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[MEDLAW]

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.

Managing Cardiac Disease Throughout Cancer Treatment

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Several critically important patterns that have occurred in healthcare mandate the improved management of the cardiac status of patients being treated for cancer, says Daniel Lenihan, MD:

1 The long-term survival of patients identified with nearly all cancers has dramatically risen, such that cardiovascular (CV) concerns after treatment become a major issue.

2 Patients receiving therapy are older and have more complex comorbidities than ever before.

3 Therapeutic protocols are now so complex that concerns about cardiac safety have become commonplace.

4 Understanding of the biological overlap between targets of cancer therapy and critical pathways in CV tissues is continuingly evolving.

With extensive developments in therapeutic options for both cancer and CV treatment and a wide spectrum of knowledge needed to address both the oncologic and CV needs of patients with cancer exposed to cardiotoxic therapy—including chemotherapeutic agents, targeted therapies and radiotherapy—"It is virtually impossible for a clinician to stay on top of all of these areas of medical care," notes Dr. Lenihan. To attempt to summarize best practices for the care of this patient population, the European Society for Medical Oncology (ESMO) published consensus recommendations on the management of cardiac disease in cancer patients throughout oncological treatment. "The recommendations cover all aspects of cardiovascular complications related to all cancer therapy," says Dr. Lenihan, and "there should be no essential difference between ESMO and the American Society of Clinical Oncology (ASCO) in terms of hematology and oncology practices, especially in regard to cardiac safety."

Key Points/Recommendations

Among the most important inclusions in the vast paper, according to Dr. Lenihan, is a spreadsheet of information on anticancer therapies associated with CV complications or toxicities; those with a common frequency of these CV side-effects are summarized in the Table. Along with patients who are or will be treated with these therapies, the consensus statement includes the following common clinical factors that may indicate a patient at higher risk for cardiovascular dysfunction during contemporary anticancer treatment:

- Prior anthracycline-based treatment
- Elderly (>75 years)
- Prior mediastinal or chest radiotherapy
- Hypertension (before or at the time of treatment)
- Smoking exposure (current or previous)
- Very young (<10 years)
- Previous combined treatment with trastuzumab and an anthracycline
- Elevated cardiac biomarkers before initiation of anticancer therapy
- Baseline abnormal systolic LV function with LVEF less than 0.50
- Pre-existing diabetes mellitus

Included in the recommendations is a proposed monitoring and management approach for patients undergoing potentially cardiotoxic anticancer therapy, which Dr. Lenihan notes is a general strategy for monitoring for cardiac dysfunction with any therapy that could be associated with heart failure or cardiac dysfunction. "An emphasis on early cardioprotective therapies so patients can remain on effective cancer therapies without having to interrupt those life-saving treatments because of a CV side effect differentiates the approach from previous algorithms focused on cardiac dysfunction," he adds.

Notes of Importance for All Oncology Experts

Dr. Lenihan notes that leaders in cardio-oncology published recommendations in cooperation with the ASCO in 2017, adding that the latest recommendations include major comprehensive updates and a dramatically broadened scope. "In 2017, we focused on cardiac dysfunction in cancer survivors," he says. "These recommendations cover *all* aspects of cardiovascular complications related to all cancer therapy, including current and previous therapies. We aim to improve communication and provide the best CV care for patients with cancer here in the US, but also around the world. I would certainly emphasize that we are on the same team as all US hematology and oncology experts: the team that wants to eliminate cancer but protect the person!"

Table Anticancer Therapies With Common* CV Complications or Toxicities

Agent	Cardiotoxicity Type
Doxorubicin	HF, LVD, Arrhythmia
Epirubicin	HF, LVD, Arrhythmia
Ifosfamide	HF, LVD, Myopericarditis, Arrhythmia
Cisplatin	VTE, HTN
Melphalan	Arrhythmia
Fluorouracil	Coronary vasospasm
Capecitabine	Coronary vasospasm
Rituximab	Hypotension (infusion reaction), HTN
Bevacizumab	HTN, VTE
Trastuzumab	HF
Dabrafenib	QT prolongation
Pazopanib	HTN, Bradyarrhythmia, HF, LVD
Ponatinib	HF, LVD, HTN, Ischemia, ATE, VTE
Sorafenib	HTN, HF, LVD, Ischemia
Trametinib	HF, LVD, Bradyarrhythmia, QT prolongation, VTE, HTN
Sunitinib	HTN, HF, LVD, VTE
Axitinib	HTN
Ibrutinib	AF, HTN, Bleeding
Ramucirumab	HTN
Regorafenib	HTN
Imatinib	Edema
Vandetanib	HTN, QT prolongation
Ziv-aflibercept	HTN, QT, prolongation, VTE
Cabozantinib	HTN
Erlotinib	VTE
Bortezomib	HTN
Carfilzomib	HF, LVD, VTE, HTN, ACS
Everolimus	HTN
Temsirolimus	HTN
Lenalidomide	VTE
Thalidomide	VTE
Vorinostat	QT prolongation
Selective ER modulators	VTE, QT prolongation
AIs	VTE, HTN, Hyperlipidemia
Antiandrogens	HTN
Tisagenlecleucel	Tachycardia, Arrhythmia, Hypotension, HTN, HF, Capillary leak syndrome, MI
Tretinoin	HF, LVD

*Common toxicity frequency = ≥5% incidence.

Abbreviations: ACS, acute coronary syndrome; AI, aromatase inhibitor; ATE, arterial thromboembolism; HF, heart failure; HTN, hypertension; LVD, left ventricular dysfunction; MI, myocardial infarction; QT, corrected QT interval (preferably by Fridericia's formula); VTE, venous thromboembolism.

Source: Adapted from: Curigliano G, et al. *Ann Oncol.* 2020;31(2):171-190.

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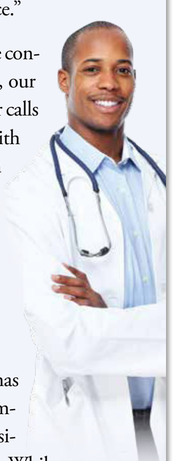
The Importance & Power of Physicians Advocating for Themselves

By David Blitzer, MD, and Tomas Diaz, MD

In the past, we as physicians have not done a great job of advocacy, and we have largely been removed from policy discussions. The emergence of physician advocacy is a relatively new phenomenon. During the AIDS crisis, a unified physician voice was largely missing from policy conversations. Since that time, physician advocacy for social change has grown. Physicians have led movements calling for sensible gun control only to be told to "stay in our lane." Physicians have supported broader access to healthcare, defending the ACA against repeated repeal attempts by a government body with minimal healthcare experience."



Despite bearing witness to the consequences of policy decisions, our expertise is dismissed, and our calls for action go unnoticed. With COVID-19, we have begun to find our voice but, as in the past, have lacked the power to push forward important structural changes to address current and future healthcare challenges.

If the current pandemic has taught us anything, it is the importance and power of physicians advocating for ourselves. While we are currently advocating for the supplies and support we need, this is also an opportunity—a call to action—to continue to represent our field, our patients, and our communities. While we enjoy the privilege of caring for others on a daily basis, we must not forget that our profession affords us a class privilege, which we should leverage to promote health equity. There is no doubt that there will always be a need for competent and dedicated clinicians to serve on the frontlines. But, this pandemic has shown that we will also always be in need of effective advocates for our patients and our profession.

If there is a silver lining in all of this, it comes from the affirmation that when we unite and advocate for ourselves and our patients, we can do great things. As the curtain of isolation lifts, we will continue to draw upon this newfound strength, and we hope you, dear reader, will join us.

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Mohs Micrographic Surgery for CSCC

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Few prospective studies on outcomes in cutaneous squamous cell carcinoma (CSCC) have been performed, and outcomes for patients treated specifically by Mohs micrographic surgery (MS) have not been described in the US. To address this research gap, we conducted a 5-year, multicenter, prospective cohort study on the long-term clinical outcomes of patients with invasive CSCC treated with MS and published our results in the *Journal of the American Academy of Dermatology*. Our goal was to prospectively quantify outcomes by tumor stage (T stage) using the Brigham and Women's Hospital (BWH) and the American Joint Committee on Cancer Staging Manuel, Eighth Edition (AJCC8)T staging systems, as well as to verify historically high-risk features in MS-treated CSCC.

Fifteen US institutions participated to obtain data on 745 patients with invasive CSCC, which showed a 1.6% local recurrence (LR) rate after treatment with MS, the lowest 5-year LR for any CSCC treatment modality reported to date. Increasing Breslow tumor thickness (BT) was the primary predictor of poor outcomes, with an increased tumor thickness showing an increased risk of LR, nodal metastasis (NM), and disease-specific death (DSD) on multivariate modeling. Location on the lip also increased NM risk. Incidental perineural invasion (IPNI) did not show statistically worse LR, NM, nor DSD on multivariate modeling, contrary to previous findings. Whereas this population often receives adjuvant postoperative radiation therapy, no tumors with IPNI were adjuvantly radiated. Histologic differentiation, tumor size, and immunosuppressed status also showed no significant effect on outcomes, suggesting a mitigating effect of histologically tumor-free margins provided by MS. Neither the BWH nor AJCC8 T staging systems were predictive of LR; however, both were predictive of NM and DSD.

Our study validates the assertion that MS provides the lowest LR rate possible and supports its use, even in high T stage CSCC, and allows clinicians to pause and consider close clinical monitoring over referring for radiation therapy when clear margins have been achieved via MS. The lack of significance of all traditionally high-risk characteristics other than BT suggests that consideration should be made for reporting Breslow thickness on pathology reports, as it was predictive of all outcomes of interest.

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