



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.

Endocarditis in Younger Patients With HIV, Hepatitis C, and/or Opioid-Use Disorder



Contributor
Karen W. Hoover, MD, MPH
 Medical Epidemiologist
 Division of HIV/AIDS
 Prevention
 Centers for Disease
 Control and Prevention

The incidence of endocarditis appears to have increased among young people with hepatitis C infection and/or opioid use disorder but not in those with HIV. Prevention efforts are greatly needed to reduce the burden of endocarditis in groups at increased risk.

Endocarditis is a potentially fatal bacterial infection of the heart valves that is most commonly diagnosed in older patients and those with prior cardiac surgery. “Recent data show that the rate of endocarditis has increased among young men and women with injection drug use behaviors, opioid use disorder, and/or hepatitis C virus (HCV) infection,” says Karen W. Hoover, MD, MPH. As injection drug use has risen over the past two decades among younger people, it has become increasingly important to understand trends in endocarditis because of its associated mortality, morbidity, and cost burden.

For a study published in *Clinical Infectious Diseases*, Dr. Hoover and colleagues estimated national trends in endocarditis among people with HIV, HCV infection, opioid use disorder, or a substance use disorder other than opioid use disorder. Using commercial and Medicaid health insurance databases, the researchers estimated incident cases of endocarditis in the United States in 2017 and stratified data by HIV, HCV infection, and opioid use disorder. The study group also estimated annual percentage changes (EAPC) in endocarditis from 2007 to 2017 among people with commercial insurance.

Key Findings

According to the analysis, the weighted incidence rate of endocarditis increased slightly over the 11-year period of the study. The incidence of endocarditis among people with HIV decreased from 2007 to 2017, with an EAPC of -4.3%. However, the incidence increased among those with HCV infection from 2007 to 2017, with an EAPC of 3.2%. The incidence also increased among people with opioid use disorder, with an EAPC of 5.7% over the study period.

Some groups in the study had markedly higher rates, including people aged 18 to 29 years, those who resided in rural locations, persons with HCV infection, and individuals with diagnoses that might indicate opioid use disorder. “Endocarditis

is a rare infection in young persons, but our data demonstrated a notably large increase in endocarditis among individuals with HCV infection or opioid use disorder,” says Dr. Hoover (Figure). “These increases mirror the growing opioid crisis in the US. Our study highlights that endocarditis, a serious and potentially deadly complication, is associated with injection drug use behaviors.”

Critical Implications

Findings from the study underscore the importance of primary prevention for endocarditis. “This is an infection that causes significant morbidity and mortality, and treatment is expensive,” explains Dr. Hoover. “Interventions for harm reduction in the opioid crisis have focused primarily on preventing overdose deaths and HIV and HCV infection. However, it is also important to implement prevention efforts that focus on endocarditis as a possible result from sharing injection equipment or from injecting skin that has not been disinfected.”

Physicians should be aware of the risk of endocarditis in people who inject drugs and counsel their patients with opioid use disorder or HCV infection on strategies for preventing the infection, according to Dr. Hoover. “This includes education on the importance of not sharing injection

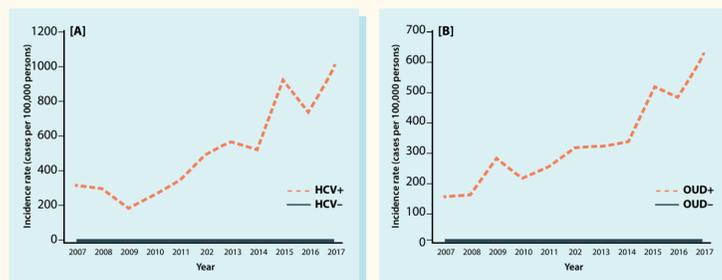
equipment and using good injection hygiene practices,” she says. “In addition, referring patients who report injection drug use behaviors to harm reduction services may help prevent HIV and HCV transmission; prevent endocarditis among people who inject drugs; and reduce risk for overdose deaths. These are important opportunities to connect people to medications for opioid use disorder and regular testing for infections.”

Future Research

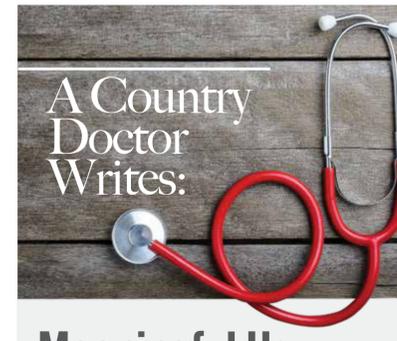
The study sheds light on the seriousness of endocarditis and its association with injection drug use behaviors, but more studies are needed. “Future research should evaluate outcomes related to endocarditis in young people,” Dr. Hoover says. “This includes assessing the rate of reinfection in young persons with endocarditis who continue to inject drugs, stroke, surgical valve treatment, and mortality after treatment of endocarditis. Studies are also needed to examine costs associated with the diagnosis and treatment of endocarditis in young persons and to gain a better understanding of patient awareness between endocarditis and injection drug use behaviors. Interventions and educational campaigns should be developed, implemented, evaluated, and scaled-up accordingly to prevent endocarditis related to injection drug use.”

Figure Infective Endocarditis Incidence Rates in Younger People

The figures below depict the incidence rate of infective endocarditis among commercially insured persons aged 18-29 years by (A) hepatitis C virus (HCV) infection and (B) history of opioid use disorder in the United States from 2007-2017.



Source: Adapted from: Wong CY, et al. *Clin Infect Dis*. 2020 Apr 9 [Epub ahead of print].



A Country Doctor Writes:

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?

The Influence of Weight Gain & HIV on TB Treatment Success



Written by
Lauren S. Peetluk, MPH
 Division of Epidemiology
 Department of Medicine
 Vanderbilt University
 School of Medicine

Unsuccessful tuberculosis treatment outcomes—including death, treatment failure, losses to follow-up, and recurrence—not only contribute to individual morbidity and mortality, but also influence community transmission and drug resistance. With current tuberculosis treatment lasting at least 6 months, early treatment predictors are needed to identify patients with tuberculosis at greatest risk of unsuccessful outcomes to enable timely tailoring of treatment programs and interventions toward those who need it most.

In a prospective study published in *The Journal of Infectious Diseases*, my colleagues and I sought to examine, among 547 patients with culture-confirmed, drug-susceptible, pulmonary tuberculosis whether 1) HIV influences weight change during the first 2 months of treatment, and 2) whether HIV, weight change, or both impact tuberculosis treatment outcomes.

Results suggest that persons living with HIV (PLWHIV) gained a median of 1.3 kg less weight during the first 2 months of treatment than those who were HIV-negative. Differences between the groups were more pronounced among PLWHIV with low CD4 cell counts (CD4 ≤50μL) or high viral loads (viral load ≥400 copies/mL). Additionally, HIV and weight change were predictors of unsuccessful treatment outcomes after adjusting for relevant confounders.

We conducted mediation analysis to examine the extent to which HIV impacts tuberculosis treatment outcome if patients with and without HIV gained the same amount of weight. Results revealed that 35% of the effect of HIV on tuberculosis treatment outcome could be reduced if patients with and without HIV gained the same amount of weight during tuberculosis treatment, suggesting HIV alone additionally exerts direct influence on tuberculosis treatment outcome.

Because tuberculosis is a disease of wasting, nutritional improvement during treatment is an essential aspect of recovery. Our study proposes that weight gain during tuberculosis treatment can be used to monitor treatment efficacy and highlights that PLWHIV—especially those with more severe presentation—gain less weight during early tuberculosis treatment and are at greater risk of unsuccessful tuberculosis treatment than patients who are HIV-negative, suggesting they would likely benefit from more targeted treatment. However, additional research is needed to identify what types of interventions would best promote weight gain and recovery during tuberculosis treatment, particularly among PLWHIV.