

[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.



Comorbidities & Risk of Migraine Progression

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Research indicates that chronic migraine (CM; ≥ 15 monthly headache days with 8 or more linked to migraine) is associated with higher rates of disability and comorbidities, as well as reductions in health-related quality of life compared with episodic migraine (EM; < 15 monthly headache days). Approximately 2.5% of patients with EM develop CM each year. "Identifying individuals at risk for progression from EM to CM and optimizing treatment plans in the hopes of preventing progression is a promising strategy for reducing the public health burden of migraine," explain Richard B. Lipton, MD, and Dawn C. Buse, PhD. In a study published in *Neurology*, Dr. Lipton, Dr. Buse, and colleagues sought to test the hypothesis that subgroups of migraine identified by comorbidity con-

stellations vary in rates of progression from EM to CM. The study team used data from the Chronic Migraine Epidemiology and Outcomes (CaMEO) Study, which surveyed 16,789 people with migraine every 3 months from 2012 to 2013. CaMEO tracked comorbidities and patterns of treatment. In a previous report, the group used latent class analysis (LCA) to identify eight naturally occurring subgroups of people with EM based on comorbidities and symptoms and showed that the groups differed at baseline in demographic features, disability, and headache characteristics.

Identifying Progression Risk

The eight LCA-defined migraine subgroups included: many comorbidities (most comorbidities); respiratory/psychiatric; respiratory/pain; respiratory; psychiatric; cardiovascular; pain; few comorbidities (fewest comorbidities). Discrete time hazard modeling was used to analyze the migraine subgroups and to estimate rates of progression from EM to CM, adjusting for a range of variables, including demographics (Table). During the study period, 6.7% of patients identified with EM progressed to CM.

Among people with EM at baseline, the subgroup with the fewest comorbidities had the lowest risk of progressing from EM to CM. Conversely, the subgroup with the most comorbidities had the highest risk of progression, with a hazard ratio (HR) of 5.34, when compared with the fewest comorbidities group in models adjusted for demographics excluding race. The subgroup with a combination of respiratory and pain comorbidities had the second highest rate of progressing to CM (HR, 3.64). However, when a respiratory or pain comorbidity was the sole comorbidity, HRs for new-onset CM were significantly lower (1.53 and 1.93, respectively). "This result suggests that when certain comorbidities occur together, the risk for progression to CM is increased," says Dr. Lipton. "We hypothesize that subgroups defined by comorbidity profiles may differ in disease biology in a prognostically significant way." These findings suggest that treating comorbidities could have a significant impact on migraine patients' quality of life and risk of progression.

Looking to the Future

The study findings suggest that physicians should be aware of how migraine comorbidities can impact their patients' disease course and quality of life, according to Dr. Buse. "The clinical importance of the subgroups we have identified is demonstrated by the differences among the groups in the risk of progression to CM over time," adds Dr. Lipton. He believes that identifying migraine subgroups and observing their relationship with the disease over time could provide a greater understanding of the heterogeneity of migraine.

"This analysis forms an early step in the identification of naturally occurring subgroups of migraine that are related to prognosis," says Dr. Lipton. "Future research on this topic should look to externally validate comorbidity classes and determine whether we can predict responses to different types of treatments for each comorbidity group. Additionally, future studies should determine whether treatment of these risk factors can prevent or reduce rates of progression and target which comorbidities have the greatest impact and which treatments are most effective." ■

Table Discrete Time Hazard to Chronic Migraine Onset

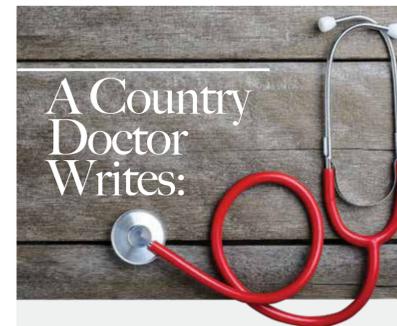
Variable	Frequency n(%)	Demographic model Hazard ratio (95% CI)	Demographic model (excluding race) Hazard ratio (95% CI)
Sex		1.20 (0.99-1.45)	1.19 (0.99-1.44)
Age, per 10 years of age		0.86 ^a (0.81-0.92)	0.86 ^a (0.81-0.92)
Race: white		1.05 (0.82-1.35)	Trimmed
Income: \geq \$50,000		0.74 ^a (0.63-0.88)	0.73 ^a (0.62-0.87)
LCA class			
Most comorbidities	409 (4.7)	5.41 ^a (3.94-7.44)	5.34 ^a (3.89-7.33)
Respiratory/psychiatric	928 (10.7)	2.43 ^a (1.82-3.25)	2.40 ^a (1.80-3.20)
Respiratory/pain	655 (7.6)	3.67 ^a (2.68-5.02)	3.64 ^a (2.67-4.98)
Respiratory	1,719 (19.9)	1.55 ^a (1.18-2.03)	1.53 ^b (1.17-2.01)
Psychiatric	650 (7.5)	2.36 ^a (1.73-3.23)	2.41 ^a (1.77-3.28)
Cardiovascular	724 (8.4)	1.63 ^b (1.11-2.39)	1.62 ^b (1.10-2.37)
Pain	519 (6.0)	1.97 ^a (1.35-2.88)	1.93 ^a (1.32-2.82)
BMI, baseline, per point change in BMI		1.01 ^b (1.00-1.02)	1.01 ^b (1.00-1.02)

Abbreviations: BMI, body mass index; CI, confidence interval; LCA, latent class analysis.

^a $p \leq 0.001$, compared with the fewest comorbidities class.

^b $p \leq 0.05$, compared with the fewest comorbidities class.

Source: Adapted from: Lipton R, et al. *Neurology*. 2019;93(24):e2224-e2236.



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.

Nou, isn't that more inspiring?

Assessing Migraine Care in the Urgent Care Setting



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Evidence suggests that many people with migraine visit the emergency department (ED) due to disabling acute or episodic attacks. "Unfortunately, the ED is not a good place for these patients," explains Mia T. Minen, MD, MPH. "Migraine medications work best when given early, yet EDs often have long wait times.

Also, EDs are often loud and bright, conditions not conducive to people with migraine who may have photophobia and/or phonophobia." Urgent care centers offer an alternative to EDs, usually with shorter wait times and extended hours.

For a study published in *Headache*, Dr. Minen and colleagues examined the use of urgent care visits for migraine, focusing on trends in management and treatment of migraine in this setting, as well as prescriptions and instructions given to this patient population upon discharge. The study team reviewed the charts of patients with migraine diagnoses at urgent care locations, determining baseline patient demographics, previous migraine characteristics, frequencies of reasons for urgent care visits, various medications administered, medications prescribed on discharge, and characteristics of patient outcomes post-discharge.

Nearly 80% of patients had a self-reported history of recurrent headache or migraine before their urgent care visit. Among those with a documented frequency of prior headaches, 94% had episodic migraine and 79% experienced 1-2 headache days per month at most. Intravenous metoclopramide—one of the three medications with the highest level of evidence by the American Headache Society (AHS) for acute migraine treatment in the ED—was administered to only 12% of those who presented to urgent care while currently experiencing pain (94%). Neither of the other two medications with the highest evidence—subcutaneous sumatriptan or intravenous prochlorperazine—were administered. Among patients with reported nausea or vomiting with migraine, 46% received an anti-emetic during their visit and 33% received a prescription for one. A triptan prescription was given to only 11% of those who did not have a record of previous triptan use.

"We believe increased education about the AHS guidelines for migraine management in the ED might be transferable and useful for urgent care providers," says Dr. Minen. "These medications should probably be included within the urgent care pharmacy and tried first when there are no contraindications." ■