PHYSICIAN'S WEEKLY
NEUROLOGY
Vol. IV • Issue No. 5 • July 2020
WWW.PHYSICIANSWEEKLY.COM

MEDPAGE TODAY'S
KevinMD.com
Social media's leading physician voice

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.

David Blitzer is a cardiothoracic surgery resident.
Tomas Diaz is a clinical emergency medicine fellow.

Q AND A
Special Considerations for Patients With Multiple Sclerosis: COVID-19

In an interview with James D. Bowen, MD, Medical Director, Multiple Sclerosis Center, Swedish Neuroscience Institute, Seattle, WA, he reviewed special considerations for the management of multiple sclerosis during the COVID-19 pandemic.

What advice are you giving patients with multiple sclerosis (MS) in terms of COVID-19, especially those who are newly diagnosed? What concerns do they have?

I think some patients with MS have the misconception that MS is a disease in which you're immune suppressed, but in fact, it's a disease in which the immune system is overly active. So, first, we have to reassure them that MS does not put them at any increased risk of getting this virus, as far as we know.

They have also shown concern that their treatments for MS may affect their risk of getting the coronavirus. We have developed protocols for MS medications; for most of the protocols, I tell people to stay on their medicines, because for most, if we stop the medicine, the immune effects of that medication last for months. So, you're not really helping them immediately avoid the risk of coronavirus if the medication is stopped, and at the same time, you're putting them at increased risk of having an MS exacerbation. So, for the most part, they should stay on their medication.

We have also worked with our patients quite a bit on how they can decrease their risk of getting the coronavirus. There's a lot of misinformation out there about this. One aspect that we've wrestled with in our region of the country, in particular, is that there are two levels of personal safety recommendations that have been going around based on airborne and droplet precautions. Because droplets are the way that coronavirus is spread, we're having to tell patients that they really just need a surgical mask, not an N95 mask. Another aspect that we have to educate patients about regarding the droplet precaution is the purpose of staying 6 feet from others, based on the radius at which globs of mucus will land when people sneeze or cough.

It's rare that a patient would be so rude that they would just cough right at you like that, so we also had to educate our patients that the biggest risk of catching this disease is not the 6-foot radius but that people will touch their face, wipe their nose, and then touch a desk or other surface, after which they could touch that same surface and scratch their nose. We spend a lot of time also talking about hand sanitation to try to prevent this illness.

Since you are in Seattle, where a lot of news has been made about COVID-19, what are your supply chain issues there now?

One of our biggest supply chain issues is personal protection equipment for medical providers. Some of our hospitals in the region have less than 2 days of a supply of these masks on hand, and it's unclear what will happen when we run out of those masks.

We also have not been able to run down the contacts of patients who have this virus because we do not have adequate access to the coronavirus testing.

And, one of the challenges, of course, is that about 80% of people with this virus are either asymptomatic or minimally symptomatic. The asymptomatic are probably spreading it more, because they feel well enough to be out in the community and we do not have the capacity to test those. The number of people who have been tested in our region is limited, not only because the test—the agents that we have are in short supply, so they can't run the test—but also because we're running short on nasal swabs to even take the specimens.

What has your experience been with converting to telemedicine visits versus in-person visits, and how have patients accepted this change?

In late January, our clinic anticipated that we might be struggling with this, so we developed a comprehensive protocols for how to deal with patients calling about questions with this virus and what to do when someone shows up at your front desk with a potential symptom. We have a detailed outline of what should be done, who should greet the patient, where they should be seated depending on the ventilation of our building, what exam room to put them in, and things like that.

We are shifting toward doing only urgent cases in person in the clinic and have converted most of these to telehealth visions or telehealth visits, and every patient I have contacted in this way has been pleased. Many patients with multiple sclerosis have disabilities and would prefer a telehealth visit anyway, regardless of coronavirus. The reason we're able to shift to this now is, in the past, you really could not effectively bill for a telehealth visit. But, on an emergency basis, insurance is covering this now to prevent exposure of these patients. So, the acceptance from a patient standpoint has been very high.

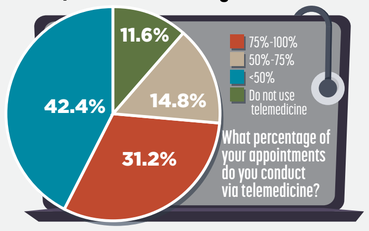
And, CMS has added a related billing code.

Yes, and they reimburse at the rate of a normal office visit. In the past, you could only do telehealth facility to facility, which kind of defeats the purpose for a person with a disability. They'd have to leave their home and go to another facility, and the other facility got the facility fee, a big chunk of the amount of money, and you would get perhaps 60% of the fee. Now, you can telehealth right into the patient's home and get a normal charge for that visit.

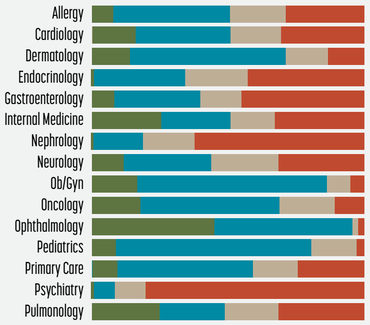
The Impact of COVID-19 on Physician Practices

There's no denying the significant impact the COVID-19 pandemic has made on medicine. "We're practically developing new protocols every day," says PW Editor-in-Chief Linda Girgis, MD. "We now are conducting many visits by telemedicine to limit contact between people and sterilize every surface of the office—for those patients who do come in—like we've never done before." To get a better sense of the impact, we conducted a survey of our physician eNewsletter recipients, during the latter half of 2020. Among the approximately 1,500 recipients representing 15 specialties, we found striking, but understandable, differences by specialty in response to two key questions that reveal and overall trend.

Nearly 90% of offices are using Telemedicine



[TELEMEDICINE APPOINTMENT PERCENTAGES BY SPECIALTY]



More than 2/3 of physicians are concerned about the future of their practice.

64.2% Yes | 35.8% No

[PERCENTAGES OF CONCERN BY SPECIALTY]

	Yes	No
Allergy	63.0%	37.0%
Cardiology	69.6%	30.4%
Dermatology	84.6%	15.4%
Endocrinology	32.3%	67.7%
Gastroenterology	77.4%	22.6%
Internal Medicine	87.5%	12.5%
Nephrology	52.5%	47.5%
Neurology	54.8%	45.2%
Ob/Gyn	60.5%	39.5%
Oncology	48.4%	51.6%
Ophthalmology	86.4%	13.6%
Pediatrics	77.5%	22.5%
Primary Care	69.6%	30.4%
Psychiatry	45.5%	54.5%
Pulmonology	70.0%	30.0%

Source: 2020 Physicians Weekly COVID-19 Survey

In light of these impacts, Dr. Girgis says "Hang in there, and don't forget to take a pause! We need to speak up and let people know the conditions we are working under and keep pressuring administrators to provide a safe work environment."

Mediterranean Diet, High Fish Intake May Be Neuroprotective

Adhering to a Mediterranean diet is associated with a lower risk of cognitive impairment and with higher cognitive function, but not with a slower decline in cognitive function, according to a study published in *Alzheimer's & Dementia* by the Age-Related Eye Disease Study (AREDS) and AREDS2 Research Groups. A high intake of fish was associated with a decreased risk of cognitive impairment and slower cognitive decline.

"Diet may be an important factor in influencing progression to [mild cognitive impairment] and dementia," write the study authors. "As a modifiable environmental factor, diet can exert profound effects on biological aging and has been associated with age-related conditions linked to dementia, including cardiovascular disease and diabetes. The Mediterranean diet pattern has received interest."

For their observational study, Tiarnán D. Keenan, MD, PhD, of the National Eye Institute, National Institutes of Health, and colleagues conducted a post hoc analysis of data from 7,756 participants enrolled in two randomized trials of the efficacy of nutritional supplements on progression to late age-related macular degeneration (AMD)—AREDS and AREDS2. At randomization, all subjects completed food frequency questionnaires (FFQs), which the researchers used to determine the number of medium-sized servings of each food item subjects consumed per week. They also determined the intake for each of nine categories: whole fruits, vegetables, whole grains, nuts, fish, legumes, red meat, monounsaturated fatty acid: saturated fatty acid ratio, and alcohol. These were combined to calculate the modified Alternative Mediterranean Dietary Index (aMED) score.

Upon cross-sectional analysis, the study team found that higher aMED scores were associated with significantly lower risk of cognitive impairment and higher cognitive scores in both studies. In AREDS, the odds ratios for cognitive impairment in aMED tertile 3 was 0.36 for Modified Mini-Mental State and 0.56 for composite score in AREDS. In AREDS2, these odds ratios were 0.56 for Telephone Interview Cognitive Status-Modified and 0.48 for composite score. Fish intake was associated with higher cognitive function. Among participants in AREDS2, the rate of cognitive decline over 5 to 10 years was not significantly different according to aMED but was significantly slower in those with higher fish intake. Unlike with other studies, no interactions were observed between APOE or other genes associated with Alzheimer's disease and either aMED or fish intake that influenced cognitive function.