

# Transitions in Neurology



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We face many passages in life, some of them in Neurology. There is currently discussion on the movement from paediatrics to adult neurology care for those with long term or ongoing neurological conditions. The buzz word is transition, not transfer, and the goal is seamless gliding of young people between services rather than a crash landing into adult clinics. The need for education, preparation and a smooth landing for adolescents in the world of adult medicine was the subject of a recent Royal College of Physicians workshop on transitional care.

The stereotype of paediatrics is a cloistered world full of teddy bears, smiling doctors with oodles of time and a kind if patronising devotion to their patients and families. Adult neurology is the big bad world inhabited by gruff consultants, a world of choice and responsibility.

Why has this issue come to the fore? The good reasons are the attempts to improve standards for those with long term conditions as laid out in the, sadly toothless, National Service Framework. No one would argue against clear handover letters, accurate summaries of previous and past investigations and management, and most importantly, accurate records of current treatment.

At the Royal College meeting, it was horrifying to hear from a young man who had major complications when he moved from school to university and it took months for his summaries and notes to follow him. That is bad, but you do not need transition medicine to prevent that. Clear communication must occur at all interfaces in medicine for it to be good, or even adequate.

The idea of transition medicine or adolescent medicine comes with the possible extension that health care would be further age stratified. It could be worrying for a 17 year old with diabetes to sit next to a man in outpatients who is 78 with an amputation resulting from poor diabetic control. So perhaps clinics attended by younger people should be kept separate.

This is not how life is. Most of us are not twenty and have a few wrinkles and scars to show for the passing years. Do we really want an apartheid system which shields the young from this, reinforcing the celebrity cult of young is beautiful and nothing else counts. I reject the idea that age defines people, any more than their illness, their sex or their occupation does. The same 17 year old in clinic may have chatted with his neighbour and been finally convinced that the hard work of good diabetic control was worth it.

The evidence which supporters of transition medicine point to is highly subjective. Attempts at research in this area are hampered enormously by this and by the bias of their questioning. The provision of joint clinics with paediatric and adult doctors is extremely expensive. There are few additional resources at this stage to cover the cost of these joint clinics.

Surely these needs must be individualised. That will require a shift in thinking, as many Trusts in the United Kingdom forbid adult neurologists from seeing people younger than 16. My paediatric colleagues cannot ask their 15 year old patient to be seen, or to visit, my clinic, no matter how mature. This inflexibility is a real barrier to good communication. We are all aware of the reasons there are separate wards for little children and adults, but there is room in outpatients for an intelligent and individual approach to transitions.

Even with a sample size of two teenage children, it is clear that adolescence is no more homogeneous than any other facet of human behaviour. The idea that we need separate training in communicating with teenagers, separate clinics and separate guidelines for teenagers is quite prevalent. Its worth thinking about, as there is no good evidence either way on this. If you have a view on this I urge you to make your opinion heard before another set of guidelines on this matter are cast in stone. ♦

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