The Nerve! Readers Speak

Reader response: The burnout patient

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I read with interest Dr. Sergay's¹ commentary on patient burnout. Patients are increasingly becoming disillusioned about their caregivers. The reasons for this disillusionment run deep, but the fundamental reason is the erosion of the physician-patient relationship, a sacred relationship founded on the Hippocratic Oath.

"I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice....In purity and holiness I will guard my life and my art....If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come..."²

From the lofty principles enshrined in the oath, we have sunk to the depth where the relationship itself is now referred to as physician-client or physician-customer relationship. Physician-patient interaction is now reviewed on the internet in much the same way as one would review a restaurant or a movie. This has evolved into a catch-22 situation, and we cannot address patient burnout until we address physician burnout.

1. Sergay SM. The burnout patient. *Neurol Clin Pract* 2018;8:346–348.

2. Hippocratic Oath Today. Available at: pbs.org/wgbh/nova/body/hippocratic-oath-today.html. Accessed September 22, 2018.

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Author response: The burnout patient

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Thank you, Dr. Sethi, for adding your voice to this vital discussion.¹ I concur that the mainspring of health caregiver fulfillment and motivation, and of patient well-being, is optimizing the patient-physician relationship while delivering the highest quality cognitive and procedural care. Over the centuries, medicine has bobbed on the ocean of scientific progress, social mores, and economics. Our times are no different. Health care planning, lauded as creative destruction, has made way for disruptive innovation both of which have undoubtedly contributed to care delivery evolution. However, change will neither be free of unintended consequences nor be absolved from societal change. Therefore, no iteration of care delivery ever will be final; re-evaluation will always be necessary. Humility must be foundational in all enterprise planning. When patient and physician sustainability are not the required outcomes of change, that change will be untenable and superseded more rapidly. I have written on health care delivery challenges in the United States² and described restorative methods for caregivers and patients.³ In characterizing the "burnout patient," I hope to advance discussion from the consequences of planning on doctors to the inevitable repercussions for patients, surely the ultimate focus of health care planning and delivery.

Author disclosures are available upon request (ncpjourn@neurology.org)

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2. Sergay SM. Doctoring 2009, embracing the challenge. *Neurology* 2009;734:1234–1239.
3. Sergay SM. Charter on physician professional flourishing, *Neurology* 2016;87:2259–2265.

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Reader response: Traumatic and spontaneous intracranial hemorrhage in patients with atrial fibrillation on warfarin

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We read with interest the study by Lehtola et al.¹ Anticoagulation (AC) in atrial fibrillation (AF) reduces the risk of ischemic stroke, but at the cost of increasing the risk of hemorrhagic stroke.

We feel that the burden of cerebral microbleeds (CMBs) might provide additional information as to the true risk of spontaneous intracranial hemorrhage (ICH) in the study population. CMBs are a logical marker for ICH risk in patients with AF. An adjusted pooled analysis performed by the META-MICROBLEEDS study group showed that CMBs conferred a 3-fold increase in the risk of ICH in patients with AF.² Moreover, it has also been suggested that warfarin is independently associated with the development of new CMBs.³ Because males and the elderly population have a higher prevalence of CMBs, it is hard to ignore the higher mean age (78 years) and the higher proportion of men (58%) in this study¹ suggesting a possible “triple” interaction among AF, CMB, and warfarin increasing the overall risk of ICH.

Systematic studies in identifying patients at high risk of hemorrhagic stroke in the setting of AF and AC might open doors for physicians to preferentially reduce the risk of ischemic stroke by other means.

1. Lehtola H, Palomäki A, Mustonen P, et al. Traumatic and spontaneous intracranial hemorrhage in atrial fibrillation patients on warfarin. *Neurol Clin Pract* 2018;8:311–317.
2. Charidimou A, Karayiannis C, Song TJ, et al. Brain microbleeds, anticoagulation, and hemorrhage risk: meta-analysis in stroke patients with AF. *Neurology* 2017;89:2317–2326.
3. Soo YO, Yang SR, Lam WW, et al. Risk vs benefit of anti-thrombotic therapy in ischaemic stroke patients with cerebral microbleeds. *J Neurol* 2008;255:1679–1686.

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Author response: Traumatic and spontaneous intracranial hemorrhage in atrial fibrillation patients on warfarin

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We thank Vilanilam et al. for relevant and interesting comments regarding our article.¹

In our study, patients with anticoagulated atrial fibrillation (AF) with spontaneous intracranial hemorrhage (ICH) were older (median age 78 years) and more often men than women; this was suggested by Vilanilam et al. to result in “triple” interaction among AF, cerebral microbleeds (CMB), and warfarin, increasing the overall risk of ICH. However, a prospective study by Wilson et al.² reported results where age and male sex were not associated with the risk of symptomatic ICH in patients with AF with oral anticoagulation (OAC). Age is also

a well-known risk factor for ischemic stroke and carries a bidirectional risk of both ischemic and hemorrhagic stroke.^{3,4}

In patients who had previously suffered ischemic stroke or transient ischemic attack (TIA), the CMBs with cut-off $\geq 2-5$ increased the risk of ICH by 5.5- to 5.6-fold, also in multivariable analysis, which included age and hypertension.^{2,5} Unfortunately, our study data do not include CMBs because of its retrospective nature. In our study, only 27% had suffered previous ischemic stroke/TIA. Comparing our study with most of the studies in patients with AF treated with OAC, the number of ICHs has been relatively low. Therefore, large prospective randomized trials about CMBs with anticoagulated AF patients are needed.

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2. Wilson D, Ambler G, Shakeshaft C, et al. Cerebral microbleeds and intracranial haemorrhage risk in patients anticoagulated for atrial fibrillation after acute ischaemic stroke or transient ischaemic attack (CROMIS-2): a multicentre observational cohort study. *Lancet Neurol* 2018;17:539–547.
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