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Our Passion Protects Your Practice
Recently showed a videotape to a colleague of mine, also a movement disorder neurologist. The patient had an inherited ataxia, which affected motor function but not cognition or behavior. As the patient walked out of the exam room on the videotape, I asked him to turn to the left and walk down the corridor. He turned to the right. I corrected him but he made the error again, and so I commented, “This disease isn’t supposed to affect your thinking, just your movements.” He laughed. I laughed. A positive interaction.

My colleague said, “I made a comment to one of my patients that was just like yours and she fired me. She thought I was demeaning and unsympathetic. She accused me of making fun of her. She was irate.”

It was difficult to imagine anyone who knew my colleague to think he had made fun of his patient. He is a kind, sensitive physician who has never been flippant or dismissive, that I’ve ever seen, and while many people behave differently in different situations, I’ve seen him with patients, students, colleagues and it just doesn’t ring true that he could have, in any way, slighted the patient.

Laughter in the medical office is good. Although many people think that “laughter is the best medicine,” I am not one of them. But I do think it helps lighten the load. It is crucial, of course, to be certain that patients will not respond as my friend’s patient did, so, when in doubt, I don’t joke. I must insert here that I have been informed by many observers that I am known among patients for not smiling, not joking and being overly serious, even to the point of being called “Dr. Smiley.” I do think that joking makes the doctor more accessible, more humane, and it can help make the disorder distinct from the patient. I think of myself as humorous, although it is true that I don’t smile much. Perhaps it’s concern about “laugh lines” as I age. The important thing is that one can laugh at the disorder, not the bearer of the disorder, and it calls for sensitivity and judgment to decide which patients cannot appreciate the difference – these are the ones who will feel insulted. “I have Parkinson’s,” said one of my patients. “Parkinson’s doesn’t have me.” We can laugh at one, not the other.

A man once told me that his father was hallucinating and seeing people in his apartment who weren’t there. This didn’t usually upset his father – except for the time when he saw his upstairs’ neighbor, a woman who regularly came down to check on him, in the apartment when she wasn’t supposed to be there. So he called her on the phone to come down and get rid of herself. Laughing at the disease, not the patient.

I did not laugh when another patient, who had hallucinations of people outside his home, told me, in response to my query, that the hallucinations he saw were always outside and never inside the house. “I double lock the door,” he explained, giving a rational answer to an irrational situation. The door was locked. How could anyone get in? I must admit that I did laugh later on. It took me a while to understand the humor. I would have explained to the patient what was funny. His disease and medications had produced this surreal experience.

It is never good for the doctor to laugh at the patient, or laugh with any other possible interpretation than “with” the patient. It is never good for the doctor to laugh at the patient, or laugh with any other possible interpretation than “with” the patient.
Psychogenic disorders
Unfortunately, however, we physicians sometimes do laugh at patients. Not long ago there was an outbreak of psychogenic movements among teenage girls in Buffalo, NY. It was widely featured on the national news, on the Internet and in newspapers. It was quite clear to the practiced eye that these were not physiologically-based movements, and the physicians who cared for the girls were quite definite about this, although the news reporters seemed somewhat skeptical. This occurred not long after a young woman became a YouTube sensation when she developed “dystonia” following a flu inoculation. TV stations nationwide reported her story and again, it was quite clear that her movements were psychogenic, much to the chagrin of the anti-vaccination movement. Her disorder transformed over the next few weeks to include an amateur French accent and walking like a crab. It was quite common for physicians discussing and reviewing these videos to laugh at the patients. And it is very common for the audience to laugh when bizarre psychogenic seizures and movement disorders are seen on video.

I admit to this transgression, although it has not happened recently. I became embarrassed when I realized that I was laughing at, and not with, the patient. I was adding insult to injury. If one posits that the movements are involuntary, that they occur due to unconscious mechanisms of the psyche, then they are reflections of emotional pain. It is the brain’s flawed way of “hiding,” transforming or converting psychic distress to a somatic disorder, clearly indicating to the world a person in distress, needing help, able to present a visible wound.

So why do well-intentioned and well-trained doctors, even senior ones, laugh? I think I’ve figured it out. I think that it is for the same reason that adults laugh when a child says he didn’t eat the chocolate although it’s on his hands and face. We laugh because we find ourselves as an opponent in a contest of “fool the doctor,” and the patient’s maneuvers are so obviously “phony” that we laugh to show our disdain for the notion that we can be fooled by something so obviously factitious. I have observed that we don’t laugh when the disorder looks so real we’re unsure. The tremor that looks “organic” until it is unmasked by distracting maneuvers is not amusing, but the histrionic patient who groans and strains, crossing his eyes with the effort of touching his finger to his nose is. After all, who could be fooled by that?

Neurologists have changed their approach to psychogenic disorders. We used to render a diagnosis of “psychogenic,” “functional” or “not organic” and send the patient to a psychiatrist, who might or might not embrace this diagnosis. If not, the patient would continue having more tests and seeing more neurologists. The referring neurologist would wash his hands of the patient, not to be seen again. We have come to see that the disability from psychogenic disorders is every bit as bad, often worse, than the organic disorders on which they’re modeled. We now try to work with the other physicians and therapists. The chances of improving from psychogenic dystonia are a whole lot better than of improving from an organic dystonia. Psychogenic disorders can even be cured.

The bottom line is that pain is pain, whether emotional or somatic. We should never allow ourselves to be drawn into a contest with our patients. No one emerges a winner.

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“The rules of fair play do not apply in love and war.” So declared English playwright John Lyly in 1578. However worded (often quoted as “All’s fair in love and war”), the message, as it pertains to warfare at least, is clear: none of the customary rules of civility apply. And yet warfare, in recent centuries at least, is governed – perhaps modulated would be more accurate – by a number of international conventions making certain warfare practices tacitly acceptable and others explicitly not.

The Geneva Convention, convened in 1949, provided rules to insure the safety of non-combatants, particularly health workers, forbade torture, guaranteed access to prisoners of war, established neutral committees to facilitate communication and forbade certain warfare practices such as the deployment of poison gases. Subsequent Geneva protocols also precluded the use of microbial pathogens as vehicles of warfare.

Germ warfare – the deliberate dissemination of disease-causing bacteria or viruses for purposes of harming civilians or military – is now widely condemned by the many Geneva Conventions. Yet there have been many documented instances of planned, deliberate bioterrorism in prior centuries.

Jeffery Amherst (1717–1997) was commander of British forces in North America during the French and Indian War (1754–1773). In 1763, when Pontiac’s army of Native Americans had besieged Fort Pitt, the local officer in command of the British garrison suggested that contaminated blankets from smallpox victims be sent to the Indians in the hopes of deliberately spreading smallpox amongst the besieging tribes. In a letter dated July 9, 1763, Amherst expressed his enthusiasm for “measures as would bring about the total extirpation of the Indian Nations.”

Thirty-six virologically uneventful years have passed since any human has been naturally afflicted with smallpox. Fears still lingered that the smallpox virus might be employed for purposes of terror. In 2001, the Johns Hopkins Center for Civilian Biodefense Strategies hosted a tabletop exercise, entitled, “Dark Winter” to assess the epidemiological implications of a covert smallpox attack upon the United States.

The conference envisioned three shopping centers (Oklahoma City, Philadelphia and Atlanta) each intentionally contaminated with 30 grams (about one ounce) of aerosolized smallpox virus. Each atmospheric contamination would infect about 3,000 individuals in each of the shopping centers. And, based upon past epidemiologic experience, each newly infected person (during a latency interval when this “first-generation” victim was still symptom-free) would infect about 10 additional persons. Thus, before the virologic catastrophe became clinically apparent, the number of infected, in each of three attack areas, would increase tenfold leading to an estimated 30,000 victims. Within a month, the numbers infected would exceed 300,000; and, since many during the symptom-free incubation-interval would have traveled to other cities and other countries, the seeds of smallpox would inadvertently spread.

This blackboard exercise simulating the likely effects of a terrorism
attack employing the smallpox virus indicates the vulnerability of this nation to the deliberate seeding of a civilian population with a lethal pathogen. If a weapon is judged by the amount of damage it causes, in terms of morbidity and mortality per ounce of weaponry, then weaponized smallpox ranks with the nuclear weapons.

Thirty-six virologically uneventful years have passed since any human has been naturally afflicted with smallpox. No one, born after 1977, has been protectively vaccinated. And while this nation still maintains a stockpile of smallpox vaccine, the interval of time between intentional dissemination of the virus and the time when the peril is recognized by public health officials is sufficiently great so as to allow carriers of the lethal virus to have traveled extensively thus increasing the infected population exponentially.

Under the best of circumstances, this tabletop exercise concluded, the mortality would be massive.

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Quotes: Rx for Life

“It is enough for me to contemplate the mystery of conscious life perpetuating itself through all eternity, to reflect upon the marvelous structure of the universe which we dimly perceive, and to try humbly to comprehend an infinitesimal part of the intelligence manifested in nature.”

— Albert Einstein

Submitted by Daniel Lederer, MD, Providence

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