Claims for Functional Neurological Disorder

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This blog looks at Functional Neurological Disorder ("FND"): what it is, how it is diagnosed, what medico-legal issues arise, and potential treatments.

What is FND?

FND is an umbrella term which can cover a whole spectrum of symptoms that do not arise as a consequence of neurological pathology.

Historically, what we now call FND has been called hysteria and, more recently, "conversion disorder". Both terms are outdated but the latter was coined by Sigmund Freud, who theorised that physical symptoms lacking an organic cause could arise as a result of sub-conscious psychological conflict.

Whilst this might sound surprising or concerning at first blush, think of stress or grief. Both are, first and foremost, psychological states; but stress can physically manifest with sweating, gastrointestinal disturbance or tremor, and grief can physically manifest with tears or increased heart rate, for example.

FND is perhaps best illustrated by some examples, such as: patient (1) who suffers seizures yet but does not respond to epileptic treatments or show the characteristic brain activation patterns associated with epilepsy; patient (2) who presents with blindness yet is able to identify visual stimuli; or patient (3) who presents with limb paralysis but whose reflexes and involuntary movement is intact.

Symptoms of FND can be distractible, inconsistent, variable and may spontaneously resolve in one area of the body only to be replaced with a different set of symptoms in a different area of the body.

It is vital to note that patients with true FND are not making up or imagining their symptoms. In the above scenarios, patient (1) genuinely suffers seizures, patient (2) does not consciously perceive visual stimuli and patient (3) cannot voluntarily move the affected limb. FND can be severely debilitating.

Historically, FND has been dismissed by clinicians but in recent years it has been given more recognition by both neurologists and psychiatrists. Indeed, FND has been described as a disorder at the interface between psychiatry and neurology.

The causes are unknown but can include psychological illness, trauma or stress, abuse, or sometimes sudden onset of a physical disease. But that is not to say that every patient with FND has an identified psychological trigger; in many cases the cause remains elusive. As the causes are many and varied, FND has the potential to crop up in any claim for personal injury, disease or clinical negligence.

How is FND diagnosed?

It is important to note that, however it may have been perceived in the past, FND is not a diagnosis of exclusion. That is not to say that any diagnosis is immutable, but it does need to be made in accordance with the accepted diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), namely:

1. one or more symptoms of altered voluntary motor or sensory function;
2. clinical findings that show evidence of incompatibility between the symptoms and recognised neurological or medical conditions;
3. symptoms or deficit that are not better explained by another medical or mental disorder; and
4. symptoms or deficit that cause clinically significant distress or impairment in social, occupational, or other

important areas of functioning or warrants medical evaluation.

Advances in scanning in the last few decades have led to clinicians now being able to diagnose FND and such a diagnosis is absolutely vital in order to avert unnecessary treatment e.g. administration of a cocktail of drugs to alleviate varied symptoms or removing part of the brain in an attempt to alleviate seizures, when in fact there is no organic cause of the symptoms in either case. Clearly any such course of (unnecessary) treatment would be damaging and potentially life-changing, hence the importance of diagnosing FND.

What medico-legal issues arise?

Alternative diagnoses

One of the obvious issues that will crop up in any case where there is an actual or potential diagnosis of FND is whether there is an alternative diagnosis. There are various possibilities, all of which the medical expert (on either side) should be alive to.

Hypochondriasis or Illness Anxiety Disorder is one alternative diagnosis. This is where a person is preoccupied by anxiety about their physical or mental state and it is often associated with abnormal perception of perfectly normal bodily stimuli e.g. perceiving a rash to be a symptom of serious disease. It is important therefore to carefully look at a Claimant's medical records and medical history.

Factitious Disorder, where a person feigns illness behaviour in order to elicit certain emotional or behavioural responses from another or others around them, is an outside possibility, however this is unlikely to feature in litigation since this disorder is not associated with an intention to procure economic or financial benefit.

Finally, it cannot be ruled out that the Claimant is malingering. This is not a disorder, but conscious deception to achieve personal or financial gain, which upon a court's acceptance of malingering, will very likely lead to a finding of fundamental dishonesty.

Fundamental dishonesty

There are obvious difficulties differentiating FND from malingering due to the trouble with detecting whether the Claimant is consciously feigning symptoms, or subconsciously exhibiting symptoms which do not in fact have a physical pathology. Both the malingerer and FND sufferer may, for example, have a degree of voluntary control over their symptoms. Markedly different histories given to medical professionals or experts may be an indicator but is unlikely to be sufficient evidence in and of itself that the Claimant is malingering, since in FND the presentation of symptoms may genuinely vary from week to week, or year to year. As such, the key to distinguishing the two really lies in surveillance evidence.

Causation

It is important to firstly consider whether the Claimant was exhibiting signs or symptoms of FND prior to the negligent event. Analysing and even tabulating the Claimant's attendances at their GP, psychologist or other medical professional can assist arguments either that the Claimant was previously not a regular or anxious attender, or indeed the opposite.

Given that FND can be triggered by a relatively innocuous event, the question often arises whether the Claimant was predisposed such that they would have suffered FND in any event and all that the negligent event did was bring forward the inevitable. Again, consideration of medical records and expert medical psychiatric opinion will be of the utmost importance if Defendants wish to pursue such arguments.

In more complex claims, FND can occur with a number of co-morbidities and it will be necessary for experts to consider any overlap between or increased vulnerability caused by concomitant disorders, and in turn whether that affects the likelihood of the Claimant having developed FND in any event absent the negligent event.

Is there any treatment for FND?

Psychological intervention such as CBT is widely recognised as the most effective treatment. Early diagnosis and intervention with CBT has the greatest impact for a positive prognosis. As such, it is in the interests for Claimants to seek it and Defendants to offer it in order to prevent the disorder and patient from spiralling (along with the litigation, damages and costs associated with this).

Other interventions can include physiotherapy, which is most often required to overcome secondary complications of FND such as muscle weakness and stiffness. Medication can also be helpful to treat any underlying or co-morbid psychological disorders which may be contributing to and worsening FND.

Points for the practitioner

Cases involving FND are serious, complex, potentially high-value and require careful management from the start. Practitioners faced with claims in which the Claimant has a potential or actual FND diagnosis would be best advised to:

1. comprehensively review all medical records;
2. ensure that any medical experts have considered alternative diagnoses and reasoned their opinions;
3. invite or offer (as the case may be) rehabilitation at an early stage; and
4. warn of (if acting for the Claimant) or consider (if acting for the Defendant) surveillance evidence if there may be concerns.

Overall, it is necessary treat the Claimant sensitively and with respect – if they do not accept the diagnosis of FND then the prognosis will be poor and the cost of the claim will spiral.