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## Medicine Is Just a Job

This article originally appeared on KevinMD.com and is written by KPeds, MD.

A couple of years ago, I read an article by Dr. Profeta at LinkedIn called "These four words that may offend you ... may also just save you: It's just a job."

The "it" in this case is medicine. Let that sink in. Everything you've worked for and sacrificed for is just a job. Do you find that liberating? Or does it hurt a bit?

Medicine is my job, and I am a professional with a code of ethics, integrity, and compassion. Medicine is intellectually engaging, emotionally rewarding, and meaningful work. But it can also be all-consuming, overwhelming. We share in the very best and worst moments in people's lives.

Thinking of medicine as a job doesn't mean I am uncaring or "faking" my compassion.

Sure, my sense of self and identity is tied into it a bit. But I go to work as a pediatrician, and then I come home and am me. I'm not a pediatrician at home. I'm someone who has a baby boy, a wife, a loving family.

Our identities are so easily wrapped around being physicians, but to tie too much of ourselves to this profession can be a recipe for disaster.

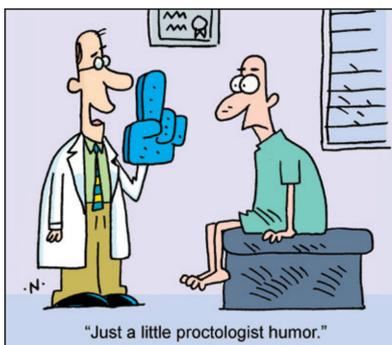
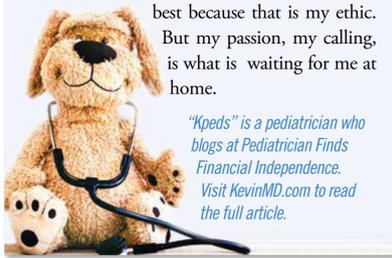
There is too much nonsense with managed care, administrative burden, and systems that are designed to fail us all. To tie yourself completely to this mess means that each one of these failures cuts a little deeper than it should. Every time the quality of your care suffers or the impossible expectations surrounding the work you do aren't met, then part of you is wounded.

I am not burned out. I'm mostly cool with the work, the hours, the stress of caring for sick kids and supervising residents. I've had some hard moments, like anyone else, but they pass, and I'm back to enjoying the job.

Medicine is my job, one that I care deeply about—but it does not define who I am. Although it forms part of my identity, I do not derive my self-worth from it. I will work hard and do my best because that is my ethic.

But my passion, my calling, is what is waiting for me at home.

"Kped's" is a pediatrician who blogs at Pediatrician Finds Financial Independence. Visit KevinMD.com to read the full article.



## Inhaled Cannabis for Headache & Migraine



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Today, a substantial proportion of medical cannabis users report using cannabis to manage headache and migraine, claiming that it is effective. However, research on the effectiveness of cannabis for these purposes remains sparse. To date, only one clinical trial has been conducted, wherein the effectiveness of nabilone (a synthetic cannabinoid) was examined. In that study, nabilone was found to be more effective than ibuprofen at reducing pain and increasing quality of life.

### Expanding Upon the Literature

For a study published in the *Journal of Pain*, my colleagues and I sought to expand upon this limited literature by examining the short- and long-term effectiveness of cannabis on headache and migraine. We obtained anonymous archival data from the medical cannabis app Strainprint™, which allows medical cannabis patients to rate the severity of their symptoms immediately before and after cannabis use. Specifically, we obtained pain severity ratings immediately before and after cannabis use from more than 1,300 patients using medical cannabis to treat headache and more than 650 to treat migraine across 16 months.

We also obtained information on the percentage of delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD) in the cannabis used, the type of cannabis used (flower vs. concentrates), dose, and patient gender. Only sessions in which cannabis was inhaled and in which symptoms were re-rated within 4 hours of use were included. We also only examined sessions for which the THC and CBD concentrations were obtained directly from the cannabis

producer. We analyzed data from nearly 20,000 cannabis use sessions.

### Significant Relief

The results of our analyses revealed that headache severity ratings were reduced by 47.3%, and migraine severity ratings 49.6%, after cannabis use. While both cannabis flower and cannabis concentrates were associated with significant reductions in headache and migraine, cannabis concentrates produced significantly larger reductions in headache than did cannabis flower. Similarly, while both men and women reported significant symptom relief, men reported larger reductions in headache than did women. These results suggest that cannabis, particularly cannabis concentrates, provide significant and substantial relief from headache and migraine severity.

We also explored potential long-term ramifications of using cannabis repeatedly to manage

headache and migraine. Medical cannabis users reported using significantly increased doses of cannabis across time. Further, they reported smaller reductions in headache severity across time but no changes in relief of migraine across time.

Collectively, these results indicate that tolerance to the effects of cannabis may develop over time, and people may require larger doses of cannabis to achieve smaller reductions in headache severity and equivalent reductions in migraine severity across time. In contrast, we found no evidence for the development of medication overuse headache that is often associated with more conventional treatments. Specifically, pre-cannabis use headache and migraine severity ratings did not change across time, suggesting that repeated use of cannabis to manage headache and migraine does not exacerbate baseline headache or migraine severity.

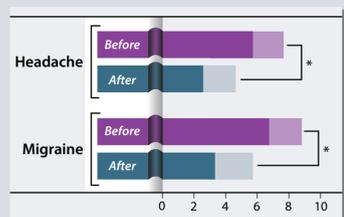
### Looking Ahead

Study limitations include the lack of a placebo control group and use of a self-selected sample of people using cannabis to treat headache and migraine. As such, these results likely overestimate the effectiveness of cannabis, and some of the reported symptom relief may be attributed to users' expectations of pain relief from cannabis. The results are also specific to the effects of inhaled cannabis; further research is needed to examine whether other routes of administration produce equivalent effects.

Nevertheless, our findings of nearly 50% reductions in headache and migraine from before to after cannabis use and the lack of evidence that cannabis is associated with medication overuse headache are encouraging. Hopefully, these findings will serve as a catalyst for clinical trials to examine the effectiveness of cannabis flower and concentrates in treating headache and migraine in a more controlled manner.

Figure Pre- & Post-Cannabis Use Headache & Migraine Ratings

Each bar in the figure represents the mean, with standard error bars representing standard deviations. Severity ratings could range from 0 (none) to 10 (extreme).



\*significant difference.  
Source: Adapted from: Cuttler C, et al. *J Pain*. 2019, Nov 9. [Epub ahead of print].

## Asking Dr. MedLaw: Physician-Patient Privilege

**Q:** I am being sued for a claim of failed back surgery. The plaintiff had an IME by my side's doctor, and the complaints of pain were about what you would expect—hard to prove or disprove. However, the plaintiff mentioned to the doctor that she was "gonna get a hot car when I get a pile of money" from the case. I want the doctor to testify about this because it can really show the jury that this is a shake-down. The plaintiff is trying to block that. Can she do so?

**A:** The issue here is whether there is physician-patient privilege in this setting. Physician-patient privilege is a sub-set of this general stance on physician-patient confidentiality and refers to the ability of a patient to bar their doctor from testifying about them in a legal proceeding.

You did not say whether you are being sued in state or federal court, which matters, as the privilege is not recognized under the Federal Rules of Evidence. It may also be only allowed to a limited extent under the laws of your state.

However, let's just look at whether, assuming that it is potentially extant in the case, it could apply here.

The critical point for it to apply is that the doctor whom the patient wants to restrain from speaking must have been the patient's, well, doctor, and here that is not the case. Not only was the plaintiff not seeking diagnosis or treatment from the doctor performing the IME, he was actually examining her for her adversary. The physician-patient relationship that underpins a duty of confidentiality and that gives rise to the privilege was completely absent.

Even if the plaintiff did not know the legal issues, she likely—since such are routine in IMEs—signed a form indicating that she understood that a physician-patient relationship was not created by the examination.

The plaintiff may try to get the judge to rule that this comment is "more prejudicial than probative"—in other words, that it will turn the jury against her more than it will add to a search for the truth—but that will truly be a last-ditch ploy to keep it out.

It is likely coming in.

This article was written by Dr. Medlaw, a physician and medical malpractice attorney. It originally appeared on SERMO, which retains all rights to it.



## nVNS for Vestibular Migraine



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Although data indicate that vestibular migraine (VM) is the most common neurologic cause of vertigo in adults, no FDA-approved agents exist for its treatment. With few studies having pursued rescue treatments for VM, Shin C. Beh, MD, and colleagues sought to address this area of need to help their patients with VM. For a study published in *Neurology*, Dr. Beh and colleagues analyzed the benefits of noninvasive vagus nerve stimulation (nVNS) treatment on acute VM. "Many patients are sensitive to, or concerned about, potential adverse effects of medications; a drug-free and efficacious therapy for VM would be a significant breakthrough for patient care," says Dr. Beh.

The study was a retrospective chart review to determine if patients with VM experienced significant relief of their VM attack, after receiving nVNS. Patients graded their level of discomfort from vertigo and/or headache using a 0-10 point scale (0 = no pain, 10 = worst ever symptoms) before and 15 minutes after nVNS treatment. Patients with vertigo experienced a 92% relief rate (complete resolution in 14%, at least 50% improvement in 35%), dropping 46.9% in intensity, from a mean pre-nVNS level of 5.2 prior to 3.1 after. All patients reported improvement in headache after nVNS treatment, with a mean pre-treatment headache severity of 6 and a mean post-nVNS score of 2.4. However, all VM patients with persistent perceptual postural dizziness reported no benefit with nVNS.



"It is important to emphasize that VM is a treatable condition, and that drug-free, safe, and effective treatment options like nVNS are available," notes Dr. Beh. "The most likely explanation for the effects of nVNS on VM is the close link between the vagal, trigeminal, and vestibular systems in many brainstem nuclei, particularly the nucleus tractus solitarius, but that has not been proven. Our study was small and unblinded, and of course, a large, randomized-controlled trial is needed to investigate the role of nVNS in VM. However, specialists should be aware that nVNS is a therapeutic option that is highly tolerable, drug-free, safe and can be very efficacious in VM."

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