grateful pupil, who was no more than a blip on Dr Fisher’s extraordinarily rich radar screen. For more complete treatments (including a reprinting of Dr Louis Caplan’s 1982 accurate and insightful compilation of Fisher Rules), the reader is referred to several excellent obituary publications from prized students and colleagues of Dr Fisher.1,2

Listing just the most prominent contributions of Dr Fisher to elucidating the pathophysiology and clinical behavior of stroke (Table) is a humbling experience. The list is striking not only for its length, but also for the degree to which the concepts espoused by Dr Fisher 30 to 60 years ago remain relevant today in thinking about these diseases. The breadth and depth of this list reinforces the notion that the contributions of Dr Fisher to stroke were ultimately limited only by the number of healthy years he had on this planet.

With the kind permission of Dr Fisher and family, I was able to interview him on March 26, 2012, in Albany, NY. One observation from this conversation was that Dr Fisher cared deeply about his legacy for the stroke community in general and the International Stroke Conference audience in particular. This determination of Dr Fisher, not to grasp credit that was not his but rather to set the facts straight on his role, could be heard in the following recollection of the origins of the term transient ischemic attack.

...Here I have patients who have a blocked carotid and had transient blindness in the opposite eye [opposite to the subsequent stroke], and it meant that carotid disease causes trouble—I knew that by then—and that there are warning spells. Transient blindness was a warning that a stroke was coming. That was the birth of transient ischemic attacks. I didn’t give it that name at that time, but then I went to veterans hospitals on Sunday and spoke to relatives of people with strokes. And just one after another [they reported] warnings before the stroke came. So within a few months I had found out about carotid disease, that it is associated with transient blindness, and that there are transient warning symptoms of different kinds before the big stroke comes.

...I used different terms for about a year and [then] decided on transient ischemic attack. A neurologist in Texas somewhere was at a meeting and he put up a slide and for transient ischemic attack, he didn’t have room to put it all in one place, so he [wrote] “TIAs.” That gave me the idea to shorten it to TIA. I told Ray Adams and—this is not complimentary—I told him that I had finally decided to call the warning spells TIs. And he said, “It’ll never fly.” Just like that.

A very subjective listing of the qualities that distinguished Dr Fisher and allowed him to achieve so much in his life would start with his tremendous sympathy for patients and corresponding antipathy for the strokes that laid them low. A patient with stroke wheeled back to his room after being presented to Dr Fisher, touched by the respect and interest with which he had been treated, would remark, “He’s a very special man.”

Second on this list is the quality perhaps best known to anyone taught by Dr Fisher: his unceasing pursuit of clinical details and pathological correlates. Dr Fisher left behind him stacks of patient notes and even higher stacks of serially sectioned brain tissue slides. At times, the obsession for seemingly meaningless clinical or pathological details could seem a rigged-up game, a pointless exercise without purpose beyond introducing endless complexity.

The truth was quite the opposite. Data collection for Dr Fisher was always at the service of his unshakeable...
conviction that strokes, although complex, do not occur at random but rather follow rules that make sense. When Dr Fisher would present his 21-item table of lacunar syndromes, a know-it-all resident might sniggeringly whisper, “This is nuts. Lacunes can cause anything.” But no, they cannot. They cause 21 syndromes, and if you implicate them in a 22nd, you should be prepared with your own stacks of notes and slides or else be prepared to be wrong. The conviction that strokes occur not at random but by definable mechanisms is the quality of Dr Fisher that ultimately had the greatest impact on this particular sniggering resident.

The final item on this subjective list of qualities is the thirst of Dr Fisher for discovery. This feature had in no way dimmed at age of 98 years made evident by the comment below. Dr Fisher was greatly troubled by his inability to swallow and attributed it to a Zenker diverticulum by a well-meaning local physician.

I have not found a description of my throat trouble in the literature. Well they say, it is probably the Zenkers. I would never say anything like that. I would go and wash my mouth out with soap if I said “it’s probably a Zenker’s” and walk away. You know, if you stay for another minute, you will make a discovery.

There it is: The need to make sense of the natural world, spoken by someone better at it than anyone our field has produced in our lifetimes. I recall the saying of Dr Fisher that every minute he spends with a patient, a hundred observations come flying at him—historical details, symptoms, sensations—and at that point in his career, he could make sense of around 3 of them. This does not leave the rest of us in very good shape. Let us just say, to paraphrase a quote originally applied to legendary Boston basketball stars, that the next Dr Fisher is not walking through that door anytime soon.

**Disclosures**

None.

**References**


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