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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.

Understanding the Association of Dysanapsis With COPD Among Older Adults

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A large retrospective study has found that dysanapsis—a condition in which there is a mismatch airway tree and lung size—appears to be a risk factor associated with COPD among older adults, even if these individuals do not smoke or have other COPD risk factors.

Smoking tobacco is the best-known COPD risk factor, but recent data from a multitude of population-based observational studies show that only a minority of life-long smokers develop COPD. "Furthermore, 25% of COPD cases occur in people who were never smokers," says Benjamin M. Smith, MD, MS. "These observations suggest that additional factors contribute to COPD risk. While other risk factors have been identified, such as air pollution, occupational exposures, and asthma, recent studies have suggested that early life factors might also contribute to COPD risk."

In the 1970s, researchers noted considerable variation in lung function among healthy adults. Investigators speculated that such variation may be due to a developmental mismatch between airway tree caliber and lung size, which they termed "dysanapsis." They hypothesized that dysanapsis, if present, may contribute to lung disease susceptibility later in life.

Taking a Deeper Look

For a study published in *JAMA*, Dr. Smith and colleagues sought to determine if dysanapsis was a risk factor for COPD in people who did not smoke or possess other risk factors. "We hypothesized that dysanapsis might be a major risk factor for COPD," Dr. Smith says. The study team performed detailed measurements in more than 6,500 older adults who participated in 3 studies that included smokers and nonsmokers with and without COPD.

The studies—the Multi-Ethnic Study of Atherosclerosis (MESA) Lung Study, the Canadian Cohort of Obstructive Lung Disease (CanCOLD) study, and the Subpopulations and Intermediate Outcome Measures in COPD Study (SPIROMICS)—assessed dysanapsis using lung CT scans. The MESA Lung study was conducted in six United States cities and included patients with an average age of 69. CanCOLD study participants were located in nine Canadian cities and had an average age of 67. SPIROMICS was based in 12 US medical centers and included people with an average age of 63. SPIROMICS also collected data on patients reporting 20 or more pack-years of smoking tobacco.

Assessing Key Findings

In the community-based MESA Lung and CanCOLD studies, participants with smaller airways relative to lung size were much more likely to develop COPD compared with those with the larger airways relative to lung size (Table). The association remained after considering standard COPD risk factors, including smoking, environmental and occupational pollutants, and asthma. When investigators focused on participants from the CanCOLD study who never smoked and on heavy smokers from the SPIROMICS study, they found that never smokers with COPD had smaller airways relative to lung size, whereas heavy smokers who did not have COPD had larger than normal airways.

"Using multiple large cohorts from the US and Canada, we showed that dysanapsis was a major COPD risk factor—a finding that is on par with smoking and other standard risk factors," says Dr. Smith. "People with smaller airway trees relative to lung size tended to have lower lung function and higher COPD risk, even among never smokers. Conversely, lifelong heavy smokers who did not have COPD tended to have larger than expected airway trees relative to lung size."

Analyzing the Implications

Findings of the study may help explain why some lifelong heavy smokers do not develop COPD, but Dr. Smith says more work is needed. "While the harmful effects of smoking are well established and reducing smoking is essential to public health, we need to start thinking more broadly about the origins and pathophysiology of COPD if we want to better prevent and treat this heterogeneous disease," he says. "In our study, we observed that patients with dysanapsis-related COPD had a very different prognosis in terms of lung function decline when compared with patients who had COPD related to traditional causes. In the future, gaining a better understanding of the biological basis of dysanapsis may lead to early life interventions that will help us promote the development of healthy and resilient lungs."

Table Airway to Lung Ratios and COPD: Assessing the Associations

The table below depicts the incident rate ratio between the lowest and highest airway to lung ratio quartiles in the Multi-Ethnic Study of Atherosclerosis (MESA) and Canadian Cohort of Obstructive Lung Disease (CanCOLD) community-based studies.

Incident rate ratio, lowest to highest airway to lung ratio quartiles	MESA	CanCOLD
Unadjusted	7.14	2.66
Age, age × age, sex, height, height × height, and race/ethnicity	8.90	3.52
Primary tobacco smoke exposures	8.62	3.42
Secondhand smoke exposures, occupational or environmental pollutants, and asthma	8.12	3.33

Source: Adapted from: Smith BM, et al. *JAMA.* 2020;323(22):2268-2280.

Meaningful Us

Meaningful Use was a vision for EMRs that in many ways turned out to be a joke. Consider my list of Meaningful Us for medical professionals instead.

When electronic medical records became mandatory, federal monies were showered over the companies that make them by way of inexperienced, ill-prepared practices rushing to pick their system before the looming deadline for the subsidies.

The feds tried to impose some minimum standards for what EMRs should be able to do and for what practices needed to use them.

The collection of requirements was called meaningful use, and by many of us, nicknamed "meaningless use." Well-meaning bureaucrats with little understanding of medical practice wildly overestimated what software vendors—many of them startups—could deliver to such a well-established sector as healthcare.

For example, the feds thought these startups could produce or incorporate high-quality patient information that we could generate via the EMR, when we have all built our own repositories over many years of practice from Harvard, the Mayo Clinic, and the like or purchased expensive subscriptions like UpToDate. As I have described before, I would print the hokey EMR handouts for the meaningful use credit and throw them in the trash and give my patients the real stuff from UpToDate, for example.

I'd like to introduce an alternative set of standards, borrowing the hackneyed phrase, with a twist. **Meaningful Us for Medical Professionals:**

Unbiased, Understanding, Unflappable, Unhurried

Like the software meaningful use items, these may be hard to attain, but especially in today's healthcare environment, they seem worthy of striving for.

UNBIASED Able to fairly represent alternative approaches to allow patients to make up their own mind about their care.

UNDERSTANDING Able to listen to patients' concerns and reflect back that you "get it" and will work to help address them.

UNFLAPPABLE Able to, in Osler's words, maintain equanimity in the face of the challenges of medical practice.

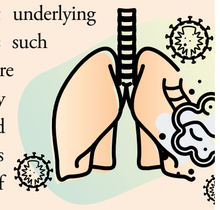
UNHURRIED Able to use time wisely, therapeutically, without frenzy, to make the most of the most valuable resource we all have.

Now, isn't that more inspiring?

In Case You Missed It

Asthma Seems Not to Be Linked to COVID-19 Hospitalization

Asthma seems not to be associated with COVID-19 hospitalization, according to a study published in the *Journal of Allergy and Clinical Immunology.* Study investigators examined the prevalence of asthma among patients with COVID-19. The clinical characteristics and comorbidities in patients with COVID-19 with and without asthma were assessed by searching medical records. In addition, the risk for hospitalization associated with asthma and/or inhaled corticosteroid use was determined. Of the 1,526 patients with COVID-19, 14% were classified as having asthma. After adjustment for age, sex, gender, and comorbidities, asthma was not associated with an increased risk for hospitalization (relative risk [RR], 0.96). In a similar adjusted model, the ongoing use of inhaled corticosteroids was not associated with an increased risk for hospitalization (RR, 1.39). "Interestingly, asthma did not increase the risk of hospitalization after adjusting for covariates," the authors write. "This is notable as it has been anticipated that underlying chronic lung diseases such as asthma, which are typically triggered by a viral illness, would place these patients at increased risk of severe exacerbations."



Triple Inhaled Therapy Aids in Moderate-to-Very Severe COPD

Triple therapy, including glucocorticoid at either of two dose levels, is beneficial for moderate-to-very severe COPD, according to a study published in the *New England Journal of Medicine.* Researchers conducted a 52-week, phase III trial to assess the efficacy and safety of triple therapy at two dose levels of inhaled glucocorticoid in patients with moderate-to-very severe COPD and at least one exacerbation in the previous year. A total of 8,509 patients were randomly assigned to receive either twice-daily inhaled doses of triple therapy (inhaled glucocorticoid [320 or 160 µg], a long-acting muscarinic antagonist [LAMA; glycopyrrolate], and a long-acting β2-agonist [LABA; formoterol]) or one of two dual therapies (glycopyrrolate plus formoterol or budesonide plus formoterol) in a 1:1:1:1 ratio. The annual rates of moderate or severe exacerbations were 1.08 and 1.07 in the 320- and 160-µg budesonide triple therapy groups, respectively; 1.42 in the glycopyrrolate-formoterol group; and 1.24 in the budesonide-formoterol group. Compared with glycopyrrolate-formoterol or budesonide-formoterol, the rate was significantly lower with 320-µg glucocorticoid triple therapy (rate ratios, 0.76 and 0.87, respectively). Similarly lower rates were seen with 160-µg glucocorticoid triple therapy (rate ratios, 0.75 and 0.86, respectively). "Our findings show the benefits of triple therapy with a budesonide-glycopyrrolate-formoterol combination over dual therapy with a LAMA-LABA or an inhaled glucocorticoid-LABA combination," the authors write.