Functional Disorders

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I recently took a look at online patient reviews of my doctoring, and came across the following post:

Unless you have Parkinsons or are quite seriously demented, do not go to this provider. If you do not fall into his areas of expertise, he is completely unable to diagnoses symptoms...and even dismissed my symptoms as "clearly having "no physiological" origin and told me that I could be "100% cured through cognitive behavioral therapy."

He did not even bother ordering any tests at all—just called me crazy and asked me to come back in 6 months so he could charge my insurance, again, for doing absolutely nothing.

Needless to say, I got a second opinion and am now being treated and evaluated for my symptoms CORRECTLY. Turns out, if I had listened to this man, I would have been incontinent and immobile in a year...all while being blamed for the progression of my chronic medical conditions (that he overlooked as the source of my symptoms!) because I didn't do well enough in psychotherapy. He set me up to fail because of his own inabilities as a medical professional.

BE AWARE OF HIS LIMITATIONS AS BOTH A HUMAN BEING AND A DOCTOR PRIOR TO YOUR APPOINTMENT.

Unless you either have Parkinsons or are demented and purposefully seeking to be a human test subject—AVOID THIS DOCTOR AND HOSPITAL LIKE THE PLAGUE.

I assume that some medical providers get reviews like this, but hopefully not this bad. We can't please all the people all of the time and have to tell our patients things they don't want to hear. I decided to follow the maxim, "When all you have is lemons, make lemonade," so I have taken this lemon and tried to use it constructively in the commentary which follows.

The word "functional" when applied to medical conditions is the current terminology we often use to label disorders that used to be called psychogenic, or non-physiologic. Long ago they were termed "hysteric." In the epilepsy field, functional seizures are often labeled as "non-epileptic seizures." These types of occurrences are not uncommon. In my sub-specialty, movement disorders, 2–5% of new referrals are diagnosed with this disorder (ICD 10 F44.4). The movements are varied, usually tremors or gait disorders, but Parkinson-like disorders, dystonic disorders, dysarthria and muscle jerks also occur. Diagnosing such disorders is sometimes easy but sometimes challenging or impossible. A few years ago a study was done of a rare entity called propriospinal myoclonus, in which myoclonic jerks (sudden jerks that we all experience when one's head falls forward when falling asleep during a lecture, or when dreaming of falling from a great height) spread up or down the back. Patients had electromyograms and were videotaped. A panel of experts were asked, each in isolation from the others, if they thought the disorder was physiologic or not, and there was disagreement on every case.

We can sometimes diagnose a case if we are fortunate enough to watch the patient when he is unaware and see the problem resolve, but even then we may err, as organic disorders, like tremor in Parkinson's disease, may only appear when the subject is anxious. PD patients may become suddenly unable to walk and freeze in place only when they are being watched, and, although there is an obvious psychological component to the disorder, there is an underlying organic pathology. In addition, there are rare episodic movement disorders.

One way to evaluate a possible diagnosis is to determine if the movement can be mimicked. I evaluated a man with a tremor of his epiglottis. It was remarkably persistent and rhythmic and seemed virtually diagnostic of a very rare disorder, until he showed me how he could stop these movements by adopting very odd postures of his trunk. I wondered then if he had an organic and a non-physiological problem and decided to try to mimic his disorder. After several minutes, I was able to, although not as well as he did; he had been at it for years. At our next meeting I explained to him why I thought this was a functional disorder, that these types of disorders were very serious but were treatable with behavioral therapy rather than medication. He was irate, told me that I was crazy if I thought he was crazy, and was unable to be mollified. I suggested that he see me again, if he was willing, and he stalked out. He later called me, yelling on the phone, calling me incompetent in a stream of denunciations that was non-stop, continuing for several minutes, despite my trying to interrupt him. Finally, I asked him to stop speaking for two minutes so that I could explain my thinking. He became quiet. I talked about two minutes, calmly explaining his problem as I saw it. I was gratified by his silence until I realized he had hung up.

The remarkable thing about this interaction was the resolution. Instead of denouncing me on the internet, he kept his appointment, apologized, and agreed to treatment, which has been very helpful.

This story is definitely an unusual one. Some patients embrace the functional diagnosis: "It's better than having

Parkinson's disease or a brain tumor." Others interpret the diagnosis as demeaning, an accusation of mental infirmity.

Like everyone else, I make mistakes. I never tell anyone they're crazy, nor do I ever imply it. I never tell anyone they will be healed "100%." My favorite medical motto is, "You can't always be right, but you can always be nice." Making a functional diagnosis is important. One is that there may be treatment that sometimes is helpful or even curative. It is a "real" diagnosis (with ICD codes) and should prevent needless testing and useless treatments.

Patient reactions posted on the internet, like the ones above, are examples of the stigma attached to mental illness and may keep some physicians from making this diagnosis even when they believe it is the correct one, preferring either to refer the patient elsewhere or to order some tests and shrug their shoulders. ❖

Author

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