



PART 1 Medicolegal Issues During the COVID-19 Pandemic

These are extraordinary times with extraordinary challenges, but even within this unique framework, the principles that doctors need to follow remain familiar.

This three-part series will review a few topics giving physicians concern:

Patient Confidentiality

IN THE OFFICE | Re-emphasize to staff, now, that PHI is never to be shared for non-work purposes in writing so you have proof that you did so. The COVID-19 pandemic has caused stress and shock, and there is simply too great a chance for a worried employee to vent that worry in a way that can identify a patient.

REMOTE WORK | HIPAA's rules on patient confidentiality still apply to a covered entity's employees, wherever work is performed. Any device an employee will use should be strongly password-protected, and all PHI should be encrypted before it is transmitted. The connection must be secure. Talk to your IT person about levels of security that can be set up, such as two-factor authentication or having to login again after a period of absence.

If employees will be using personal computers, specifically deal with that, at least with written instructions and at best with a Bring Your Own Device agreement. It is essential to give any employees being sent home to work a formal written policy on maintaining PHI safely and to require them to sign that they received it. Employees must be cautioned about disposal of paper containing PHI. A cross-cut shredder should be used to destroy what minimal printing is done.

TELEMEDICINE | The Office for Civil Rights (OCR) is temporarily waiving penalties for the use of non-HIPAA compliant communication platforms and/or not having a Business Associates Agreement with the service used during the COVID-19 emergency. The service must not be public facing, but Skype, Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, and Zoom are acceptable.

You should inform the patient that what will be used is potentially not secure and get their express confirmation that they understand and agree. A standardized e-mail to which they reply affirmatively is a good approach for proof.

This is to last during the emergency, a period for which there is no end-date. You will need to stay alert for termination of the current emergency so as to not incur fines that will recommence for what would again then be a HIPAA violation.

This article was written by Dr. Medlaw, a physician and medical malpractice attorney.



Guidelines on Neuroimaging for Migraine



Guidelines from the American Headache Society recommend against using neuroimaging in patients with headaches consistent with migraine who have normal neurologic exams and if no atypical features or red flags are present. Other important considerations are also provided.



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Determining when and how to use neuroimaging for migraine is an important issue that physicians face when seeing the 40 million Americans with migraine. Neuroimaging for suspected migraine is used for many reasons, including exclusion of secondary conditions that mimic migraine. Other reasons include medicolegal issues, busy practice conditions in which tests are ordered as a shortcut, providing neuroimaging to appease patient requests, and addressing concerns and expectations of referring clinicians.

Recommendations on the role of neuroimaging in diagnosing headache vary by specialty. An American Academy of Neurology (AAN) evidence-based review published in 2000 gave a Grade B recommendation indicating that neuroimaging is not usually warranted for patients with migraine and normal neurological examination. A Grade C recommendation from AAN states that a lower threshold for neuroimaging may be applied for patients with atypical headache features or patients who do not fulfill the strict definition of migraine or have some additional risk factor.

The American Headache Society's (AHS) "Choosing Wisely in Headache Medicine" campaign advises against performing neuroimaging studies in patients with stable headaches that meet criteria for migraine. The American College of Radiology's "Choosing Wisely" campaign also recommends against performing imaging for uncomplicated headache. "This is an important issue to address, because deciding on neuroimaging is a daily issue for clinicians who manage migraine," says Randolph W. Evans, MD.

Addressing an Unmet Need

Dr. Evans and colleagues at AHS conducted a systematic review, published in *Headache*, in which they gathered evidence about the diagnostic utility of neuroimaging—specifically MRI and CT—in adults seeking outpatient treatment for episodic, chronic, and progressive migraine and in migraineurs with and without aura. For the analysis, 23 articles met inclusion criteria and were included in the final review. Articles were included in the study if they evaluated adults 18 and older who sought outpatient treatment for any type of migraine and who underwent neuroimaging.

"Incidental findings from neuroimaging are common in both migraineurs and control patients," Dr. Evans says. "People who meet ICHD-3 criteria for migraine are no more likely to have significant neuroimaging findings than the general healthy population. We gave a Grade A recommendation stating that it is not necessary to do neuroimaging in patients with headaches consistent with migraine who have a normal neurologic examination." The systemic review noted that neuroimaging may be considered for presumed migraine for a myriad of other reasons, but this was only given a Grade C recommendation due to little or no literature support (Table).

Proceeding With Caution

Patients with concerning clinical or exam features may have abnormalities that require attention and should still be imaged, but Dr. Evans says to proceed with caution when considering neuroimaging in other situations. "Even when the yield is low, neuroimaging is often done in migraineurs because of patient expectations or concerns from patients and their family," he says. "Unfortunately, even when physicians follow guidelines, they are not indemnified in medical malpractice lawsuits when the rare migraine patient has significant incidental pathology."

Rather than routinely neuroimaging patients with migraine, an alternative approach is to educate patients about the low yield of neuroimaging. Patients should also be reassured that neuroimaging can be performed at a later date if new signs or symptoms develop. "In addition, it is important to recognize that if a scan is performed, MRI is preferred over CT," Dr. Evans adds. "MRI without contrast is usually adequate for an initial study unless there is a specific indication for contrast, such as concern for neoplastic disease or spontaneous intracranial hypotension."

Although there are no plans for an update to this systematic review in the near future, Dr. Evans says a large prospective or retrospective study of the incidence of significant pathology in cluster headaches would be of interest in future research. ■



As a urologist, I am very sensitive to my patients' need for privacy. However, I was really surprised when a new patient got very nasty with my receptionist because he was asked to sign in on a sheet at the front desk. He was carrying on about how this is a HIPAA violation because other patients signing in can see his name. I thought that a sign-in sheet is actually acceptable under HIPAA.

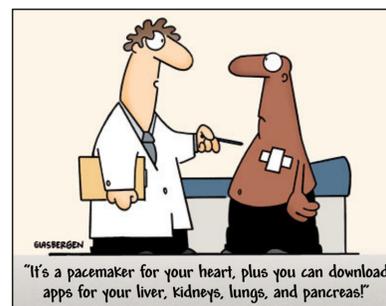
It is, as is announcing a patient's name in the waiting room to tell them that they are the next to see you or saying their name in the hearing of other patients or visitors. Under HIPAA, these revelations of PHI are considered incidental to medical care.

However, you should be doing your part to minimize that revelation. Start with the fact that PHI is an identifier coupled to a medical fact. All that a sign-in sheet alone therefore reveals is that someone is your patient, so make sure to not expand it beyond that—why the patient is there should never be included. Using a peel-off type of sign-in sheet is also a good idea—while not a HIPAA requirement, it does make patients feel more protected and avoids a situation like this.

Similarly, when discussing a patient where others might overhear, keep your voice low, and when calling a patient in from the waiting room, do not mention the reason that they are there. For example, your MA saying "Mr. Joe Smith, come with me please" is acceptable, but "J.S., we are ready for your cystoscopy" is not, because the issue is not the completeness of the name but the association of that identifier to the specific personal medical fact.

Having these as policies in your employee manual will stand you in good stead if you ever have to defend against a complaint from a troublesome patient.

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



Migraine & Sleeping Disturbances



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Although anecdotal evidence suggests that patients who suffer from migraines often report an increased rate of sleep disturbances, including trouble falling and staying asleep, studies conclusively addressing this issue are lacking. With the hypothesis in mind that migraine can directly impact sleep, Angeliki Vgontzas, MD, and colleagues sought to determine how long or well migraineurs slept the night of an attack for a study that was published in *Sleep*.

Led by Suzanne Bertisch, MD, MPH, the researchers conducted a 6-week prospective cohort study, collecting data daily from patients through twice-daily logged electronic diaries and an actigraph, a device worn on the wrist that estimates duration and continuity of sleep. The actigraph was used to track sleep duration, time awake after sleep onset (WASO), and percentage of time asleep while in bed. Participants continued their daily lives while recording migraine attacks in their diaries and wearing the actigraph. "We also used data on sleep collected from the morning diaries (duration, quality)," explains Dr. Vgontzas. "We then compared sleep on the nights a headache was reported with nights on headache-free days." The team also controlled for factors such as daily use of caffeine, alcohol, physical activity, and sleep medications that could impact sleep.

Dr. Vgontzas and colleagues tracked more than 4,400 days, including more than 1,000 reported migraine days. Participants reported an average of 5 migraine days per month. The average nightly objective sleep duration was 7.3 hours, efficiency was 89.5%, and WASO was 44.8 minutes. No significant difference in objective sleep duration (7.3 minutes longer) was observed on nights following a migraine day.

"We recommend clinical evaluation and treatment of sleep disturbances in patients with episodic migraine who have sleep complaints in the clinical setting," emphasizes Dr. Vgontzas. "Physicians should not assume that treatment of their migraine attacks will necessarily improve their sleep complaints."

The study team believes further research is needed to understand the biological mechanisms in both migraine and sleep disturbance. Dr. Vgontzas hypothesizes that there may be a subset of those with migraine whose sleep disturbance is biologically related to their migraine. Structures in the hypothalamus and brainstem could be involved, as could the glymphatic system (a newly identified waste clearance system in the brain primarily active in sleep), as well as neurotransmitters like dopamine and serotonin. ■

Table Summarizing Key Recommendations

Grade	Recommendation
Grade A (Strong Recommendation, High Quality Evidence)	It is not necessary to do neuroimaging in patients with headaches consistent with migraine who have a normal neurologic examination
Grade C (Strong Recommendation, Low Quality Evidence)	Neuroimaging may be considered for presumed migraine for the following reasons: <ul style="list-style-type: none"> • Unusual, prolonged, or persistent aura • Increasing frequency, severity, or change in migraine clinical features • First or worst migraine • Migraine with brainstem aura • Confusional migraine • Hemiplegic migraine • Late-life migrainous accompaniments • Migraine aura without headache • Side-locked migraine • Posttraumatic migraine Most of these are consensus based with little or no literature support

Source: Adapted from: Evans RW, et al. *Headache*. 2020;60(2):318-336.