

# EPIC



The Magazine of the  
Georgia College of  
Emergency Physicians  
*SUMMER 2015*

## Legislative Advocacy & Leadership Summit



**In this issue:**  
GCEP Board Accomplishments and 2015-17 Priorities  
Intimate Partner Violence in Georgia

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# From the President

## GCEP 2015-2017 Priorities

**Matt Lyon, MD, FACEP**

As I transition to the President of GCEP, one of the first tasks is to develop the priorities of our College. Setting priorities gives us direction for developing our message to the membership and the general public, as well as directing our advocacy and educational agendas.

The following priorities were developed in conjunction with the Executive Committee as well as the Board of Directors. These priorities were presented at the general membership meeting held during the Coastal Emergency Medicine Conference in June 2015. Along with each priority is the College's stance on the issue as well as possible solutions. These solutions are not exhaustive; instead they are meant as a starting point to stimulate further ideas and action plans. We also know that during the next two years, there will be issues beyond these priorities that the College will need to devote time, attention, and resources. Be assured that we will be monitoring for any issues that may affect the practice of Emergency Medicine in the State of Georgia or the care we deliver to patients in our departments. I very much welcome comments, questions, and especially solutions for any of these priorities.

### GCEP 2015-17 Priorities

The Georgia College of Emergency Physicians is committed to promoting the highest quality of emergency care for our patients in the State of Georgia through advocacy, education, professional development and the advancement of emergency medicine as a specialty. GCEP's vision is to actively improve all aspects of emergency care delivery in the state of Georgia. We aspire to be the state resource of choice when it comes to matters related to the care of emergency patients in Georgia.

### The Priorities of the GCEP for 2015-17 are:

#### Improving the Acute Psychiatric and Substance Abuse Care in the ED

GCEP believes that acute psychiatric and substance abuse issues are an emergency. GCEP is committed to finding solutions for these emergency conditions, which provide appropriate care for these conditions in the right environment with the right resources. We believe that the ED should be used for medical evaluation and treatment of contributory medical issues. However, access to a psychiatry and substance abuse specialist for ongoing treatment and evaluation is a patient right.

#### Solutions:

- 1) Adequate tele-psychiatry for all ED's in Georgia
- 2) Appropriate funding for regional hospitals and crisis stabilization units to meet the burden of care
- 3) Statewide metrics collection coordinated by the department of Behavioral Health and Developmental Disabilities regarding access of care and quality of care

#### Providing Access to All Patients with an Emergency Condition

GCEP believes that all people need adequate access to quality emergency care. Access to care must not be based on geography or area of residence.

#### Solutions:

- 1) Adequate funding for Rural ED's
- 2) State wide expedited transfer agreements



**Matt Lyon, MD, FACEP**  
**mattlyonmd@gmail.com**

Dr. Lyon is a Professor of Emergency Medicine at Georgia Regents University. He serves a Vice Chairman for Academic Programs, the Director of the Section of Emergency and Clinical Ultrasound and Director of the Emergency Ultrasound Fellowship. He is currently President-Elect for GCEP and Chairman of the Georgia Emergency Medicine Political Action Committee.

- 3) Telemedicine support and reimbursement (Georgia law and regulations)
- 4) GME expansion to provide rural ED care

**Providing Appropriate End of Life Care in the ED**

GCEP believes that patient’s wishes for care should be known and followed in the ED. Patient’s desires for care should be available to all ED physicians at the time of treatment. This includes clear direction for emergency medical care.



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**Important Dates**

**Rural Emergency Practice Course**

This will be a course focused on the practice of Emergency Medicine in a rural setting. However, all concepts will be applicable to any EM practice. We will also have recertification courses for PALS and ACLS as well as GCEP’s Emergency Procedure Course. This will be a great time to catch up on these certifications as well as obtaining VERY cost effective CME.

September 26-27, 2015, Valdosta GA, Location TBA

**Medical Director and Leadership Forum**

This is the annual GCEP course focused on legislative and medical practice issues in Emergency Medicine. We are currently in the planning stages, however, our plan is to focus on the GCEP Priorities and solutions to problems affecting almost all EM physicians in Georgia.

December 8-9, 2015, Lake Oconee (Ritz Carlton at Reynolds Plantation)

**Coastal Emergency Medicine Conference**

An annual tri-state conference focused on Emergency Medicine education. This is the most family friendly conference that I know of! If you have never been, you are missing out on one of the best medical activities of your career.

June 13-16, 2016, Kiawah Island



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**The following Bylaws change was approved by the membership at the Annual Membership Meeting on Friday, June 5, 2015.**

The GCEP Executive Committee has unanimously approved a Bylaws change for your consideration and your vote.

This vote will be held at the Annual Chapter Meeting of the general membership at Kiawah Island on June, 4, 2015. A 2/3 vote of the members present is required for a Bylaws amendment to pass. Per the Bylaws, proxy votes are not allowed.

The Proposed bylaws changes are noted in the paragraph below taken directly from the current GCEP Bylaws:

Bylaws, Article VI (Board of Directors), Section 4 (Ex-Officio Members)

The following members shall be seated on the Board of Directors as Ex-Officio Directors: (a) any Georgia Chapter member holding Office in the College to include Board of Directors, Council Officer or as Chair of a Committee or Section; (b) the Chapter Delegate to the Medical Association of Georgia House of Delegates; (c) Chapter Councillors, (d) one (1) Candidate member (Resident or Fellow) from each of the ACGME approved Emergency Medicine Training Programs in the State, ~~and~~ (e) Chairpersons of the Emergency Medicine Departments with ACGME Emergency Medicine Residency Training programs located in Georgia, and (f) former Presidents of the Chapter.

Currently, the composition of the GCEP Board of Directors is made up of two segments, At Large Directors who are elected by the membership at the Annual Chapter Meeting, and Ex-Officio Directors who are Board members on the basis of their "office."

GCEP has outstanding members who are Past Presidents but who are no longer on the GCEP Board of Directors, where their active participation could make a big difference for our specialty society. One of the main reasons why these talented individuals aren't remaining on the Board is that they do not want to prevent other, younger members from obtaining Board membership and subsequent leadership progression. However, by removing themselves from Board consideration in favor of others, they are unintentionally depriving GCEP of their knowledge, experience and leadership.

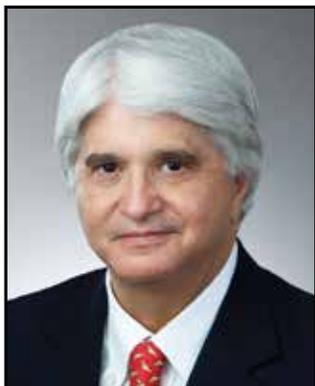
GCEP needs to reach out to these Past Presidents who devoted so much for so long, but under our current Bylaws there is no official way for them to have a meaningful presence at our Board meetings. By allowing GCEP Past Presidents to be Ex Officio members of the Board, GCEP may again capture the expertise, knowledge and energy of these very important legacy physician leaders for our specialty society for a long time to come.

The Executive Committee (GCEP Immediate Past President Matt Watson, President John Rogers, President Elect Matt Lyon, Secretary/Treasurer Matt Keadey, and At Large Director representative Chip Pettigrew) all encourage you to favorably consider this Bylaws amendment. We believe that this amendment will encourage participation and reward long-standing commitments for those who served so well for so long.

## From the Immediate Past President

# What Your Board Accomplished

**John J. Rogers, MD, CPE, FACS, FACEP**  
Immediate Past President, Georgia College of Emergency Physicians



**John J. Rogers, MD, FACEP**  
jrogers@acep.org

Dr. Rogers is immediate past president of GCEP.

In June my term as President ended and Dr. Matt Lyon assumed the role. I have complete faith and trust that he will lead you in an exemplary manner and accomplish much on your behalf. This transition has given me pause to reflect on what your Board of Directors has accomplished during my term. I want to thank each member of our Board and our Councillors for their commitment, work and sacrifices.

### Increased attendance at Legislative Advocacy and Leadership Summit

This year 12 members attended, which is nearly double our usual attendance. Those new to the experience found it rewarding and a great deal of fun. Our increased participation has not gone unnoticed. We met with the legislative leads for Senator Isakson, Senator Perdue, and almost all of our Representatives.

### Increased Membership

One of our goals was to increase our membership. In 2013 we had approximately 670 members. By the end of 2014 we had surpassed 700 and qualified for an 8th Councillor to ACEP. As of early June, we now have 792 members and are eight away from qualifying for a 9th Councillor. Having nine Councillors will rank us 11th in the College.

### Began Residency and Medical Student Visits

Under the leadership of Dr. John Sy, we began visiting the EM Special Interest Groups at the Medical and Osteopathic Schools in Georgia. We have also made presentation to the Residency Program at Georgia Regents University.

### Instituted the GCEP Leadership Fellowship

To help build our future leaders, GCEP modeled a Leadership Program after that developed in other states. Dr. Mark Griffiths and Dr. Matt Astin were in our first class and completed their term in June. Dr. Ben Lefkove and Dr. John Wood began their one-year fellowship at the Coastal Emergency Medical Conference this year.

### Strategic Plan

Two years ago we held our first Strategic Planning Retreat and had our second this past spring. This was essential to establish fundamentals for the Chapter such as:

- Annual Budget
- Goals and Priorities
- Strategic Plan
- Mission Statement
- Vision Statement

### Strengthened Bonds with MAG

Through our participation in MAG's Georgia Physicians Leadership Academy (GPLA), several of our Directors have established deep ties with MAG leadership. MAG now often calls upon GCEP for our input and assistance, and vice versa. Marcus Downs, MAG's Legislative Director, has made several appearances at our BOD meetings.



**On the Cover: (left to right) Drs. John Sy, Matt Lyon, John Rogers, Jim Dugal, and Matt Rudy at the US Capitol for the Legislative Advocacy and Leadership Summit**

### Revamped Legislative Day Activities

During his term as President-Elect, Dr. Matt Lyon changed our legislative day activities. No longer a one-day event, it has become a week long effort. Now GCEP has a booth in the Capitol building for a week and uses it as a base for advocacy. We have held a luncheon with the legislators at the Capitol that has also been fruitful.

### Created a Board Development Manual

Thanks to Chip Pettigrew and the other members of the Board Development Committee, GCEP now has a manual for all existing and new Board members. This document serves as an introduction to the Chapter.

### Established an Awards Program

To recognize the important work many of our members have done, and the contributions they have made, it seemed proper for GCEP to establish an Awards Program. This past December our first recipients, Rob Higgins, Haney Atallah, and Ben Lefkove, were recognized.

### Established Formal Liaisons with SEMPA and AAENP

Georgia was the first Chapter to have a formal liaison from the Society of Emergency Medicine Physician Assistants (SEMPA) on its Board. This past year, we included the American Academy of Emergency Nurse Practitioners (AAENP). This too is a first, and by our example, other Chapters are following our lead. Naaz Malek PA is our SEMPA liaison and Dr. Dian Evans represents AAENP.

### Created our Legislative Advocacy Network (LAN)

As part of his project for the Georgia Physicians Leadership Academy, Dr. Matt Lyon undertook the development of a Legislative Network. It will be useful to engage and inform members of legislative activities, particularly those in their own districts.



**2015 Doc of the Day, Dr. Matt Lyon, his wife and son with Governor Deal**



**(left to right) Drs. Matt Rudy, John McManus, John Rogers, Matt Lyon and John Sy at the United State Senate.**

# Emergency Medicine Residency Update: Georgia Regents University

**Daniel McCollum, MD, Assistant Residency Program Director**



**Daniel McCollum, MD**  
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Dan graduated from the Georgia Regents University Emergency Medicine Residency Program in 2013. He is currently serving as an Assistant Residency Director at GRU. His interests include Free Open Access Medical Education (FOAMed) and teaching adult learners.



The Emergency Medicine residency at Georgia Regents University is very excited about the upcoming academic year. After a very busy recruitment season, an excellent set of new interns is now part of our family. We have a very diverse group of new interns, including those from Georgia, Virginia, Pennsylvania, Oklahoma, and Alaska.

With the arrival of our excellent group of new interns, we must bid farewell to our graduating seniors. Our civilian residents will be providing care in Georgia, South Carolina, and Florida. Our military residents will be serving at several locations. Some will be serving at Fort Gordon in Augusta, Georgia. Others will be serving as far away as San Diego and South Korea. We are incredibly proud of our graduating residents, and we are certain they will provide excellent care during their career.

We continue to expand our ultrasound program at GRU. In addition to continuing our ultrasound fellowship, faculty in our program are now involved in teaching those outside of our department as well. We now are involved in teaching ultrasound skills to medical students, residents from other services at GRU, and attending physicians

from outside of our institution. Please contact us if you are interested in learning more about improving your ultrasound skills.

Our residency recently competed in the SonoGames ultrasound competition. This is a simulations based national competition that took place in San Diego. GRU was capably represented by Clay Carter, Jason Barter, and Daniel Reed. They did very well, advancing to the semi finals of the competition. They were ranked sixth in a field of over 50 teams. This same team will be competing again in this year's SonoGames in New Orleans after qualifying by winning our local ultrasound competition.

This upcoming year promises to be another exciting one for us at GRU. Our residency continues to grow in both numbers and quality. Our alumni continue to do great things both locally in Georgia as well as nationally. Thank you to everyone who is continuing to improve the residency and to all the great residents that make up our program.

# Update from Emory Emergency Medicine

## Jeffrey Siegelman, MD

As we ended another academic year, our graduating residents developed that familiar senior itch tempered by the anxieties of becoming an independent physician confronted with true accountability for the first time. Still, they showed themselves to be ready for independent practice, and we have full confidence they will do well. We are proud that half will be staying in Georgia, while others will be building Emory's national alumni network in nine other states. One of our graduates secured a prestigious Epidemic Intelligence Service (EIS) fellowship with the CDC, and two others will be pursuing EM-based fellowships in international medicine. We are delighted to have three staying at Emory to undertake fellowships in education, critical care, and toxicology.

In saying goodbye to our graduates, we also welcome our new intern class, representing a diverse and talented group chosen from one of the most competitive application seasons we have seen. Medical students applying in emergency medicine nationwide are applying to more programs, have higher

USMLE scores, and have more accomplishments than ever before. We feel fortunate, both to have matched an amazing group to the Class of 2018, and to have matched in emergency medicine ourselves before the process became quite so grueling.

During this intern class's residency, they will see Grady Memorial Hospital transformed, as construction continues on the new Emergency Department slated to open in spring of 2017. The ED extension currently rising next to the hospital along I-75/85 should be completed in the summer of 2016. Along with our patients, we look forward to practicing in a new environment that supports and enhances the care we provide, while allowing for an improved patient experience.

But first, following our 30+ year tradition, the new Emory interns manned the finish line medical tent at the Peachtree Road Race on July 4<sup>th</sup>. They were gloved up and ready to serve this proud tradition for our community.



**Jeffrey Siegelman, MD**  
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Dr. Siegelman is assistant professor of Emergency Medicine and assistant residency director in the department of Emergency Medicine.



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Karen Bowers	Virginia Tech Carilion School of Medicine
Megan Clary	Sidney Kimmel Medical College at Thomas Jefferson University
Shayla Freeman	Medical University of South Carolina College of Medicine
Latanya Gobin	Morehouse School of Medicine
Waleed Hussein	King Khalid University College of Medicine and Health Sciences
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Kristen Liska	University of Massachusetts Medical School
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William Malcolm	University of Michigan Medical School
Sar Medoff	Icahn School of Medicine at Mount Sinai
Cristina Mullins	Morehouse School of Medicine
Kahra Nix	University of North Carolina at Chapel Hill School of Medicine
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Kristy Whyte	University of Miami Leonard M. Miller School of Medicine
Darin Williams	Tulane University School of Medicine
Lauren Wingo	Medical University of South Carolina College of Medicine

# Intimate Partner Violence in Georgia

Lauren Hudak MD, MPH and Sheryl Heron MD, MPH



**Lauren Hudak, MD, MPH**  
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Dr. Hudak is finishing her final year of residency at Emory and will start as junior faculty at Emory University Hospital in the fall.



**Sheryl Heron MD, MPH**  
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Dr. Heron is a professor/vice chair of Emergency Medicine at Emory who practices clinically at Grady.



Intimate Partner Violence (IPV) is often a difficult topic to conceptualize as Emergency Physicians. The task of defining the problem within our community, identifying patients at risk, and providing adequate resources can be daunting for Emergency Department (ED) physicians. In this brief review, we hope to clarify terminology, review current statistics, and discuss various screening practices. Having knowledge of local resources and enlisting appropriate support may prove to be lifesaving for our patients who present with IPV.

## IPV Terminology and Statistics

There remains confusion regarding terminology related to IPV. The Centers for Disease Control and Prevention (CDC) updated their Sexual Violence Surveillance report to clarify terminology in order to more appropriately longitudinally measure and track sexual violence (including IPV). Per CDC, the term “intimate partner violence” is defined as physical, sexual, or psychological harm by a current or former partner or spouse. IPV can occur among heterosexual or same-sex couples and does not require sexual intimacy. Due to CDC’s efforts to clarify the definition of IPV,

injury surveillance has been more successful in tracking incidence data over time at the national and state level. Nationally in 2010, a large number of people experienced IPV. Specifically, more than 1 in 3 women (35.6%) and more than 1 in 4 men (28.5%) in the United States have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.<sup>1</sup> The statistics in Georgia are equally grim, with 39.9% of men and 35.1% of women having experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.<sup>2</sup>

## IPV in Georgia

The Georgia Commission on Family Violence (GCFV) is a valuable resource in understanding how IPV impacts people who live in Georgia. The GCFV publishes an annual fatality report that details how IPV impacts our state in its most severe form. From 2003-2014, at least 1,400 Georgia citizens lost their lives due to IPV.<sup>3</sup> The GCFV also collects data about children involved in IPV. Alarming, in 29% of the cases examined through Georgia’s Domestic Violence Fatality Review Project, children had witnessed the fatalities.<sup>4</sup> Firearms were the cause of death in 76% of the domestic

violence fatalities between 2004-2012.<sup>5</sup> Homicide-suicide is also a disturbing phenomenon. In 2014, 51 lives were lost in 24 murder-suicides, which accounts for 44% of IPV related deaths. In this setting, 96% of IPV murder-suicides involved the use of a firearm and 92% were perpetrated by men.<sup>3</sup>

These are sobering statistics, which clearly demonstrate the link between use of firearms and mortality data in this population. The GCFV have increased their efforts to disseminate information about the federal law prohibiting those convicted of domestic violence misdemeanors and those subject to a qualifying temporary protective order (“restraining order”) from possessing firearms and ammunition. Per the federal mandate, violations of either of these provisions of the Gun Control Act can carry up to a maximum prison term of 10 years, subject to enforcement at the state level. It is generally known that many Georgia courts may not consistently enforce the federal law to the fullest extent possible.<sup>3</sup>

### What Can We Do?

As Emergency Physicians and health care providers, we have a unique opportunity to reach patients in violent intimate partner relationships, as well as perpetrators. Our efforts can improve the lives of individuals as well as positively impact our community. Multiple EDs have implemented various screening modalities (including asking questions about IPV at triage or computer based screening) to help identify victims of IPV and discreetly provide local resources to assist patients. Researchers on this topic advocate for universal screening for all female ED patients, with a special emphasis on screening trauma, pregnant, chronic pain, and frequent utilizers of emergency services.<sup>6</sup> Novel areas of research include formalized screening for perpetrators of IPV in an effort to stop the violence from the causative source.

### Patient-Doctor Screening – “If it doesn’t make sense, screen”

The direct relationship that we share with our patient is a powerful tool in identifying both victims (and perpetrators) of IPV. The common presenting complaints are as complex as the issue, with a general theme of “if the patient’s history and physical doesn’t make sense, screen.” As ED providers, we often take our patient’s histories and physical exams and filter out key components that lead us toward or away from the life threatening medical problems. If we refocus our histories and physical examinations on the life threat of IPV, we may be able to accurately capture this vulnerable population. We often encounter patients with vague somatic complaints such as chronic pain, Irritable Bowel Syndrome, headaches, and musculoskeletal pain. If it is a patient’s second or third visit to the ED for such complaints it is critical to

think carefully about IPV as a possible root cause. Injury patterns such as injuries to the head, face, neck, torso and genitalia; commonly referred to as the “Central Zone of Injury” should also raise concern. We must become comfortable with asking the patient directly about IPV. When doing so, it is important to normalize the inquiry to encourage the patient to disclose the violence. It is helpful to frame the conversation before directly asking about IPV. Recommended states include:

- “I have seen patients with injuries/symptoms such as yours who are experiencing violence in their lives.”
- “Many patients I see are coping with and living within an abusive relationship, so I’ve started routinely started asking if they are experiencing violence by their significant other.”

Directly asking patients about IPV can be intimidating for ED providers. In our busy ED settings, we may only have time for one question related to the issue. The Massachusetts Medical Society committee on violence has drafted several useful options:<sup>7</sup>

- “At any time, has a partner hit, kicked, or otherwise hurt or threatened you?”
- “Has your partner or a former partner ever hit or hurt you? Has he or she ever threatened to hurt you?”
- “Every couple has conflicts. What happens when you and your partner have a disagreement? Do conflicts ever turn into physical fights or make you afraid for your safety?”

Oftentimes patients will deny abuse on initial or subsequent inquiry, however, it is still important to continue to screen at each subsequent encounter if clinical suspicion remains high.

### Perpetrators

While the common presenting symptoms for victims has garnered much research attention, there is little known about how to effectively screen and provide resources for perpetrators. In certain instance, perpetrators have been victims of violence, which further complicates the issue. For ED providers, we may see patients who present with alcohol intoxication, are emotionally unstable and have access to firearms. Given the Georgia statistics of murder-suicide, it should be a consideration to selectively screen and involve social work/1013 for safety if clinically warranted.

### Resources for Patients and Providers

IPV is a complex public health problem, with multiple, cultural, legal and economic factors that require consideration. Each provider is different in their comfort level with caring for patients who are victims or perpetrators

of IPV. As health care professionals on the front line, it is imperative we keep IPV on our clinical radar just as we do for numerous other life-threatening disease processes. Providing specific community resources for victims and perpetrators of IPV can be a lifesaving intervention that can directly impact your patients and community.

**Online resources:**

- CDC IPV resource center: <http://www.cdc.gov/violenceprevention/intimatepartnerviolence/resources.html>
- GCFV resource center: <http://www.gcfv.org/>
- GCFV violence prevention programs (by county, for women, for LGBT) [http://www.gcfv.org/index.php?option=com\\_content&view=article&cid=81&Itemid=13](http://www.gcfv.org/index.php?option=com_content&view=article&cid=81&Itemid=13)

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# RURAL EMERGENCY PRACTICE CONFERENCE

SATURDAY, SEPTEMBER 26 - SUNDAY, SEPTEMBER 27, 2015  
RAINWATER CONFERENCE CENTER • VALDOSTA, GA

The course will focus on Rural Emergency Medicine, bringing academic lecturers to the rural communities. It will provide current literature review, Emergency Medicine Best Practices, ICD-10 and EMTALA updates, and a full procedure and simulation course.

**Course Objectives:**

- Discuss best practices and current protocols in emergency care.
- Utilize simulation to develop skills and strategies to improve patient outcomes.
- Demonstrate appropriate ability to code patient encounters to reflect ICD-10 changes.

**Pricing:**

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ACLS Recertification Course - \$25  
PALS Recertification Course - \$25  
Emergency Procedures Course - \$50

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**Agenda:** a full agenda can be found on [www.gcep.org](http://www.gcep.org)



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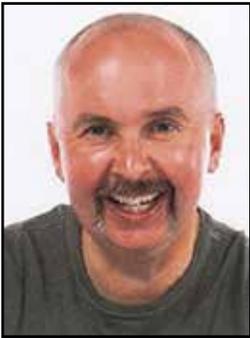


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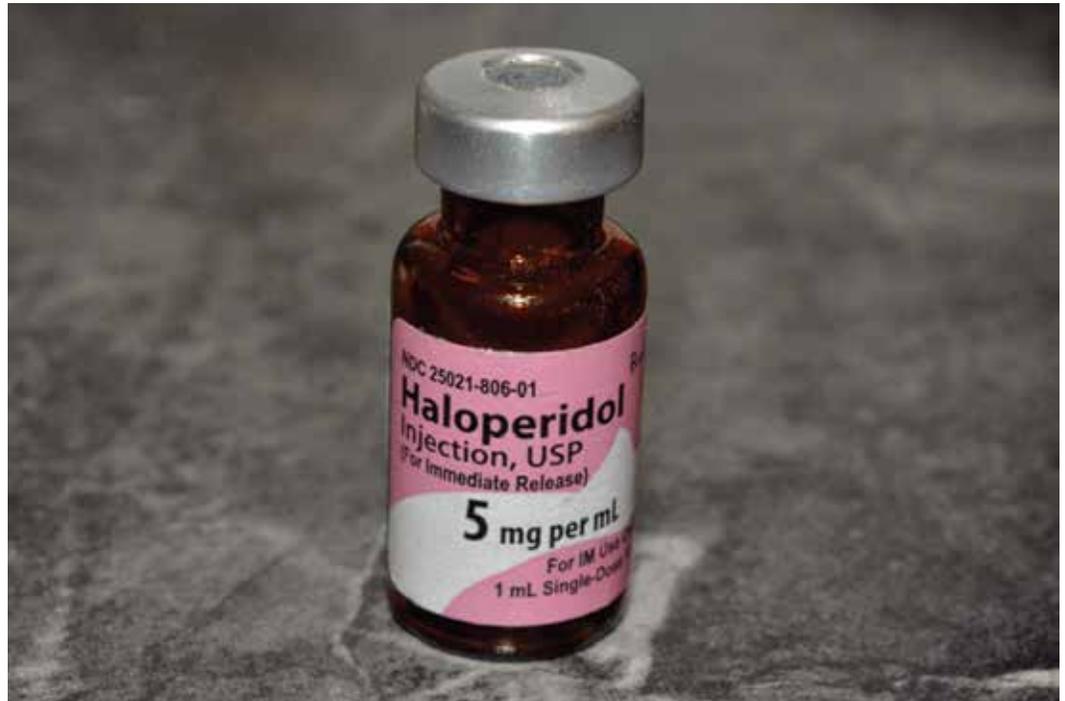


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# Use of Butyrophenones for Acute Migraine Headache in the Emergency Department

**Thomas White, DO and Larry B. Mellick, MD, MS, FAAP, FACEP**



## Abstract

Headache is a common complaint in emergency departments in the United States and any throughout the world. Despite evidence to the contrary over half of patients diagnosed with migraines in the United States are still receiving opioids. Evidence is plentiful for the use of medications like prochlorperazine, metoclopramide, triptans, NSAIDs, and ergotamines. In this paper research involving the use of butyrophenones (first generation antipsychotics) such as haloperidol and droperidol for acute migraine pain in the emergency department (ED) setting was reviewed using U.S. National Library of Medicine and *PubMed* as well other journal searches. Specifically we searched for any article or publication dealing with the use of haloperidol or droperidol for migraine headache relief. Our goal was to present current evidence for the use of this class of medications in the

acute migraine headaches in the emergency department setting.

## Introduction

Migraine headaches account for 1.2 million (headaches in general account for 2.1 million) visits to the emergency department each year in the United States.<sup>1</sup> Migraines can be a debilitating condition and the acute management of migraines has wide clinical variability. Despite years of research the exact pathogenesis of migraine related pain is still not completely understood.<sup>2</sup> Neurotransmitters such as serotonin and dopamine have been implicated in this disease process and that is why medications that bind certain serotonin and dopamine receptors, such as triptans, ergotamine, and metoclopramide have been used with moderate success. It is physiologically consistent that medications which have effects on dopamine receptors, such as butyrophen-

ones, could be effective in migraine headache relief.

Dopamine receptor hyperactivity has been documented in patients with migraine with aura.<sup>2</sup> The D2 receptor was specifically found to be hyperactive in these patients. Butyrophenones are dopamine antagonist, mostly of the D2 receptor, that have long been used as safe sedating agents for agitated ED patients.<sup>3</sup> Droperidol was once commonly used for this purpose until the Black Box warning for QT prolongation caused a vast reduction in ED use in favor of haloperidol. Studies using both of these drugs are outlined in this paper.

## Methods

The objective of the authors of this paper was to perform an update on the use of butyrophenones in the management of acute headaches in the emergency department setting. An in depth review of the literature was performed by electronically searching the United States National Library of Medicine, National Institutes of Health literature archives using the search words such as droperidol, Inapsine, haloperidol, Haldol, butyrophenones, migraine, and headache. When articles addressing these topics were found, they were carefully reviewed and, if relevant, were included in this paper.

## Results

For decades butyrophenones have been used in the treatment of migraine headaches in the emergency department setting. The first reports of the effectiveness of intravenous and intramuscular droperidol were made in the late 1990s.<sup>4,5</sup> Since then direct comparison studies involving droperidol vs. prochlorperazine showed an 83.3% versus 72.3% success rate (defined as a 50% reduction in headache intensity) respectively.<sup>6</sup> The study compared droperidol 2.5 mg IV to prochlorperazine 10 mg IV. The most common reported side effect for both medications were akathisia and the rates for this were similar between the different medications. Another study compared haloperidol versus placebo.<sup>7</sup> Haloperidol 5 mg in a 500 mL normal saline (NS) bag was given compared to 500 mL of NS alone. In the haloperidol group 80% of participants had a significant reduction in pain compared to 15% in the placebo group. The most common complaint in the treatment arm was side effects, mainly consisting of akathisia and sedation. Sixteen percent of the haloperidol group said they would not want the treatment again due to the side effects.<sup>7</sup> Interestingly, more than half (57%) of the subjects in this study had already tried a triptan.

Several 2015 reviews of the use of headache medications have been published. The American Headache Society's evidence assessment of migraine pharmacotherapies gave a level B classification (Level B evidence requires 1 Class

I or 2 Class II studies) which states that antiemetics prochlorperazine, droperidol, chlorpromazine, and metoclopramide are probably effective.<sup>8</sup> A comprehensive review of current literature and recommendations on the treatment of migraine pain were carried out by the Canadian Headache Society. That organization recommended prochlorperazine above all other medications.<sup>9</sup> It actually recommended against butyrophenones citing they are effective but the side effect profile outweighs the benefit.

## Discussion

Surprisingly, patients diagnosed with migraines in the United States are still being treated with either parental or oral opioids 59% of the time.<sup>1</sup> Opioids are known to be poor treatment options for migraine headaches due to rebound pain and the associated addiction concerns are well-known. The most common opioid given in 1998 was meperidine but that has fallen out of favor and has been replaced by hydromorphone as the most common parental opioid treatment for migraines.

Phenothiazines like prochlorperazine and promethazine are known to be effective in acute migraine management. Phenothiazines have well documented side effects including akathisia and sedation. The literature also clearly documents that butyrophenones like haloperidol and droperidol are very effective and have potential roles in rescue therapy.<sup>7</sup> However, butyrophenones also have side effects and one review reported a range of 10-45% of patients receiving butyrophenones had side effects.<sup>10</sup> Anticholinergic agents such as benztropine or diphenhydramine have been used in conjunction with both phenothiazines and butyrophenones to prevent the akathisia and prevent any possible dystonic reactions. Unfortunately, these medications can contribute to the sedation side effect.

It is clear from the literature and decades of clinical experience that the butyrophenones are highly effective in treating migraine headaches. Nevertheless, the use of these medications to treat headaches in the emergency department is not widespread. The black box warning for droperidol may have simultaneously dissuaded many clinicians from using haloperidol. Nevertheless, there are proponents who feel that the black box warning for droperidol is an overstatement of the risks involved.<sup>11,12</sup> Consequently, there are others who feel that butyrophenones medications like droperidol have the potential for regaining its former role.<sup>13</sup> Additionally, the side effects of the butyrophenones as a class may also discourage their use. Nevertheless, many feel that the side effects associated with butyrophenones, just like those of prochlorperazine and promethazine, are easily managed and transient.

In summary, butyrophenones have well-established

roles as antipsychotics and antiemetics. However, as confirmed by our review of the literature they are also at least as effective as the current industry standards for migraine headache relief. And, they do not have the serious risk of drug dependency seen with opiate medications. As with any medication there are side effects. The emergency medicine physician should become comfortable with preventing and managing the side effects associated with the butyrophenones and preemptively explain these to patients during the treatment process. The butyrophenones should be welcomed by emergency medicine healthcare providers as another arrow in their quiver for treating acute migraine headaches.

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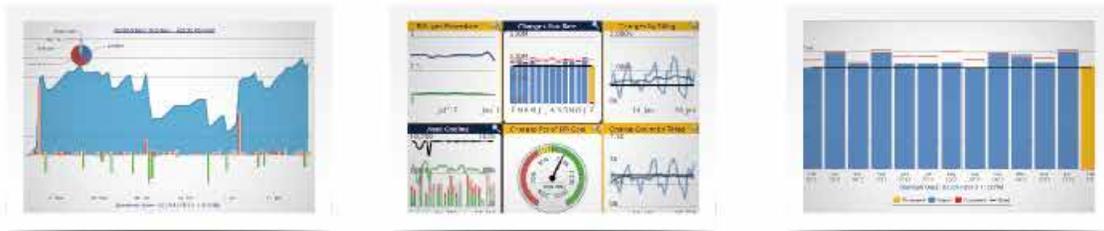


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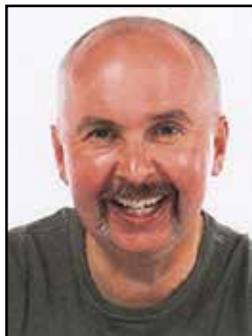
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## The Dicing Injury

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**Figure 1: Tempered glass fragments removed from a patient's clothing and gurney**

A trauma patient left over from the night shift who was metabolizing to freedom needed some dried blood cleaned from his face and scalp. In the process of cleaning him up I noticed small lacerations over the left side of his face that seemed to go perfectly down the midline starting at his nose. He also had similar lesions on the left wrist and a contusion on the left scalp. However, when asked, the patient adamantly claimed he was not the driver of the car. I was pretty confident that he was not telling the truth based on the pattern of his injuries. There is no way for a front seat passenger (as he claimed to have been) to have gotten the injuries to the left side of his face that he had. What were these injuries?

My interest in forensics began in undergraduate school when my part-time job was as an autopsy diener and my Master's degree in graduate school was in pediatric pathology. My training included several months of anatomical pathology training at The Ohio State University. As part of those autopsies an injury pattern analysis (IPA) was often undertaken in order to help determine the identity of the driver at the

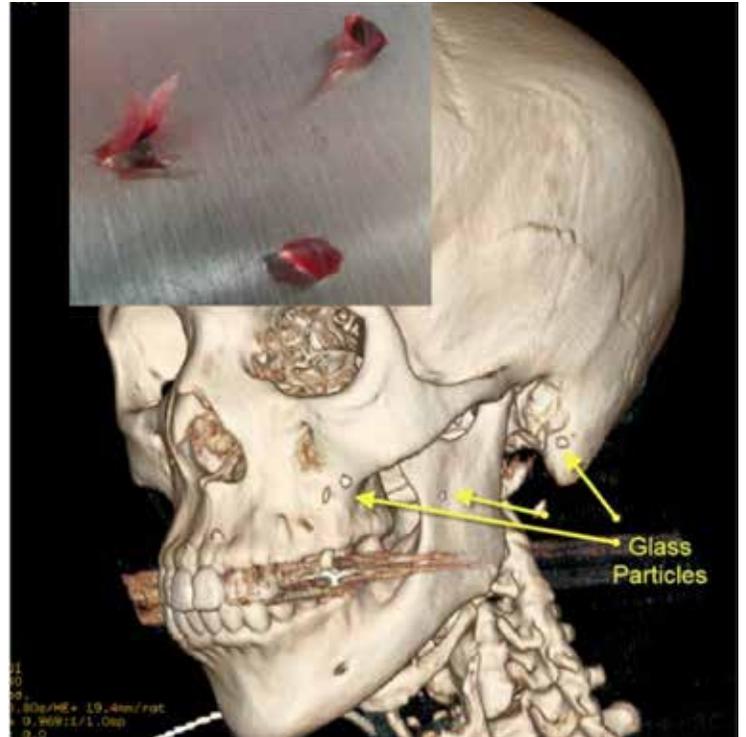
time of the crash.<sup>1</sup> One of the most useful injury pattern was the dicing injury pattern that occurs when skin comes in contact with the shattered tempered glass of the side and rear windows.

In the United States around 1903 the first automobile windshields were of plate glass which breaks into long, sharp and dangerous shards. The laminated windshield was introduced by Henry Ford for the Model T in 1927. Cheaper, tempered glass was developed in Europe and was first introduced in a Chrysler model in 1936.<sup>2</sup> While the front windshield remains as laminated glass, tempered glass has become standard in the side and back windows of all car models.

Tempered glass is heat treated glass and is designed to completely break into small, rectangular, square or cube-shaped fragments. (Figure 1) The windshield, on the other hand, is made to spider with impact. If the vehicle occupant impacts one of the tempered glass windows, the fragmented cubes produce a characteristic cluster of short, linear, angular, rectangular or square incised wounds and the injury is called a



**Figure 2. Right arm dicing Injuries seen in another patient who was sitting on the passenger's side of the car.**



**Figure 3: Glass particles seen on CT scan reconstruction**

“Dicing Injury.” (Figures 2 and 3) In forensics, it is sometimes not clear who the driver of the car actually was and the location of the dicing (left side of head and face) can provide useful clues. It is not uncommon for the driver and passenger to switch locations after an accident in order to avoid arrest for driving without a license or for being intoxicated. Or, everyone in the car may have been thrown out of the car and/or killed. The dicing injuries help determine on which side of the car the occupants may have been sitting.

My Lt. Columbo (Peter Falk) style comment, “Hmmm, that’s very interesting, because your pattern of injury suggests you were the driver” didn’t stimulate any quick confession. In fact, my patient and his buddy in the adjacent trauma room (who claimed to be the driver) agreed that this was their story and they were sticking to it.

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## Excuses, Excuses, Excuses

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Dr. Setu Mazumdar helps physicians like you make smart decisions about your money so you can take control of your financial life. He is President and Wealth Manager at Lotus Wealth Solutions, an independent fee-only wealth management firm in Atlanta, GA exclusively for physicians. Setu received his MD from Johns Hopkins School of Medicine and he is board certified in emergency medicine.

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Over the years I've reviewed personal finances and investments for hundreds of physicians. During those reviews I've noticed that doctors hate being challenged about their money. We think that our ideas are always right despite being shown otherwise.

I heard a quote somewhere that said, "Winners make commitments. Losers make excuses." That's a great way to summarize why many physicians are unsuccessful managing their money.

Look at the excuses some physicians have made based on comments they've sent me from some of the personal finance articles I've written:

**Comment:** "You make the numbers seem so simple. I am 12 years post residency and haven't been able to pay off my debt yet, which was about \$125k."

**My Response:** I wrote an article showing how you can pay off \$250,000 in student loans in less than five years after residency and still live a more comfortable lifestyle. This reader claims he can't pay off half that amount in more than double the number of years! Let's do some quick math again. If he's \$125k in debt and he's 12 years out of residency, he only has to pay \$10,000 a year to pay it off in 12 years. That is easily achievable with your emergency medicine income. On a personal note I had almost the same amount of debt when I graduated from residency and I paid it off in less than 1 year. I worked my butt off and picked up extra shifts. I ain't no mathematical genius but I do know simple addition and subtraction. If I can succeed so can you. It's all about the proper mindset. As Nike says, "Just do it."

**Comment:** "I'm still paycheck to paycheck...Living expenses, food, car payments, auto and home insurance; the basics eat up a sizable amount of that left over money...I have many colleagues in EM who are still living paycheck to paycheck."

**My Response:** Anytime I hear "living paycheck to paycheck" from someone making a couple hundred thousand dollars in income, I wonder where the money is going. Basic living expenses, food, car payments, and insurance premiums should not eat up 100% of your



after tax income. If they do, then you've got a spending problem not an income problem. You need to hire Suze Orman. The reader goes on to say that he does not live lavishly but that he renovated his house and concludes that paying off loans is "just not realistic to most of us." Wrong. What isn't realistic is your definition of lavish. While you might consider the house upgrades to be necessary, I bet your retirement portfolio disagrees.

**Comment:** "We do provide an 'incredibly valuable service,' but not more so than police officers, fire fighters, social workers, teachers, etc. Yes, our education lasts longer and we accrue more student loans, but I still don't agree that that justifies a disproportionately higher income. I, for one, am happy to pay my taxes."

**My Response:** This comment refers to an article I wrote summarizing the new 2013 tax laws. No matter which part of the political spectrum you fall on, you simply cannot deny that taxes have gone up. Here's how you can find out. Take the numbers on your 2012 income tax return and plug them in to your 2014 income tax return and see which year you paid more taxes. Then account for the higher Social Security taxes in 2014 versus 2012. The comment that we "accrue more student loans" than other professions is a huge understatement. Many residents are now graduating with \$300,000+ in student debt. That combined with higher income taxes on these dreaded "rich" doctors and the fact that we start our careers in our 30s means that in my mind doctors are vastly underpaid.

Interestingly the reader admits that she claims deductions on her income tax return even though she is "happy to pay my taxes." That smells like hypocrisy to me. Any physician who is happy to pay more taxes should do the following (for those of you who want to pay less taxes, do the opposite):

1. Do not own any tax exempt investments like municipal bonds
2. Choose investments that pay only non-qualified dividends which are taxed at your highest rate
3. Sell any gains in taxable investment accounts in less than one year
4. Do not deduct any business expenses on your 1099 independent contractor income. This increases your income taxes and self employment taxes.
5. Do not contribute any pretax money to a SEP IRA, 401k, or any other retirement plan
6. Do not fund a health savings account and do not deduct health insurance premiums
7. Do not report and deduct your student loan interest

8. Do not deduct mortgage interest, medical expenses, property taxes, or state income taxes on your federal tax return

Here's what I want you to do. Go back to your 2012 tax return and transfer your numbers again to 2014. Then get rid of the above deductions and find out how much more in taxes you would pay. Then tell me you're happy to pay them. Don't just talk the talk. Walk the walk.

**Comment:** "No one has a crystal ball...Have you seen the movie *Wolf of Wall Street*? Those guys get 1% or \$10,000 grand a year on my million regardless of their performance? Its a fixed game. I'm buying real estate and the stocks that make up the market are not valued properly and therefore should not even be considered anything but gambling."

**My Response:** Looks like I hit nerve when I wrote an article showing the spectacular investment returns you should have gotten over the past few years with a well diversified investment portfolio to the point where you should have catapulted closer to financial independence. While I agree that no one has a crystal ball and cannot predict the stock market, that does not change the fact that the returns I described actually happened. If you missed these returns which were there for you to take, then you can't blame anyone but yourself. Simply put, you lack an investment plan whether you want to admit it or not.

Many people think that the market is rigged or fixed but then they have a hard time explaining what they mean by that. Do you believe the past century of gains are artificial and just fake money? If so, you do not understand how markets work. When you invest in stocks, you expect that capital markets around the world will grow over time, and you expect to participate in that growth with positive returns with the risk you've taken. Contrast that with gambling which has an expected negative rate of return and relies on hope of positive returns instead of expectations.

Finally, millions of investors determine the correct price at any moment in time for the market as a whole. To state that the market is not valued properly is equivalent to saying that you are right and all these millions of investors that determine prices are wrong. That's arrogant to say the least.

The 2013 Nobel Prize in Economics was awarded to the founder of the Efficient Market Theory which disagrees with your view. Read about it, apply it to your portfolio, and stop gambling.

# The Right Approach to Obtaining a Good Physician Employment Agreement



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The right approach to signing a good physician employment agreement begins by *not* seeking a *perfect* contract. As is true with many things, maximizing is counterproductive in the process of reviewing and negotiating favorable terms in a physician employment agreement. There is no perfect contract. While advantage and care for details is certainly very important for any contract, obsessing for perfection may effectuate a bad outcome, which can range from causing the employer a sour taste to retraction of a job offer. The better objective is to obtain a *good* contract – one that actually gets signed, reasonably protects long-term interests, and fosters a good start to a sound working relationship. So, how do you do that?

## 1) Realistically assess bargaining position

The first step to obtaining a good physician employment contact is to measure the opportunity. Ask yourself: “How much do I want this job?” “How will this employment advance my career?” “Will I fit in?” “Will I be paid fairly?” “What other options do I have?” “How will I transition out of this employment?” Before reviewing contract terms and language proposed by the hospital or medical practice employer, a physician should evaluate these and similar elements of the circumstances to grade how important the opportunity is to him. Then, in similar fashion, measure the opportunity for the employer. Ask: “How much do they want me?” “What other options do they have?” “Can they easily hire someone else who is right for this particular job?” But put ego aside, of course. A physician should critically and realistically assess what he brings to the table for the employer. The point of this step of the process is to properly gauge bargaining position, so that you will know how hard you can safely push for particular terms or language in the written employment agreement.

If this subjective assessment indicates uniformity is very important to the hospital and its form physician employment agreement is generally a “take-it-or-leave-it” deal for all physicians, the employer will likely be less amenable to proposed changes. This reality would tend to favor subtle or more restrained efforts to negotiate for improved terms or language. If only one job offer is pending, an even more subdued approach may be in order. On the other hand, if the physician has three offers pending and any one of them would be a good opportunity, a more proactive approach in seeking particular contract terms and language might be beneficial. Realistically assessing negotiating position is essential, before scrutinizing a proposed employment agreement with a highlighter in hand. Ultimately, the physician’s gut-call assessment of the leverage equation based on his overall circumstances and experience in dealing with the employer’s representatives will be the best way to decide how hard to push.

## 2) Define expectations

What do you want an employment agreement to provide? Create and carefully consider your own “wish list” of terms that regard the elements of the job, including, for example:

- Location
- Start date
- Term
- Duties

- ❑ Autonomy/oversight
- ❑ Hours/call schedule
- ❑ Salary
- ❑ Benefits
- ❑ Ownership track

And so on. Once you have completed that list, overlay your expectations with the particulars of the proposed contract to identify discrepancies between your needs and the employer's form agreement:

- ❑ What hours are required?
- ❑ At what location(s) are you required to work?
- ❑ What marketing, medical education, promotion, and/or administrative duties and services are required?
- ❑ What are the specific "on-call" provisions and compensation details for such responsibilities?
- ❑ Does the proposed contract require you to consult with other physicians requesting provisional services of the employer?

And so on. Once you have identified the proposed contract's terms that are inconsistent with your wish list or goals, then, using your assessment from Step 1 above, determine what modifications to propose.

### 3) Read carefully

Of course -- everyone reads contracts carefully, right? Not so. When presented with lengthy, single-spaced, verbose form employment contracts (as most are), physicians tend to assume "this is standard" or "a form," such that the document is perceived either "ok" just as is or, in any event, written in stone. This type of thinking creates a tendency to gloss over language. That is a big mistake -- every time.

Provisions in virtually every "form" physician employment agreement will have potentially large, sometimes problematic, consequences for the physician down the road. The way to identify the problems starts with a slow and careful review of every word. Every provision of the contract should be understood before it is signed. Written contracts are binding and carry significant, long-term ramifications for you and your family. If you do not understand a contract provision or phrase or the mechanics of how it functions in conjunction with other contract provisions (*e.g.*, a bonus formula is applied; how a termination provision operates; what triggers a

non-compete agreement), get assistance. "Can they do this" and "is this legal" are questions posed to me many times in assisting physicians with review of employment agreements. The answer is always the same: "yes, if you sign it." So, read carefully to be sure you understand your contractual commitment.

### 4. Negotiate Judiciously

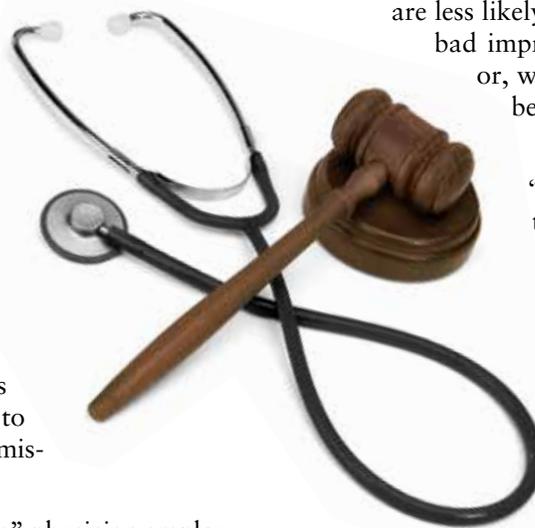
There are two parts to this tip. First, do negotiate. Do not assume a particular term or language cannot be modified. Even with a so-called "form" contract prepared by a hospital system's legal counsel or the involvement of hospital business people that seemed wedded to uniformity in physician contracts for their administrative ease, most employers anticipate that serious minded medical professionals will need to change terms in a proposed contract. So, begin with the assumption that if a term or language to convey is unacceptable for good reason, a reasonable proposal to change it will be, at least, considered by the employer.

The second part, perhaps the more important part, is the qualification "judiciously." The steps to a good contract obviously fail if no agreement is reached. An offer of employment can usually be retracted. If you are perceived as too aggressive or uptight—rather than smart and reasonable—your language proposals are less likely to be accepted, you may make a bad impression with your new employer, or, worse, the employment offer could be retracted altogether.

So, how do you negotiate "judiciously"? With your realistic assessment of your own bargaining position (Step One) in mind, make a list of the terms in the proposed contract that you initially believe need to be changed. Then ask yourself as to each one: does this really matter? A term really matters if you foresee a meaningful possibility it will negatively affect your long-term best interests.

If so, you will need to address it with the employer. If not, then do not worry about it, even if the term or language seems imperfect to you.

A word about lawyers: be careful using them. While competent legal counsel can be indispensable to your efforts to obtain a good physician employment agreement that will properly protect your interest, it is very important that your lawyer balance your desire to get the job and get a good contract. A lawyer obsessed with obtaining the perfect contract for you, too zealous in



presenting proposed changes, or otherwise off-putting to the employer can be a fly in the ointment in reaching a deal. Therefore, it is very important for you to effectively communicate to your legal counsel what your goals and priorities are.

**5. All proposed changes should be unassailably reasonable, mutually fair, and reasonably precise**

When you determine you need to propose a modified term, or change language to express a term, the reasonableness of your suggested change must invite the employer's acceptance (or the employer will be unreasonable). For example, if it is unreasonable for your non-compete agreement to cover the geographic area within a ten mile radius of every practice location of a large practice or hospital system in a densely populated city, it may be reasonable to ask that the prohibited territory of non-compete be limited to the address where you actually worked. If language proposed by the employer's form contract is onerous or overbroad, softened terms that ensure the employer's real interests are protected but

without unfairly imposing upon your interests is always reasonable.

Where broad language is problematic, it is reasonable to propose more precise, mutually fair language that protects both parties' interests. For example, if the employer's form contract provides that the call schedule is "as assigned by Employer's Board of Directors in its discretion," the contract would be improved for you with more precise, mutually fair language like: "the call schedule is assigned on an equal basis as other physicians employed by Employer."

In conclusion, the process of obtaining a good contract is not served by obsessing about what would be perfect in an ideal world. Rather, judiciously proposing changes that are reasonable, mutually fair and precise, and consistent with your assessment of your bargaining strength, will foster a good start to the employment relationship and enhance your chance of signing a good physician employment agreement.

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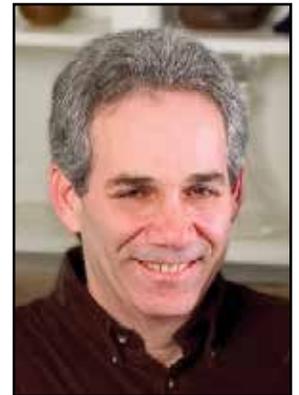
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# Physician/Midlevel Teamwork in Providing Safe and Effective Care in the ED

Peter Steckl, MD, FACEP



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Physicians Assistants and Nurse Practitioners are valuable partners in our practice in the ED. Not only do they aid in maximization of revenue, but by capably evaluating the less acute (but no less important) patients, they function to allow the physician's skills to be used in the most efficient manner in tending to the more complex and sicker patients – the ones we are best trained to evaluate. To top it off, in view of the projected deficiency of physicians moving into the future, our midlevel partners will become even more important as the population ages and increases. Once considered a staffing option, they have increasingly become indispensable to the overall efficient function of the department as population growth continues to outpace physician graduation rates. To be sure, we can only expect the need to become more acute with the predicted influx of newly insured patients associated with inception of the Affordable Care Act.

In acknowledging the value of our midlevel colleagues in confronting the above noted patient flow challenges, we must also recognize some of the risks associated with this practice model. With the incorporation of midlevel provider care into our practice, we are entrusting patient evaluation, treatment, and ultimate disposition to another practitioner whose documentation of decision-making we become legally responsible for by cosigning the chart. This is not meant to cause undue alarm (lawsuits involving midlevel care still remain relatively uncommon). Rather, I only want to make the point that certain strategies must be utilized if we want to maximize good care and minimize risk.

First and foremost, safe and effective functioning of this model mandates that lines of communication between physicians and midlevel practitioners remain open. Whether in the ED, where a collaborating physician is typically present on site or in ED associated offsite

urgent care facilities where a physicians input and judgment are most often available 24/7 by telephone, it is critical that there be no hindrance to the exchange of advice and ideas through consultation when necessary. This principle cuts both ways and puts the onus on the two parties to go the extra mile in maintaining the health of this channel of communication.

On the part of the midlevel, it requires a mixture of prudent judgment and humility to know when he or she is over his/her head in a case. Though many ED's have protocols and guidelines in place that delineate what cases should and should not be independently evaluated by a midlevel, it is indisputable that patient sorting decisions made out in triage are not infallible. Patients sometimes, on further scrutiny, turn out to be more complex than they appeared initially *and there must be no hesitation (or fear/reluctance) on the part of the midlevel practitioner to approach the physician for input.* Similarly, the physician bears a great responsibility to play their part in maintaining communication channel health. This requires, above all, *that the physician maintain an open and welcoming attitude to midlevel approach with questions* regarding care, lab or radiologic study evaluation and requests for contemporaneous bedside evaluation. Though the stress of high volumes and patient acuity can be daunting, it is important to never leave an impression on our midlevel colleagues that their concerns and requests are frivolous, inept or unwelcome. Physicians must understand that they will be consulted one way or another, either at the time of the encounter or at the time of chart cosign and it is infinitely preferable to aid in making the correct decision early and in real time than to rectify a mistake in judgment post discharge.

This brings me to my final observation. There is understandable concern on the part of physicians over risks assumed through the act of cosigning a midlevel chart that depicts a visit that he/she was never consulted upon. In

my opinion, if the cosigning process is conscientiously performed, the actual legal risks are likely less than imagined. A physician is held to the standard of caring for patients in a manner that is reasonable under prevailing circumstances and should only be held responsible for decision-making based on information available to him real time. Hence, theoretically, if a physician appropriately cosigns a hypothetical chart that depicts a patient with a described history, exam and labs consistent with gastroenteritis and this patient returns later with a ruptured appendix he should have a future strong defense in the event of a filed lawsuit. So should the midlevel for that matter. The real and substantial risk comes from the ill-advised and not infrequent practice of blindly cosigning charts that may not maintain the critical consistency in depicting a presentation that supports the prescribed therapy and disposition.

The underlying message is two-fold. The midlevel should put maximal effort towards dutifully creating a chart that is logical, consistent and easy to cosign while the physician must likewise conscientiously examine the charts they are cosigning and, if necessary, respond to identified errors in care in a timely manner to facilitate return or change in therapy as necessary.



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