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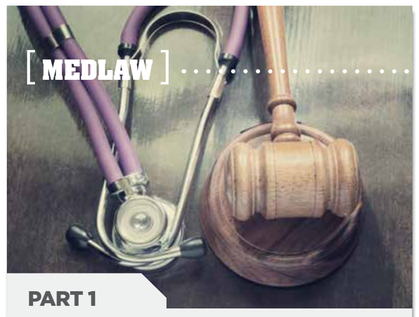


PART 1

Avoiding Liability in Telemedicine: Licensure & Coverage

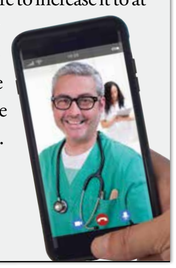
Telemedicine has exploded in scope with the COVID-19 pandemic and will leave a lasting imprint on how medicine is practiced, so it is essential for physicians to understand its basic principles and the specific rules that govern it during the pandemic.

Normally, a patient's residence does not matter, because you see them in the state where you are licensed. However, when you as, for example, a doctor in Manhattan have a video visit with your patient at home just across the river in New Jersey, you are reaching into another state to practice and so your licensure status becomes of interest to that state. As a result of the COVID-19 crisis, states have extended licensure waivers. If you will be practicing telehealth with patients from states where you do not have a license, search fsmb.org for "states waiving licensure requirements" to make sure that is permissible.

Bear in mind that these modifications are related to the current pandemic. Do not assume that a waiver will continue past the end of the crisis, and make sure you meet all requirements that may re-establish if you want to continue to offer remote visits to your out-of-state patients, or you could face charges of practicing without a license.

The advent of the pandemic originally provoked a retreat by insurers, many of whom wanted to exclude COVID-related issues, but that was essentially a brief reaction, and virtual care coverage is now an expanding and competitive market. However, again, beware that while these changes are significantly the result of carriers seeing an expanding opportunity even after the pandemic ends, they are currently backed up by laws that offer considerable immunity from suits for those involved in COVID-19 care. That rates may rise later when such immunization is lifted should be assumed.

If you are getting coverage to do telemedicine, remember that it is not just about malpractice. You will need adequate coverage for technical issues and for privacy breaches. If you have free coverage of some $50,000 for cyber issues on your current policy, make sure to increase it to at least $1 million, because any breach can be costly and telemedicine is inherently more risky being entirely in the vulnerable electronic realm.



This article was written by Dr. Medlaw, a physician and medical malpractice attorney.

Assessing MRSA Risk in the Surgical Intensive Care Unit: Who Warrants Empiric Therapy?

Written by
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Data showing an increase in prevalence of MRSA and other multi-drug resistant organism (MDRO) infections in ICU patients suggests that antimicrobial resistance continues to increase in this population. As a measure of antimicrobial stewardship, emphasis on identification of patients who are appropriate for empiric anti-MRSA therapy is needed to reduce unnecessary antibiotic exposure. For a study published in the *Journal of Infectious Diseases and Epidemiology,* my colleagues and I aimed to identify the incidence of, and risk factors for, MRSA ventilator-associated pneumonia (VAP) in surgical ICU (SICU) patients to better identify those who benefit from empiric MRSA coverage.

MRSA vs non-MRSA VAP

This was a single-center, retrospective risk factor analysis of adult SICU patients diagnosed with VAP between 2013 and 2016. VAP was defined as a lower respiratory culture isolating more than 10,000 colony-forming units/ml of pathogenic bacterial organisms collected more than 48 hours after endotracheal intubation. Respiratory cultures used for diagnosis of VAP were obtained either by bronchoscopic bronchial alveolar lavage (BAL) or non-bronchoscopic BAL (mini or blind BAL). In the case of multiple VAPs during admission, only the patient's first episode of VAP was included in the analysis. The causative pathogens of that first episode dictated group allocation (MRSA-VAP group vs. non-MRSA VAP group).

Among participants, 22.1% were in the MRSA group and 78.9% in the non-MRSA group. The most prevalent organisms in the non-MRSA VAP group were *Enterobacteriaceae* (32.1%) and *Pseudomonas aeruginosa* (29%). Significantly more females had MRSA VAP (54.8% vs. 32.1%), as did a greater proportion of patients with a history of MRSA or MDRO infection (16.1% vs. 4.6% and 22.6% vs. 9.2%, respectively). Fewer patients in the MRSA VAP group had antibiotic exposure prior to their first VAP (58.1% vs. 78.9%). The MRSA VAP group had lower sequential organ failure assessment scores at the time of VAP diagnosis, driven by fewer patients with elevated bilirubin (3.2% vs. 22%) and hemodynamic instability (16.1% vs. 34.9%). A lower proportion of patients with MRSA VAP met the criteria for septic shock at the time of VAP diagnosis (6.5% vs. 23.9%). The MRSA VAP group had lower all-cause mortality than the non-MRSA VAP group (12.5% vs. 28.7%), though this did not reach statistical significance. After multivariable logistic regression modeling, MRSA risk was 2.3-fold higher in females than males and 4.2-fold higher among those with a history of MRSA than those with no such history (Table). Patients with prior antibiotic exposure were 60% less likely to develop MRSA VAP than those without such exposure.

Table Multivariable Logistic Regression Model for MRSA Ventilator-Associated Pneumonia

Variable	Odds Ratio (95% CI)
Female	2.31 (1.03, 5.61)
History of MRSA	4.22 (1.05, 16.95)
Prior antibiotic exposure	0.40 (0.17, 0.98)

Source: Adapted from: Tollefson M, et al. *JAMA Dermatol.* 2018;154:286-292.

What the Results Suggest

This study identified an incidence of MRSA VAP that was twice what had been described in previous literature examining risk factors in a SICU cohort. Our results suggest a lower severity of illness at the time of diagnosis in the MRSA VAP group when compared with the non-MRSA VAP group, that selection of appropriate empiric antibiotics for VAP must be balanced with antimicrobial stewardship, and that empiric MRSA coverage should be considered in patients with a history of a MRSA infection and/or no prior antibiotic exposure during their admission, particularly if the VAP has developed later in the ICU stay.

Other modalities, such as MRSA nasal swabs on admission, may be useful tools to guide anti-MRSA therapy. Gram-negative pathogens, particularly MDROs, appear to be more prevalent in this patient population and conferred a greater severity of illness. Unaccounted for in our study, a patient's microbiota may play a role in the risk of VAP. Antibiotic exposure as an individual stressor has been associated with an increase in the presence of genes related to antibiotic resistance in the gut microbiome, which was demonstrated by an increased prevalence of MDR gram-negative organisms in the non-MRSA VAP population. Our results lend additional guidance to selection of empiric antibiotic therapy for VAP in SICU patients; however, further research with risk factor studies accounting for individual factors and dysbiosis are needed.

It Is Time to Assess Sexual Health in Women With Lung Cancer – The SHAWL Study

Written by
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The Lung Cancer Registry has launched a landmark new survey on the impact of lung treatments on women's sexual health. The aim is to explore the magnitude of the problem and give researchers and clinicians new insights to improve the quality of life for women lung cancer survivors. Sexual distress is an essential component of quality of life in lung cancer, but it is infrequently studied and discussed. Most of the data regarding sexual dysfunction in patients with lung cancer precede the approval of targeted therapies and immune checkpoint inhibitors, which are now the backbone of lung cancer treatment. We lack an understanding of how these new regimens that have significantly improved the survival of patients with lung cancer are affecting our patients' sex lives and intimacy. Sexual dysfunction symptoms are often not collected in the clinical trials that lead to regulatory approvals.

Sexual health in patients with lung cancer is under-reported and, therefore, understudied. Previous studies have reported that the impact on sexual function is distressing to most patients with lung cancer, and sexual concerns are related to both higher symptom distress and worse functional status in patients with lung cancer.

The SHAWL (Sexual Health Assessment in Women with Lung Cancer) study is the result of a multi-institutional collaboration between the University of Wisconsin Carbone Cancer Center and the GO2 Foundation for Lung Cancer. All women with lung cancer, independently of cancer stage, treatment type, and geographic location, can participate in the study, including women with a history of lung cancer or who are actively receiving treatment for the disease. The survey is located at lungcancerregistry.org; it takes 5 to 15 mins to complete and is strictly confidential. Participants will not be asked to provide identifiable information while completing the survey. Study participants have access to the online questionnaire for 6 months.

The data collected through the SHAWL study will help researchers better understand the effect lung cancer therapies have on women's sex life and intimacy—and, ultimately, identify solutions to improve sexual dysfunction and improve our patients' quality of life.

Patients and clinicians can access the SHAWL Study at www.lungcancerregistry.org/?utm_source=physicianweekly&utm_medium=email&utm_campaign=SHAWL1_content=community.

COPD: Can the Root Cause Be Found in the Airway Tree?

Some people have airways that are too small to adequately serve their lung capacity, explained Benjamin M. Smith, MD, MS, and colleagues in a paper recently published in *JAMA* that helps explain the cause of COPD in patients who are not current or former smokers. This dysanapsis results in increased risk for COPD as these individuals age. The finding emerged from a retrospective analysis of data collected by the 2,531-person Multi-Ethic Study of Atherosclerosis (MESA), the Canadian Cohort of Obstructive Lung Disease (n=1,272) and SPIROMICS, a 2,726-person case control study of COPD.

Among the 2,294 MESA participants without prevalent COPD, 98 developed COPD after a median of 6.2 years. "Compared with participants in the highest quartile of airway to lung ratio, those in the lowest had a significantly higher COPD incidence (9.8 versus 1.2 cases per 1,000 person-years; rate ratio [RR], 8.12; rate difference, 8.6 cases per 1,000 person-years) but no significant difference in FEV_1 decline (–31 versus –33 mL/y; difference, 2 mL/y," the researchers wrote.

There were fewer women in the CanCOLD study—564, which was 44.3% of the cohort—and mean age was 67. More of the CanCOLD participants had incident COPD at 15.0%, which developed at a median of 3.1 years. "The COPD incidence in the lowest airway to lung quartile was significantly higher than in the highest quartile (80.6 vs 24.2 cases per 1,000 person-years; RR, 3.33; 95% CI, 1.89 to 5.85; rate difference, 56.4 cases per 1,000 person-years), but the FEV_1 decline did not differ significantly (–34 vs –36 mL/y; difference, 1 mL/y)," they wrote.

Looking at the 1,206 SPIROMICS patients, the mean age was 65. Among the 542 women with COPD in SPIROMICS who were followed for 2.1 years, "those in the lowest airway to lung ratio quartile had a mean FEV_1 decline of –37 mL/y (15 mL/y), which did not differ significantly from the decline in MESA Lung participants, whereas those in highest quartile had significantly faster decline than participants in MESA Lung (–55 mL/y [16 mL/y]; difference, –17 mL/y; 95% CI, –32 to –3)," the study authors wrote.