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To Wear a Mask Is to Be Brave. To Trust Your Doctors Is to Be Brave

By Abubakr Chaudhry, MD

The pandemic is a lie. I will not wear someone else's fear. This is all fake news. It is remarkable to see these statements littered across the news and social media. Individuals with a fairly decent level of understanding and intelligence pandering to these ideas just go to show how strong anti-science culture has become.

On January 19, the first American would test positive for the novel coronavirus. By early February, the hysteria would start to set in and social media would start increasing speculative reporting. By late February, the stress and arguments about who should take responsibility began to boil over. Then there was the increase in fear among healthcare exposure rates, conflicting case fatality reports, and frustrations with the CDC on the flip-flopping in guidelines.

We became tired of the complaining, fear, and misinformation, so we decided to pen a guideline for our hospital. Georgia went on lockdown April 3. Throughout March and April, the world seemed to trust us as the scientific community to lead them through this crisis.

By April, we saw our algorithms were working, and we had some of the best outcomes in the state. People were adhering to the guidelines by staying home. Businesses had shut down, the spread was contained, and we could see the light at the end of the proverbial tunnel. Then, on April 24—with 892 deaths and 22,147 infected in GA—the lockdown restrictions were eased in our state. We were one of the last to close but the first to reopen. We knew the world needed to open; we just didn't know our world would open like this. I remember wondering why we couldn't mandate masks, contact tracing, and social distancing when we reopened. The virus became political.

When I started writing this, I was upset at a social media comment I read from a friend that read, "This pandemic is a joke, I will not wear a mask because I will not wear their fear." Now, I see that he was afraid and uninformed. People, in general, are still afraid, if not of the virus, then of loneliness, poverty, or even subjugation. When people exhibit these fears, and if their voices are loud, the politicians must bend to their will. If our politicians are afraid and their voices alleviate our fears, then we bend to *their* will. My point is, it is OK to be afraid. I am a pulmonary and critical care doctor, my wife is a pediatric intensivist, we have a small child, and we are afraid. But to wear a mask is to be brave. To social distance is to be brave. To trust your doctors is to be brave. To those with doubts, know that you are correct in your feeling that the system is broken. I don't know how to fix it, but I know that it has to be done soon. Help us get through this so we can build a better world: a world built from understanding, not from fear.

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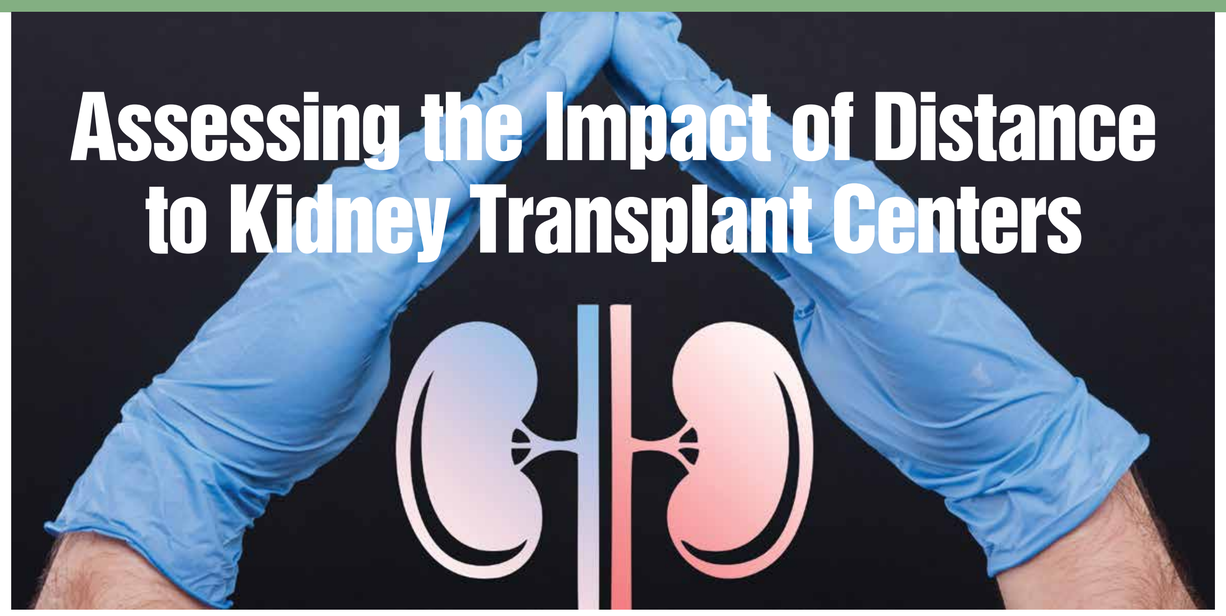

Assessing the Impact of Distance to Kidney Transplant Centers

Distance to a kidney transplant center may be a barrier for patients living more than 90 miles from the nearest center, according to a study. These patients may benefit from transplant center-associated satellite locations and restructuring of the kidney transplant medical evaluation process to reduce the number of visits to such centers that are needed to complete the evaluation.

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Most patients with end-stage kidney disease (ESKD) who are on dialysis will need to be referred from a dialysis facility to a kidney transplant center for a medical evaluation to potentially begin the transplant process. Currently, the United States has slightly more than 250 adult transplant centers, but there are well over 7,000 dialysis facilities throughout the country. As such, transplant centers may be less accessible to referred dialysis patients. Studies have suggested that the average one-way driving distance from a patient's home to the nearest dialysis facility is about 8 miles, but the mean distance between a transplant patient's home and the nearest transplant center is 23 miles.

"In previous literature, patients and nephrologists—particularly in rural locations—viewed distance and access to transportation as barriers to kidney transplant," explains Laura J. McPherson, MPH. "However, the early steps in the kidney transplant process, like referral and initiation of an evaluation at a transplant center, are not routinely studied because they are not currently collected in national surveillance data."

Taking a Closer Look

For a study published in the *Clinical Journal of the American Society of Nephrology*, McPherson and colleagues assessed the association of distance to transplant center with timely transplant center referral and evaluation initiation among patients with ESKD in the southeastern United States, a region that has historically had the lowest transplant rates in the US. The authors identified more than 27,000 adults who began treatment for ESKD at any Georgia, North Carolina, or South Carolina dialysis facility and assessed the impact of distance from the patient's residential zip code to the nearest transplant center.

The investigators did not find an association between distance from a patient's residential zip code to the nearest transplant center and referral for kidney transplant evaluation or evaluation initiation at a transplant center (Table). "However, our results suggested that distance to a transplant center may be a barrier for a subset of patients living more than 90 miles from the nearest transplant center in this region of the country," says McPherson.

In addition, the study examined associations among patient subgroups that may be more vulnerable to traveling far distances to a transplant center. "We still did not find an association between distance and access to early steps in the transplant process when we considered specific factors like race/ethnicity, socioeconomic status, neighborhood poverty, or urban/rural residential location," McPherson says.

Assessing Implications

Based on the findings, distance to the nearest transplant center does not appear to be the primary driving force in accessing kidney transplant in the southeastern US, according to McPherson. "Patients who live the farthest from the nearest transplant center—those more than 90 miles away and/or from rural areas—may benefit from additional transplant center-associated satellite clinic locations or a more streamlined evaluation process that reduces the number of visits patients need to make to a center to complete the evaluation," she says. "Other factors in the same genre as distance, like travel time or lack of transportation, may have a larger impact on these early steps in the kidney transplant process."

McPherson says their analysis was limited to dialysis patients in Georgia, North Carolina, and South Carolina because referral and evaluation initiation data is currently only available in that region. "Our research team is currently working to collect these data in the Northeast and Ohio River Valley," she says. "We also intend to examine if there is homogeneity in our results in the southeastern US across other geographic regions. In addition, we need studies to explore the role of other factors, including travel time, public transportation availability, or inability to find a caretaker for children or elderly relatives, to better understand geographic-based factors that can impact access to these early steps in the kidney transplant process."

Table Examining the Distance Effect

The table below depicts results from adjusted models showing the effect of distance on patients with end-stage kidney disease (ESKD) referrals and transplant center evaluation initiation among referred patients from 2012 to 2015:

Distance	Odds of Referral Within 1 Year of Dialysis Start* Adjusted Odds Ratio (95% CI)
Proportion of patients referred by distance category	
<15 miles	1.00 (reference)
15-30 miles	1.08 (0.96 to 1.22)
31-60 miles	1.07 (0.95 to 1.22)
61-90 miles	0.96 (0.84 to 1.10)
>90 miles	0.87 (0.74 to 1.03)
Proportion of patients initiating evaluation by distance category among those referred	**Odds of initiating evaluation within 6 months of referral among those referred****
<15 miles	1.00 (reference)
15-30 miles	1.14 (0.97 to 1.33)
31-60 miles	1.12 (0.94 to 1.35)
61-90 miles	1.04 (0.87 to 1.25)
>90 miles	0.89 (0.72 to 1.11)

*Model was adjusted for age, race, attributed cause of ESKD, atherosclerotic heart disease, other cardiac disease, cerebrovascular disease, peripheral vascular disease, diabetes, chronic obstructive pulmonary disease, cancer, insurance type, facility for-profit status, neighborhood race, neighborhood education, urban/rural, and state (model n=25,231).

**Model was adjusted for age, race, attributed cause of ESKD, atherosclerotic heart disease, other cardiac disease, cerebrovascular disease, peripheral vascular disease, diabetes, COPD, insurance type, neighborhood race, neighborhood education, neighborhood poverty, urban/rural, and state (model n=9179).

Abbreviation: 95% CI, 95% confidence interval.

Source: Adapted from: McPherson LJ, et al. *Clin J Am Soc Nephrol.* 2020;15(4):539-549.

QA 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.

In Case You Missed It

Removing Race Classifier Would Impact Care in African Americans With CKD

About one in three African American patients with chronic kidney disease (CKD) would be reclassified to a more severe CKD stage if the race classifier were removed from the Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) equation, according to a study published in the *Journal of General Internal Medicine*. Researchers examined the impact of the race multiplier for African Americans in the CKD-EPI estimated glomerular filtration rate (eGFR) equation on CKD classification and care delivery. Data were included for 2,225 African-American patients in the Partners HealthCare System CKD Registry. If the race multiplier were removed from the CKD-EPI equation, 33.4% of the African-American patients would hypothetically be reclassified to a more severe CKD stage; 24.3% would be reclassified from stage 3B to stage 4 and 3.1% would be reassigned from eGFR >20 to ≤20 mL/min/1.73 m², meeting the criterion for accumulating kidney transplant priority. After the race multiplier was removed, 64 patients were reclassified from eGFR >20 to ≤20 mL/min/1.73 m²; none of these patients were referred, evaluated, or waitlisted for kidney transplant, compared with 19.2% of African-American patients with eGFR ≤20 mL/min/1.73 m² using the default CKD-EPI equation. "Considering the inequities in kidney care and outcomes for black patients, use of the eGFR race correction factor needs to be reconsidered," a coauthor said in a statement.

Hospital Outcomes Worse for Children With Chronic Kidney Disease

Among children who are hospitalized, pediatric chronic kidney disease (CKD) is associated with longer length of stay (LOS) and increased costs compared with other chronic illnesses, according to a study published in the *American Journal of Kidney Diseases*. Investigators conducted a cross-sectional national survey of pediatric discharges to examine the association of CKD with hospital outcomes. Data were included for children with a chronic medical diagnosis included in the Health Cost and Utilization Project Kids Inpatient Database for 2006, 2009, 2012, and 2016. During the study period, a chronic medical condition was present in 6,524,745 estimated discharges, and CKD was present in 3.9% of discharges. LOS was longer for those with versus those without a CKD diagnosis (median, 2.8 versus 1.8 days). Compared with those without CKD, those with CKD had a higher median cost ($8,755 versus $5,016 per hospitalization). The presence of CKD was associated with longer LOS (29.9%), higher cost (61.3%), and higher mortality risk (odds ratio, 1.51). "These outcomes seem to be due to the higher complexity of CKD discharges compared to discharges with other chronic illnesses. Investigation is needed to identify modifiable patient characteristics and health care delivery with the aim of developing and testing interventions to reduce the adverse health outcomes of pediatric CKD in the US," the authors write.