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Let Sleeping Dogs Lie

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I recently saw a 40-year-old woman with a movement disorder that began in her teens, reportedly diagnosed at a major medical center at age 20. Since that time she’s done very well, living a normal life, married, with children, seemingly comfortable. I was surprised by her history. Her problem, presumably an autosomal recessive disorder, was progressive, yet hers had not progressed. Her movements were very intermittent, sometimes not present for hours, yet they did occasionally interfere with her life. They never occurred when exercising, so she can jog without problem. Her movements were quite odd and it became quite apparent to me that they were psychogenic. She was not seeing me for treatment, but only to “check in,” and have a doctor available should her problem worsen.

This reminded me of a couple of other cases. A 75-year-old woman who I’d followed for a few years for a very significant tremor told me that she had another neurological problem that she’d never mentioned. If she stood in one place for several seconds she would lose her balance, always falling backwards, and that she could abort this by either shaking her arms or rubbing the top of her scalp. She allowed me to film this, and I have it on file. It was a phenomenon without a physiological explanation. Yet it was not a “problem,” in that it caused her no distress. She mentioned it to me casually, wanting to share a peculiar observation, like someone showing that they can bend themselves backwards enough to touch the floor with their hands. It didn’t distress her in the least.

The third case along this line is a 50-year-old man who I diagnosed with Parkinson’s disease 20 years ago or more, who hasn’t changed during that entire time and has not required medication. He reports easy fatigue, which limits his life to a small extent, but it has not interfered significantly with his family life, raising his children, pursuing his professional career or enjoying leisure activities. He is, at least to my eye, completely well compensated. Yet, I came to the conclusion a few years ago that this had to be psychogenic. I thought about proving this with the newly developed DaT scan, a SPECT scan that provides an estimate for the number of dopamine-secreting neurons in the brain. It is a fairly reliable method of confirming the presence or absence of a dopamine cell deficiency. Since we don’t see physical signs of PD until people have lost between 50% and 80% of the dopaminergic cells in the midbrain, there is generally a marked difference between normal and abnormal. But in this case I refrained. Just as in the previous two cases I did not mention suspicions of a non-physiological explanation.

I also have followed a man for the last 25 years for severe parkinsonism while on prochlorperazine. He refused to taper or stop the drug, which commonly causes parkinsonism. Over the next few years it became increasingly clear that his parkinsonism, while possibly partly due to the drug, was mostly a psychogenic problem. I was unable to check him for stiffness, a cardinal feature of Parkinson’s disease (PD), or for slowness, another cardinal feature, because he had too much pain to move any part of his body even a millimeter. I then learned that he had severe, intractable asthma, but never had visited an emergency room, and never had pulmonary function tests because his tremors were too severe. He had never been hospitalized for this and never had wheezing detected. On top of this were seizures, occurring many times each day. I sent a videotape of him many years ago to my mentor, who thought the tremors psychogenic, but I never discussed this with the patient. I have always felt, and continue to believe, that there is no reasonable chance that he might embrace the idea that all of his disabling medical conditions were the result of emotional distress. I never thought that with appropriate therapy he might become a functional person. He was wedded to his diagnoses, which were as important to him as life itself. I would have intervened if I had seen him near the onset.

I see a lot of people with psychogenic problems. All doctors do. But most of these are for highly subjective symptoms: chest pain, abdominal bloating, dizziness, fatigue, weakness. In neurology we see non-epileptic seizures (pseudo-seizures), blindness, deafness, mutism, paralysis, tremors and a wide variety of movement disorders. Many of the neurological disorders can be demonstrated to be...
of “non-physiological origin,” either with objective testing such as video monitoring with concurrent EEG, for non-epileptic seizures, or with a variety of examination procedures. One can never “prove” that pain or discomfort or dizziness isn’t organic while we often can demonstrate that a patient isn’t truly paralyzed. This makes us more confident about the non-physiological origins of neurological symptoms.

Acute “functional” (non-physiological) neurological disorders usually resolve without treatment. The ones that persist six months often don’t resolve, ever, even with treatment. The above cases demonstrate that some people with psychogenic movement disorders do quite well over decades. If a disorder is psychogenic, it presumably has a psychic explanation. In most cases the explanation is apparently so disturbing that the person cannot deal with it consciously, transforming the emotional distress into a physical sign. Perhaps in these cases, where people can live full lives around an isolated disorder, they have successfully cordoned off the distressing problem without having to deal with it? Perhaps some psychic traumas are best NOT dealt with other than for having a few twitches now and then? I certainly believe that for these three cases, it is highly likely that, even if the patient would embrace my diagnosis, an unlikely event, the treatment might well be worse than the disease.

I published an essay a few years ago in a neurology journal calling on my colleagues to “call a spade a spade,” and tell their patients the truth when they think the problem is psychogenic and not hide behind, “I’m not sure,” “I can’t explain this,” “maybe you should see someone else,” when, in fact, they are sure. My co-author asked me how I could have written that column and then this one. The answer lies in why the patients saw me. In none of these cases was a diagnosis or a treatment sought. I was being seen for “follow-up,” for reassurance, for comfort.

Author
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Medicine: Then, Now and Perhaps in the Future

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The Rhode Island National Public Radio Station (RINPR), last summer, conducted an educational series of seminars that they called “Future Docs.” Kristin Gourlay, its moderator, chose two matriculating students at Brown’s medical school and followed them in classes, clinics and at the bedside as they learned their new and increasingly complex profession. And so these RINPR programs discussed such relevant issues as innovative curriculums, the increasing preeminence of public health in the private practice of medicine, the many ways medical education has transformed itself to meet the health-care needs of the 21st Century, and, certainly, the very character of those young candidates about to enter the profession.

The art and science of human healing has been immensely advanced since I entered the medical profession some seven decades ago. And these readily documented advances are at least as robust as the more obvious advent of antibiotics, the many evidence-based therapies, the development of newer radiographic, ultrasound and biochemical diagnostic procedures and the wider availability of health insurance.

Consider, for contrast, the typical candidate chosen to study medicine in the 100-odd American medical schools during the 1930s and early 1940s. The great majority of matriculants were tall, healthy white males chosen more for their lineage and innate sense of authority than for any visible signs of intellectual superiority or compassionate behavior. If a medical school admissions committee, say in the year 1937, had to identify a single sought-for attribute in those seeking admission, it probably would be evidence of mature leadership (as evidenced, perhaps, in extracurricular scouting, church activity or in collegiate team work).

The medical schools of that past era trained their students for a life of solo-practice, and therefore, inevitably, an immersion in a profession that required unilateral decision-making, impassivity in the face of calamity, aloofness, and a fatherly rather than brotherly demeanor. The lone medical practitioner of the 1940s fostered little collegiality with nurses, technicians or members of the clergy, and his guiding principle in life...
was equanimity in the face of stress. In the words of Sir William Osler, “...be like an immovable rock in the face of adversity.” And if he experienced occasional regrets or grief, he kept it to himself.

The patients of that remote era were either privileged clients of private practitioners; or, more likely, persons bereft of any formal medical care: at best, recipients of welfare medicine provided principally through municipal hospital clinics (called OPDs) which offered competent but an intensely impersonal and discontinuous mode of health care. It was often described as “four hours in the waiting room and four minutes in the treatment room.” And if the clinic was part of a medical school’s venue, the “attending physician” was often a fourth-year medical student.

Many Americans, therefore, went for decades without professional contact with registered physicians. Who then provided care for their surface bruises, ill-defined abdominal aches or sudden fevers? A wide variety of volunteer healers including the neighborhood pharmacist, the school nurse, the elderly grandmother and sometimes practitioners, both secular and religious, of alternate therapies.

Prior to the era of functioning antibiotics and evidence-based pharmacological agents, medicine relied principally on nature, palliatives, dietary regimes and sound advice. The anonymous third-grade teacher and her classroom instructions on personal hygiene saved as many lives as a bevy of physicians.

And what did the practitioner of 1937 consider his enemy? Sometimes the truth since the unembroidered truth was too painful to share; and so, euphemisms were often employed: tuberculosis was called a spot on the lungs; and cancers were domesticated to “lumps” or “growths.”

The most implacable enemy of this isolated physician was the imminent death of his patient. Organized hospice programs did not exist then and the public insisted that every measure be undertaken to preserve and prolong life. And if the private physician eased up on his exertions, he kept his resolve to himself. Palliation for the terminally ill patient was a private matter between the family and the physician, with never a hint of it in the written record.

Medicine, more than a half-century ago, was a lonely art consuming a minimum of 60 hours per week for its practitioners. They learned to stand alone, keeping silence to hide their doubts. And the average practitioner in that era rarely lived beyond age 58.

Describing medicine’s recent past is easy. Speculating about its future, prophesying medicine’s therapeutic capabilities fifty years hence, might also be simple but only when compared with guesses concerning affordable health care for all Americans in 2064.

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**Disclosures**
The author has no financial interests to disclose.
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Rainbow Healthcare, it takes a village

Two weeks ago my aunt fell while shopping in a mall in Johannesburg. She is 86 and frail, but still independent, driving and able to do her own shopping.

She was immediately assisted by a middle-aged South African Indian woman who stopped her own shopping to provide assistance. My aunt was bleeding from a hand laceration. After some initial aid, this woman insisted on taking my aunt directly to this woman’s primary care physician office for further assistance. She was seen immediately by the physician who seemed unperturbed about checking if she had health insurance as the information was not readily available. My aunt required 3 sutures. The young Afrikaans office manager insisted on driving my aunt home and arranged for her husband to collect my aunt’s car from the shopping mall.

This whole episode was over within 3 hours, was managed without any fuss and at a minimal cost to the health care system. It also provided an opportunity for tremendous neighborliness and goodwill that spanned age, ethnicity and social background.

I know that there will be comments made about what could have gone wrong and what liability was incurred by those who participated.

However, I thought this vignette was worth sharing, so that we may dream and strive to capture the spirit of such a health care system. The physician was only a small cog in this wellness model.

Alan Gordon, MD
Associate Medical Director, Butler Hospital
Chief, Clinical Addiction Services, Butler Hospital

Guidelines for Letters to the Editor

Letters to the Editor are considered for publication (subject to editing and peer review) provided they do not contain material that has been submitted or published elsewhere.

The Rhode Island Medical Journal prefers to publish letters that objectively comment on or critically assess previously published articles, offer scholarly opinion or commentary on journal content, or include important announcements or other information relevant to the Journal’s readers.

Letters in reference to a Journal article must not exceed 175 words (excluding references), and must be received within four weeks after publication of the article. Letters not related to a Journal article must not exceed 400 words (excluding references).

A letter can have no more than five references and one figure or table. A letter can be signed by no more than three authors. The principal author will be asked to include a full address, telephone number, fax number, and e-mail address. Financial associations or other possible conflicts of interest must be disclosed.

Cheers to CVS for tobacco stand

The Rhode Island Medical Society commends and congratulates CVS Caremark for its voluntary plan to remove tobacco products from the shelves of its 7,600 retail stores nationwide. With this decision, CVS sets an example of good corporate citizenship that all other pharmacy chains should emulate.

The juxtaposition of pharmaceuticals and other health-and wellness-related products with the sale of tobacco, which is harmful and addictive in all its forms, has always been a blatant incongruity in American chain drugstores and a disservice to consumers. That is why the Rhode Island Medical Society again this year is promoting legislation that would ban the sale of tobacco products anywhere where health-care services are provided.

Thanks to CVS’s courageous, logical and pioneering move, we can now hope that other pharmacies will consider the welfare of their customers and obviate the need for our legislation.

Elaine C. Jones, MD  
RIMS President

Governor’s Budget Threatens the Hospital Mission

Hospitals in Rhode Island will face $19 million in direct payment reductions through the governor’s FY15 budget proposal. The proposed cuts will further destabilize fragile hospitals and threaten their important mission.

This budget fails to recognize the difficulties hospitals are facing. Hospitals posted a negative operating margin in 2013, a unique occurrence that has only happened once before (FY11) and highlights financial struggles our organizations are already facing.

As lawmakers work to strengthen our state, we urge them to recognize the important role hospitals play in keeping our state healthy. We employ more than 21,000 health care professionals with a payroll of nearly $2 billion. In total, the economic impact of hospitals in our state exceeds $6 billion. It is clear that hospitals are critical to keeping our state strong.

We have significant concerns regarding the impact of these cuts. Hospitals provided nearly $200 million in uncompensated care last year to Rhode Island’s neediest. These payment reductions place the mission of hospitals in jeopardy.

Hospitals are unique, with no ability to raise prices or discontinue services. They stand ready 24 hours a day, seven days a week and 365 days a year to care for patients during their greatest time of need. Rhode Islanders turn to hospitals on more than 2 million occasions each year.

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