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Culture:
Why the US Will Experience 500,000 COVID-19 Deaths

By Robert Pearl, MD

With its "acceptable" death rate and surprisingly high rate of asymptomatic transmission, COVID-19 presents an unsolvable problem in a nation known for the words "give me liberty or give me death." The reality is that we know what to do. We just won't do it. Americans lack the cultural commitment to doing what is necessary to slow the spread of this particular virus. Given our national culture, the United States will continue to experience consistently high rates of cases and deaths until a safe and effective vaccine is broadly administered. And that time is a long way off. In a recent interview, the CEO of Moderna, a leading vaccine developer, told the *Financial Times* he doesn't expect to have approval until the Spring of 2021.

CDC Director Robert Redfield said it would take 6-9 months to get the American public vaccinated once a vaccine is approved. That takes us into the fourth quarter of 2021 at the earliest. And, according to Dr. Anthony Fauci, the chances of a first-round coronavirus vaccine being highly effective are "not great," which means nationwide viral control won't happen until even later. By that time, the math indicates the US death toll will reach half a million. Assuming the current count of 720 deaths a day in October holds steady and projected timelines for a vaccine prove correct, anywhere from 260,000 to 320,000 more people will die over the next 12 to 15 months.

I hope I'm wrong. And I'd be remiss not to recognize that almost anything can occur, including a miraculous medical discovery or a helpful viral mutation. But hoping for a "Hail Mary" solution isn't a viable strategy. The one thing we can say with full confidence is that there won't be any meaningful changes in American culture over the next year and a half. And as a result, the death toll from the current coronavirus will rise far longer and to far higher than most Americans recognize or are willing to acknowledge.

Robert Pearl, MD, is a plastic surgeon and author of Mistreated: Why We Think We're Getting Good Health Care–And Why We're Usually Wrong. *He can be reached on Twitter @RobertPearlMD.*

VIRTUAL CONFERENCE

IDWeek2020

HIGHLIGHTS

New research was presented at IDWeek 2020, the joint virtual annual meeting of the Infectious Diseases Society of America, Society for Healthcare Epidemiology of America, the HIV Medical Association, and the Pediatric Infectious Diseases Society, from October 21-25. The features below highlight some of the studies that emerged from the conference.

Device Eliminates Blood Culture Contamination

Lucy S. Tompkins, MD, PhD, reported zero blood culture contamination events (0.0% contamination rate) and zero false-positive central line bloodstream infections (CLABSIs) out of 4,462 blood cultures drawn with the Steripath Gen2 Initial Specimen Diversion Device (ISDD) during a 4-month study, versus 29 contaminated sets in 922 blood cultures using traditional methods (3.15% contamination rate). "Blood culture contamination is a serious patient safety issue and is associated with several harmful outcomes," said Dr. Tompkins. "Even though Stanford Hospital has a superb phlebotomy team, our team could not always reduce the contamination rate to below 3%, the current industry 'standard'. When using the Steripath Gen2 ISDD on in-patients and ED patients, many of whom are 'hard sticks', our team was able to reduce the contamination rate to zero over the course of a 4-month clinical trial. Our results confirm those of Dr. Mark Rupp whose seminal Steripath ISDD study clearly demonstrated that the ISDD is the most effective way to reduce, and even eliminate, blood culture contamination. Along with many other hospital epidemiologists, I did not initially believe we could reduce CLABSIs to zero. With many changes in practice and policies, it is quite clear that the goal of zero CLABSIs can be achieved. As a result of our experience with the Steripath Gen2, we join others in promoting the goal to establish a new standard of zero for blood culture contamination."

Multidisciplinary Approach Curbs Opioid Use in Patients With IV Drug Use- Associated Infections

In 2018, University of Kentucky (UK) HealthCare reported 400 cases of endocarditis, of which 73% were injection drug use-associated infections. To curb overdose deaths, ease the financial burden on healthcare, and improve patient outcomes, researchers worked with patients who need tools for recovery from opioid use disorder, such as mental health therapists, relapse-prevention services, and necessary medications. Poverty, unemployment, and legal issues are barriers, as well as transportation to treatment for those who live in rural areas—an issue that researchers say came up frequently regarding their patients. Limited access to clinics due to COVID-19-related closings has been a challenge to treatment recently. Among referrals to the program thus far in the ongoing study, 69% were eligible, among whom 625 enrolled. Among them, 35% are receiving medication-assisted treatment and 14.8% are being managed by the UK Infectious Diseases division. Among patients with other service data available, 88% were dispensed naloxone, 47% received relapse prevention services, 25% engaged in peer support, 18% participated in self-help groups, and 20% received transportation aid. "This program shows proof of concept that patients can be engaged in MAT by ID providers," write the study authors.

Dr. Fauci "Cautiously Optimistic" for COVID-19 Vaccine by Year's End

Anthony Fauci, MD, said during a presentation at IDWeek that he is "cautiously optimistic" that a COVID-19 vaccine will be ready by year's end. He noted that the country's "strategic approach" to vaccine development appears to be bearing fruit. Six US companies, he said, are working around the clock to either facilitate vaccine trials or compile the supplies necessary to distribute a COVID-19 vaccine once it is ready. Multiple studies are testing three vaccine approaches, Dr. Fauci said. And five of those studies are already in phase III. "We feel confident that we will have an answer likely in mid-November to the beginning of December," he said. While stressing there is no guarantee of success, Dr. Fauci noted that he is "cautiously optimistic that we will in fact have a safe and effective vaccine by the end of the year, which we can begin to distribute as we go into 2021." At the same time, he took pains to paint a realistic picture of the significant hurdles that lie ahead. There is "a great degree of skepticism and reluctance on the part of some populations to getting vaccinated," he added. Blacks and Hispanics in the United States are much less likely than Whites to say that they will definitely get vaccinated once the option becomes available. "We have a challenge to get these people involved so we can allow them to be afforded the protection that we feel vaccines can give," he added.

Acute HIV Cases Discovered Upon COVID-19 Screening

Although evidence indicates that undiagnosed cases of HIV are often found during routine screening in the ED, acute infections occur less often. Now, due to patients visiting the ED with symptoms similar to COVID-19 infection, patients newly infected with HIV are being diagnosed in greater numbers, according to David Pitrak, MD, of the University of Chicago. During the first 8 months of the COVID-19 pandemic, new cases of HIV infection—all diagnosed in the ED—were found at an annualized rate of 14.4 per year at Dr. Pitrak's institution, compared with a rate of 6.8 during the previous 4 years. "An HIV test is part of the diagnostic and lab evaluation when we evaluate patients at high risk for COVID-19, or who are found to be positive for COVID-19," said Dr. Pitrak. "It is vital to know their HIV status in the setting of such a viral illness." The upsurge in HIV cases may be due to patients confusing acute HIV infection symptoms with COVID-19 symptoms and thus seeking treatment over concerns of the latter, changes in behavior precipitated by the pandemic, or disruptions in care of people living with HIV and their partners or at-risk people using PrEP.

Physicians Taking a Hit in the Wallet by COVID-19

To evaluate the impacts of COVID-19—such as job loss, increased work hours, and the compensation for increased hours and new roles and responsibilities—investigators conducted a national, web-based, 31-item anonymous survey of nearly 600 physicians from community hospitals (49%), academic institutions (44%), and federal facilities (3.8%) in 46 states and the District of Columbia. Among the 31% of respondents who reported increased work hours as a stressor to their job, nearly all said the additional work hours were entirely or partially uncompensated. Negative economic impacts from dealing with the pandemic were reported by 70% of emergency physicians, 63% of anesthesiologists, 60% of surgeons, and 25% of infectious disease specialists. More than one-third of respondents (36%) had new tasks added to their job responsibilities, with 49.1% taking on an advisory role in their institution regarding how to respond to the pandemic and 28.8% involved as an investigator in COVID-19-related research. It's possible that the survey missed physicians who were too busy to even use social media (to be made aware of the survey) or to complete the survey.

Q&A
WITH DR. MEDLAW

Professional Vs. Ordinary Negligence

A patient fell off my examining table. She had felt a bit woozy when I was removing her sutures, so I stopped to give her a breather and stepped out to take a phone call. When I came back, she was on the floor, shaken and upset but not hurt other than a large bruise. She is suing me pro se; I guess she was not able to get a lawyer because she did not have serious damages. She is claiming that I was negligent for leaving her alone. In my state, malpractice claims first require a doctor to attest that the case has merit. My patient did not do this. Can I get the case dismissed?

Not every negligence case against a doctor, or based on an event in a doctor's office, is a malpractice action. Malpractice is professional negligence, a tort that can only occur in the setting of the practice of a profession, in this case medicine. Doctors can, however, also be subject to claims of ordinary negligence.

Claims of ordinary negligence raise issues within the common knowledge and experience of anyone who might sit on a jury or of any judge who might hear the case in a bench trial. Claims of medical negligence raise questions involving medical judgment beyond the common knowledge and experience of non-physicians.

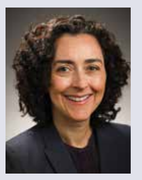
She is probably suing for ordinary negligence, precisely because it is an easier claim to bring. She would say it is within anyone's knowledge that a woozy person on an elevated table without side guards is at risk of falling and should not be left alone.

However, what would be ordinary negligence if it happened in another setting will, if it is part and parcel of the rendering of medical diagnosis or treatment, be legally viewed under the scope of malpractice, because the professional obligation to act non-negligently extends to all aspects of the care, including a safe physical setting. The test is whether the negligent act occurred in the rendering of services for which the healthcare provider is licensed. This is separate from the duty to the patient as just a visitor to the office who is owed a duty of care against dangerous conditions on the premises the doctor controls, just as is everyone else.

In your case, the patient was already in the midst of her appointment and was woozy because you were removing her sutures, bringing it fully into the ambit of medical care, which would then include maintaining her safety on the high table. You can, therefore, move to have the case dismissed. She would have to bring a new case for malpractice—or, since you actually were negligent in leaving her alone while woozy on the table but she was not seriously harmed, you can offer a reasonable settlement.

This article was written by Dr. Medlaw, a physician and medical malpractice attorney. It originally appeared on SERMO, which retains all rights to it.

Bariatric Surgery & Adolescent Nutritional Deficiency Risks



Written by
Stavra Xanthakos, MD, MS
Director
Steatohepatitis Center
Medical Director
Surgical Weight Loss Program for Teens
Professor of Pediatrics
Department of Pediatrics
University of Cincinnati College of Medicine

Research indicates that rates of severe obesity among adolescents are increasing around the world, with no signs of slowing. Although the first recommended intervention for severely obese adolescents remains lifestyle modification, according to Stavra Xanthakos, MD, MS, the majority of patients in this population do not experience significant sustained weight loss with this approach. Evidence suggests that, in an attempt to resolve this issue, the rate of bariatric surgeries conducted on adolescents has increased in recent years. Bariatric surgery can lead to increased quality of life and sustained weight loss, as well as resolve serious comorbidities in adolescents, but it comes with the major long-term risk of developing nutritional deficiencies. With research lacking on how this affects adolescents who have received the intervention, Dr. Xanthakos and colleagues conducted a 5-year study, published in *Clinical Gastroenterology and Hepatology*, to better understand the nutritional risks in adolescents after bariatric surgery.

For the study, the researchers sought to determine the prevalence of nutritional deficiencies after more than 200 adolescents had undergone roux-en-Y gastric bypass or sleeve gastrectomy from 2007-2012. The study team measured serum levels of ferritin; red blood cell folate; vitamins A, D, B1, B12; and parathyroid hormone at baseline and annually. "We broke our analysis into two phases," explains Dr. Xanthakos: "changes in the first year of rapid weight loss and then changes from 1-5 years, after weight had generally stabilized." The team also sought to better understand risk factors associated with developing nutritional deficiencies, in the hope of identifying modifiable factors and ultimately being able to reduce nutritional risk.

Both procedures resulted in similar weight loss, with a mean body mass decrease of 23%. However, sleeve gastrectomy resulted in a lower risk of nutritional deficiencies. The primary risk for sleeve gastrectomy in adolescent patients was iron deficiency, which was increased in patients who did not adhere to recommended dietary supplements. Ferritin levels significantly decreased in both groups at the 5-year mark, with hypo-ferritinemia prevalence of 71% after roux-en-Y gastric bypass and 45% following sleeve gastrectomy. At 5 years post-operation, the prevalence of two or more deficiencies was 59% in those who underwent roux-en-Y gastric bypass, compared with 27% among those who received sleeve gastrectomy. "Beyond surgery type, other risk factors associated with increased nutritional risk after the first year included female sex (iron), interval weight regain after the first year (iron, vitamin D, parathyroid hormone) and black race (vitamin A, vitamin D and parathyroid hormone)," explains Dr. Xanthakos.

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