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Section on International Organization Perspectives on Person-centered Medicine

Neurological perspectives on person-centered medicine

Johan A. Aarli, *Prof., University of Bergen, Norway, President, World Federation of Neurology*

Correspondence to: Johan Aarli, E-mail: johan.aarli@nevro.uib.no

The doctor-patient relationship has developed from unspecified good bedside manner to patient-centered medicine with an increasing focus upon the recognition of patients' ethical and legal rights. In any given clinical situation, our medical decisions are made in the balance between the physician's knowledge and experience, and the patient and his relatives' values and preferences. Shared decision-making is a part of each specialty, but it will be modified according to the clinical problems specific for that specialty.

I meet patients today in a way that differs from when I was a young man. It may partly be due to age and experience, but also to the development in clinical medicine. Medicine today is different from how it was in the 1950s.

I am confronted with the patient's subjective presentation of symptoms, anxiety, and personal interpretation of symptoms together with personal values and health-care goals. I can contribute with specialized knowledge, training and experience regarding medical diagnosis, prognosis, options, outcome and treatment. Together, we can reach a mutually agreeable medical care plan that represents the best treatment for that patient.

Each clinical specialty presents with specific problems. Every specialty has its own philosophy, its ivory tower if you like. And in each clinical specialty—from psychiatry to neurology, surgery or rheumatology—the nucleus lies in the meeting between a patient, his family and a physician.

What is person-centered medicine in neurology? For me, the recognition and identification of the concept of person-related medicine appears in the interface between neurology and other specialties, mainly family medicine and psychiatry. Some important and common disorders such as epilepsy and psychogenic non-epileptic seizures, Parkinson's disease and dementing disorders represent challenges both to neurology and to psychiatry.

Epilepsy is a common disorder, and comprehensive care of the epileptic patient requires attention to the psychological and social consequences of epilepsy as well as to the control of the seizures. But neurologists and psychiatrists do not always collaborate as needed for the treatment of patients with epilepsy. Psychogenic non-epileptic seizures are seen in 20–30% of patients referred for refractory seizures. Conversion symptoms remain very common in neurological practice, a clinical reality that is not reflected in research activity, teaching or public awareness. But these patients are not seen by psychiatrists any more. More often, they are referred to neurology outpatient units. The two specialties have been removed from each other, and these patients were orphaned.

My main problem as a neurologist is to deliver the diagnosis to patients and their families. And they are not uncommon in epilepsy units. They are easy to diagnose using EEG video monitoring. Psychogenic non-epileptic seizures are seen in 20–30% of patients referred to our epilepsy clinic for refractory seizures. The estimated prevalence in the general population is 2–33 cases per 100,000 population. They are so dramatic, because they often occur in situations where they receive attention, such as at a cinema, a theatre, in buses etc. And they are brought to hospital as emergencies, often after a physician has injected benzodiazepines intravenously. Treatment options preferred by the patients do not necessarily be medically optimal. Communicating a diagnosis such as conversion disorder may release opposition in the patient and denial in relatives, and may sometimes be felt as outside the shared decision-making process.

Psychiatric symptoms are also common in patients with Parkinson's disease, but such patients are infrequently screened for depression or dementia. Treatment strategies for depression and for dementia may differ with the two specialties of psychiatry and neurology. Are we able to participate in a shared decision-making? The patient is, because he knows the full spectre of his disease. But are we, when each of us can identify only parts of the full picture, able to participate? I firmly believe that the borders between the specialties constitute an obstacle to full understanding of the patient's situation [1].

Patients who have lost the capacity to participate in the decision process as a result of reduced mental capacity due to dementia, encephalopathy or coma, present special problems for shared decision-making. Some patients with bulbar paresis with anarthria and generalized motor incapacity are unable to communicate their decision. Shared decision-making or surrogate decision-making may not always represent the true wishes of an incapacitated patient.

The advances in modern genetics may represent future neuro-ethical challenges. Controversies will have to accompany the ethical legitimacy of using technologies that can modify the brain for the purpose of improvement [2]. There are clinical situations where the borders of knowledge are being moved, and there is a need for collaboration in which different specialties may have different codes of medical analysis. Clinical medicine is a science which develops gradually. The evolution of our medical knowledge has exploded during our time in medicine. This influences our code of conduct as well as our medical advice and decisions, and it will continue to do so.

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