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PART 3

Medicolegal Issues During the COVID-19 Pandemic

This three-part series—Part 1 covered patient confidentiality and Part 2 covered maintaining office safety—reviews a few topics giving physicians concern during the COVID-19 pandemic.

Malpractice Liability

This is primarily a concern for retired doctors who are answering the call to come back to assist overwhelmed hospitals, but who no longer have malpractice coverage. The first thing to check is whether the state has an exemption from liability for COVID-19 care, whether there is an emergency worker statute that either immunizes or indemnifies the doctor, or whether the hospital will be providing indemnification.

A Good Samaritan law cannot, however, be relied upon. These cover care outside of medical facilities that is rendered to individuals to whom the practitioner does not owe a duty. Even a hospital that is low on resources or overcrowded is still a hospital, and if you are working as physician, you will have a duty to all patients under your care and for whom you are on-call.

The most essential issue in limiting liability, though, is self-assessment. In a setting in which your skills may not be as good as those of a specialist but you can still be of benefit to the patient, an informed consenting discussion with the patient about any limitations can be adequate, but modern critical care and its technology are not roles that you can step into if, say, you have been in private practice as a neurologist for the last 30 years, there is no on-the-spot training that can compensate for that, and the patients are in no position to select their caregivers.

In this regard, also bear in mind that even immunity laws do not cover gross negligence, which would be acting so recklessly that it shows a disregard for patient safety. Accepting to intubate a patient when the last time that you tried to do so was as a supervised intern would be such conduct, however well-intentioned you are, and would remove you from the law's protection.

It is therefore up to you, if you do re-enter to help, to specify what you can and cannot do… and it is very likely that they will be glad to have you in the ER or clinic using your skills well.

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

A Look at Inappropriate Inpatient IV Opioid Use

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With evidence indicating that over-prescription of opioids has contributed to the current opioid epidemic, current Society of Hospital Medicine (SHM) guidelines recommend using the oral route of administration whenever possible—reserving intravenous (IV) administration for patients who cannot take food or medications by mouth, those suspected of gastrointestinal malabsorption, or when immediate pain control and/or rapid dose titration is necessary—given increased risks of side effects, adverse events, medication errors, and addiction with IV compared with oral formulations. IV opioids are also directly and indirectly (nursing time and equipment) more expensive than oral and can lead to avoidable complications like patient discomfort, infection, and thrombophlebitis.

Seeking Information

Despite the SHM recommendation, Amber Moore, MD, and colleagues observed that IV opioids were being overprescribed and continued longer than clinically indicated in patients in the hospital setting for a number of reasons.

For a study published in the *Journal of Hospital Medicine*, Dr. Moore and colleagues sought to identify the incidence of potentially inappropriate IV opioid use in hospitalized patients "in order to show that physicians have the potential to decrease misuse by more appropriately prescribing opioids," says Dr. Moore. The researchers reviewed the charts of 200 hospitalizations during February 2007 with any order for IV opioids using pharmacy charge data.

Defining Inappropriate Use

Based on SHM recommendations, potentially inappropriate use of IV opioids was defined as use for greater than 24 hours in patients who could receive oral medications—as evidenced by receipt of other orally administered medications during the same 24 hours—and was not mechanically ventilated. The 24-hour window was chosen based on the typical ability to determine opioid needs and transition to an oral regimen within that timeframe in patients without contraindications following initial immediate pain control with IV opioids when indicated. IV doses after 24 hours were considered potentially inappropriate except in patients with nil PO status, including medications. IV opioids for respiratory distress were considered appropriate.

Patients with an active cancer diagnosis, who had chosen comfort measures only, or with GI dysfunction were excluded from the study, as IV opioids beyond 24 hours may be appropriate in these populations. Days spent receiving opioids by patient-controlled analgesia (PCA) or continuous IV drop were excluded, given the difficulty in identifying the appropriate time to transition from PCA to IV or PO opioids.

One-Third of Patients

Among the predominantly Caucasian study population with an average age of 56.3 years, the majority were on a surgical service and were mostly commonly administered hydromorphone. Significant differences were observed between the opioid types in the percentage of doses considered inappropriate, with the highest proportion seen with morphine (44.6%), followed by hydromorphone (27.4%), and fentanyl (2.6%).

"Inpatient physicians, on both surgical and medicals services, overprescribed IV opioids," explains Dr. Moore. "Our study found that 31% of patients were administered at least one potentially inappropriate opioid, and 33% of IV doses were considered potentially inappropriate. Given the strict definition used in our research, we suspect that over-prescribing is even more common than our numbers suggest." Significant associations between potentially inappropriate IV opioid administration and age, sex, or admitting service were not observed (Table).

Looking Ahead

The need exists, according to Dr. Moore for more research examining how to improve opioid prescribing practices, as well as for quality improvement initiatives to be studied and disseminated to provide better understanding of how to best improve adherence to guidelines. "Physicians have the potential to decrease the risks of IV opioids by improving prescribing practices and choosing oral opioids over IV whenever appropriate," she says. "We hope this study encourages physicians to examine their own prescribing practices and ultimately decrease use of inappropriate IV opioids."

Table Associations With Potentially Inappropriate Opioid Use

Characteristic	Percent of Population	No Inappropriate Use	Inappropriate Use	Adjusted Relative Risk
Age <65	67%	64%	74%	Reference
Age >65	33%	36%	26%	0.55
Male	45%	46%	42%	Reference
Female	56%	54%	58%	1.18
White	68%	62%	79%	Reference
Black	11%	12%	8%	0.48
Other/unknown/patient declined	22%	25%	13%	0.39
Medical Service*	26%	25%	27%	Reference
Surgical Service**	74%	75%	73%	0.78
No Opioid drip/PCA use	84%	82%	90%	Reference
Opioid drip/PCA use	16%	18%	10%	0.40

*includes general medicine and cardiology
**includes general, trauma, orthopedic, thoracic, neuro-, and plastic surgery.
Abbreviation: PCA, patient-controlled analgesics.

Source: Adapted from: Moore A, et al. *J Hosp Med.* 2019;14(11):678-680.

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How the Pandemic Can Bring the Family-Centered Model Back

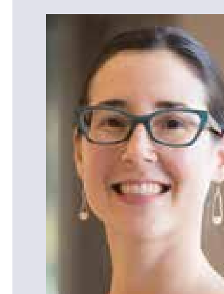
By Gabriella Gonzales, MD, and Alexander Rakowsky, MD

It is vital that we take this opportunity as a specialty to truly show our patients and families that the care we provide is worthwhile. There is no better way to do this than to focus on what human nature already motivates us to do: build relationships. We list practical suggestions to implement regardless of clinical duties and setting:

1. **Eye contact.** For in-person visits requiring masks, it is more vital than ever to look our patients and parents in the eyes. This is as important with telehealth visits.
2. **Ask the family, especially the patient, about fun things that they have started due to COVID-19.** We all need to see the good that can come out of all of this, so let your patients express it and share yours to celebrate it together.
3. **Ask the family and patient what impact the pandemic has had on them and truly empathize.** It is important that our patients/families know that we are all hurting to some extent during this time, and we are navigating it together.
4. **Ask how you can help.** We cannot be expected to have all of the needed resources, but we can provide contact information for local resources available to the myriad of COVID-19-impacted families.
5. **Talk them through the exam:** With so much uncertainty around coronavirus, calm some nerves by emphasizing normal findings as you do the exam.
6. **Make sure questions are answered:** Allowing patients/families to leave with unanswered questions is the quickest way for them to lose trust in the relationship with you.
7. **Clearly summarize what was discussed and come to mutually agreed-upon next steps.** Continue to empower families in this time of uncertainty.
8. **Thank them for coming in and trusting you.** Gratitude has shown through during this pandemic and shouldn't be forgotten as being fundamental in any relationship.
9. **Take some time to volunteer.** To best care for our community, we must take the opportunity to get to know it!
10. **Finally, let us not forget that old adage: Love makes a house a home.** We are the specialty that first promoted the concept of the medical home. Now more than ever, we have the opportunity to bring this patient- and family-centered model back to pediatrics.

To read the unabridged version, visit KevinMD.com

Prevalence of *C. difficile* Carriage & Progression



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More than 400,000 cases of *Clostridioides difficile* infection (CDI) and nearly 30,000 deaths from *C. difficile*-associated diarrhea are reported annually in the US. In the past, efforts to limit transmission have focused on isolating patients with symptomatic *C. difficile*-associated diarrhea. Sarah Baron, MD, MS, and colleagues came to a new hypothesis while witnessing the infection in hospitals. For a study published in *Infection Control & Hospital Epidemiology*, the researchers sought to better understand the transmission and prevalence of *C. difficile* through determining the number of asymptomatic patients admitted to the hospital already carrying *C. difficile* and how frequently these patients develop symptomatic infections.

The study team conducted a prospective cohort study, sampling patients at a large urban hospital between 2017 and 2018. To confirm indications from previous studies that nursing facility residents are at an increased risk of CDI, Dr. Baron and colleagues selected participants from the community and patients from nursing facilities at a 1:4 ratio. Participants were given a noninvasive perirectal swabbing within 24 hours of hospital admission, with specimens processed the same day, incubating the specimen in a meat broth for 48-72 hours, and then repeating the tests. All participants did not report diarrhea and were followed for 6 months or until death.

The prevalence of asymptomatic *C. difficile* carriers was 9.6%, including 10.2% of nursing facility and 7.7% of community patients. Prevalence of *C. difficile* detection was increased in the 45% of patients who had soiled test swabs (odds ratio, 2.7), when compared with those who did not. Among carriers identified during testing, 38.1% were subsequently diagnosed with symptomatic CDI within 6 months, compared with only 2.0% of non-carriers.

"I cannot stress the finding enough," emphasizes Dr. Baron, "that patients who carry *C. difficile* are much more likely to proceed to symptomatic CDI. This could change how we consider identifying carriers, protecting non-carriers through isolation and environmental cleaning, and protecting carriers from symptomatic infections via antimicrobial stewardship."

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