Disputes & Debates: Editors' Choice

Steven Galetta, MD, FAAN, Section Editor

Editors' note: Burnout, illness, and return in the twilight

In "Burnout, illness, and return in the twilight," Dr. Kevin Altman describes the progression of his emotional transitions over the past 40 years as a neurologist from (1) the 1980s as a resident who was enthusiastic about his low-pressure "fabulous learning experience" to (2) a private practice neurologist who grappled with the financial challenges imposed by insurance companies, to (3) a hospital consultant who felt burdened by the demands of documentation and productivity, and then to (4) a patient with leukemia who marveled at the compassion and attention his doctor showed him. He notes that his own experience as a patient allowed him to see the world through new eyes and that, as he returns to work, he will not allow himself to fall victim to burnout again and will remain focused on his priority as a physician—patient care. As Dr. Nitin Sethi notes in response to Dr. Altman's essay, burnout has become a mounting problem in all professions, and it is necessary to develop constructive coping strategies. We have noted that many institutions are doing a number of things to promote wellness for faculty and trainees such as holding exercise events and meditation programs and trying to lessen the burden of electronic medical records by improving their efficiency.

Ariane Lewis, MD, and Steven Galetta, MD
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Reader response: Burnout, illness, and return in the twilight

Nitin K. Sethi (New York)
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I read Dr. Altman's reflections on burnout and illness,[1] and I was surprised by how deeply it moved me and made me stop and ponder. First and foremost, I want to wish my colleague—who has a few years over me in experience in clinical neurology practice—Godspeed. It would be wise of us to remember that burnout is not unique to neurology or medicine as a whole. In today's competitive and demanding world, individuals in all professions are facing burnout at an alarming rate. Although the reasons for burnout may be unique to each profession, there are lessons to be learned by studying individuals who have overcome burnout, as I strongly believe that there are inherent personality traits, which make some of us more vulnerable to burnout compared with others. Emotional stability, extraversion, openness to experience, agreeableness, and conscientiousness are associated with lower emotional exhaustion and depersonalization, higher personal accomplishment, and less burnout.[2] Constructive coping strategies can help reduce the burnout rate in physicians. A quote that has served me well thus far is, "You can win the rat race, but you're still a rat."

1. Altman K. Burnout, illness, and return in the twilight. Neurology 2018;91:934–935.
2. Storm K, Rothmann S. The relationship between burnout, personality traits and coping strategies in a corporate pharmaceutical group. SA J Indust Psych 2003;29:35–42.

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

Editors' note: Boxing with the past

In "Boxing with the past," Dr. Bonnie Salomon grapples with the disconnect between her simultaneous hatred for boxing, which has caused countless patients to cross her path with chronic traumatic brain injury, and her love for the sport, which allowed her father to survive the Holocaust. In response to this essay, Dr. Nitin Sethi agrees that boxing is an "extremely contentious subject" and notes the myriad brain injuries that can result from being punched in the head, but acknowledges that he does not feel conflicted about his passion for the sweet science. Is it okay for a neurologist to love sports that injure the brain? Dr. Sethi thinks this is justified and equates it to military doctors who care for soldiers. This analogy is imperfect, though, given that it is doubtful that many military doctors would say they love war. Dr. Salomon's love/hate relationship with boxing is deeply personal. We thank her for sharing her story and for reminding us that before judging patients for engaging in behaviors that could injure the brain, we should always pause to learn their stories.

Ariane Lewis, MD, and Steven Galetta, MD
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Reader response: Boxing with the past

Nitin K. Sethi (New York)
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I read with interest Dr. Salomon's[1] reflections in "Boxing with the past." Boxing is an extremely contentious subject with high risks for both acute and chronic traumatic brain injury. Acute neurologic injuries, such as subdural hematoma, epidural hematoma, subarachnoid hemorrhage, intracranial hemorrhage, diffuse brain contusions without associated hemorrhages, diffuse axonal injuries, and dissection of the vertebral artery/carotid artery, are major causes of boxing-related mortality and morbidity. The burden of chronic neurologic injuries, such as chronic traumatic encephalopathy, dementia pugilistica, chronic post-concussion syndrome, chronic neurocognitive impairment, post-traumatic dementia, post-traumatic cognitive impairment, post-traumatic parkinsonism, and persistent post-traumatic headache, is likely much higher, but remains hidden, as most injuries express themselves after the athlete has long retired. Unlike Dr. Salomon, I am not conflicted with my passion for the sweet science. Military doctors (army physicians) work in the battlefield saving the lives of soldiers and, sometimes, even of the enemy; their role in the trenches does not mean that they personally support the war or feel that war is good and justified. Their critical life-saving skills save precious lives in battlefields across the globe. In much the same way, the presence of a neurologist at the ringside or cageside does not imply that they support boxing or think that boxing is good for the brain. Neurologists bring their unique life-saving skills to the ringside/cageside and help make the sport safer.[2]

1. Salomon B. Boxing with the past. Neurology 2018;91:1018–1019.
2. Sethi N. Neurologist at ringside—to be or not to be? S Afr J Sports Med 2018;30:1–2.

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

Editors' note: The intolerable burden

In "The intolerable burden," Ludwig Gutmann describes the anguish he felt when an 80-year-old patient with Guillain-Barré syndrome, who reluctantly agreed to intubation despite previously being DNI, died after being palliatively extubated, at her request. He acknowledges feeling distressed that (1) the patient may not have understood that the burdens of intubation and weakness were temporary, despite the fact that he'd given her and her family an optimistic prognosis, (2) the ICU team complied with her wishes, rather than sedating her and continuing treatment with IVIG, and (3) the ICU team did not "negotiate" with her and her family after extubation and instead focused on comfort and administered analgesics as needed. In response to this essay, Dr. Todd Janus notes that he believes intubating this patient, who was previously DNI, and keeping her intubated when she asked to be extubated is a "horror" and reports that he believes that there is no role for paternalism in modern medicine. Dr. Gutmann agrees that paternalism is no longer appropriate, but comments that "there are moments when physicians need to be forceful in influencing the decision-making process, especially when the patient's judgment appears flawed and prevents the strong possibility of a good outcome." It is imperative that we, as clinicians, be both transparent and thorough when we communicate with patients and their families. Ultimately, the principle of autonomy dictates that patients and their legal decision makers must be allowed to make uncoerced, independent choices, but we must facilitate the decision-making process by educating them with the information they need to do so.

Ariane Lewis, MD, and Steven Galetta, MD
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Reader response: The intolerable burden

Todd Janus (De Moines)
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I was shocked and disappointed to read "The intolerable burden" by Dr. Gutmann.[1] The story he related is about an 80-year-old who developed Guillain-Barré syndrome after surgery.

He admits that he did not know her. She and her family all agreed on no ventilatory support: "'No breathing tube,' she panted. 'No artificial ventilation.'/Her husband nodded his head. 'We decided that years ago.'" Yet, she is intubated. Finally, after days of pleading, the MICU attending removed the tube and contacted palliative care. The family will remember this horror instead of having a quiet and peaceful passing of their wife and mother.

I thought that paternalistic medicine—physician knows best—went out of favor years ago. Yet here we have a case where a patient and family clearly state her preferences and these wishes were not honored. It does not matter whether she understood the benefits of treatment.

I hope residents and students will learn from this.

Dr. Gutmann mused, "Maybe 80 years is enough for anyone, but I didn't think so."[1] It does not matter what he thinks. It is a private matter for the patient and the family. To them, 80 years was enough.

1. Gutmann L. The intolerable burden. Neurology 2018;91:840–842.

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

Author response: The intolerable burden

Ludwig Gutmann (Iowa City)
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I read Dr. Janus' comment with interest. Patients and families do have the right to reject the recommendations of physicians. However, patients should have a clear understanding of the options and their implications. It is the physician's responsibility to guide the decision-making process of patients and their families to achieve the optimal outcome.

In this case,[1] the family had agreed to the initial placement of the endotracheal (ET) tube. Throughout the illness, the patient really never understood the reversible nature of her weakness or the implication of removing the ET tube. She did not understand the high likelihood that the IVIg would result in an excellent recovery.

The patient had just had a knee replaced, suggesting that she was trying to improve the quality of her life. I wish I had been more effective in explaining the implications of the situation and the importance of keeping the ET tube in place a few more days.

1. Gutmann L. The intolerable burden. Neurology 2018;91:840–842.

CORRECTION

Traditional risk factors may not explain increased incidence of myocardial infarction in MS

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In the article "Traditional risk factors may not explain increased incidence of myocardial infarction in MS" by Marrie et al.,[1] first published online March 6, 2019, the Acknowledgements should have read "The authors acknowledge the Manitoba Centre for Health Policy for use of the Population Health Research Data Repository under project #2016-023 (HIPC #2016/2017-02). The results, inferences, opinions, and conclusions presented are those of the authors and no official endorsement by the Manitoba Centre for Health Policy, Manitoba Health, Population Data BC, the Data Stewards, or other data providers is intended or should be inferred." The authors regret the error.

Reference

1. Marrie RA, Garland A, Schaffer SA, et al. Traditional risk factors may not explain increased incidence of myocardial infarction in MS. Neurology 2019;92:e1624–e1633.

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Traditional risk factors may not explain increased incidence of myocardial infarction in MS

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