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A COVID Love Note from a Mother Physician

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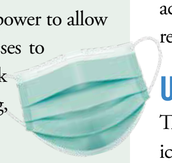
The media is reporting the division of "sides" people are taking when it comes to the pandemic. Political agendas are pervasive and infiltrate people's thoughts around COVID-19. As a physician, I think it's important that patients have facts media may not report. Two key numbers are driving behaviors around COVID-19: the positivity and death rates.

While important, these numbers don't describe the main impact of the virus: *Thousands of problems, loss, illnesses, and injuries that live between a positive test and a death rate in a person infected with coronavirus.* This morbidity is the bread-and-butter of what we do every day. It's what requires millions of dollars' worth of healthcare every year, hours of labor and lost wages, destruction of family's income, grief, and despair. What's hurting our economy just as much is morbidity.

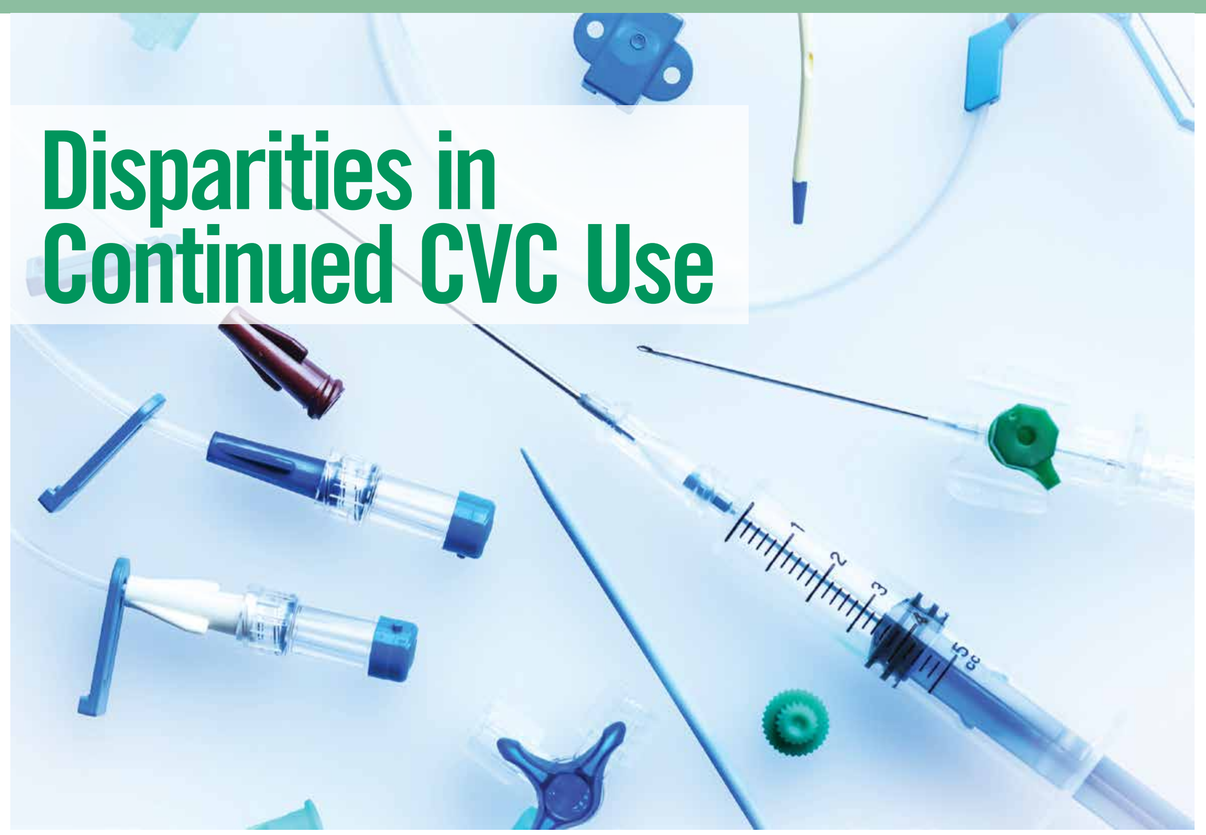
Coronavirus is causing blood clots, strokes in people who wouldn't normally be at risk, and significant respiratory problems that don't allow healthy people to walk up a flight of stairs; attacking hearts, causing young people to suffer from heart failure; leading to kidney problems and respiratory failure; and causing such extreme fatigue that people can't go back to work for weeks or even months. You can imagine what that would do to your family: lost wages, lost jobs, stressed coworkers who have to pick up the slack, fewer resources, loss of ability to take care of or teach children or take care of elderly parents.

The public doesn't read about these things in the statistics, because these are not being captured by every health system; we are overwhelmed treating these issues, and also, the media can't report on individual morbidity for privacy reasons. I want my community to know this. I wish all of us would understand the importance of wearing a mask. *Because here's the most important thing: we can actually stop morbidity from rising.* We can stop the spread of the virus. Simple, routine actions have the power to allow kids to return to school, businesses to bounce back, and us to get back to shopping, eating out, traveling, and all things we love and need.



If we all make things like wearing a mask, social distancing, and not gathering inside in large groups a priority, we can change the course. And isn't that what we want? People are going to read this and accuse me of spreading fear. Or politicizing. I am not a fearful person, nor do I consider myself overtly political. I am a doctor, and I am an advocate for my community to be healthy. I want to *encourage you* that it's within our power. I'm coming from a position of expertise—but also a position of love. Love for you and love for one another.

A full version of the following was originally posted at becomebraveenough.com.



Disparities in Continued CVC Use

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Research indicates that despite efforts to increase arteriovenous fistula (AVF) and graft (AVG) use—through the Fistula First Catheter Last Initiative (FFCL)—because of the higher mortality and infectious complications associated with central venous catheters (CVCs), 80% of patients in the United States start hemodialysis on a CVC. Studies have also shown "that nonwhite patients tend to initiate hemodialysis with AVF less frequently than white patients, even when controlling for factors such as age, comorbidities, medical insurance status, and nephrology care," explains Shipra Arya, MD, SM, FACS. "Combined with evidence that AVFs are also less prevalent in women, this suggests racial/ethnic and sex differences in incident AVF access, although evidence also supports biologic reasons for these disparities."

Uncovering Disparities

The inclusion of an access type indicator in Medicare dialysis claims beginning in 2010 allowed Dr. Arya, Elizabeth George, MD, and colleagues to take an innovative approach to studying the natural history of CVC use and longitudinal use of hemodialysis access that was not possible prior. For a study published in the *Journal of the American Society of Nephrology*, the researchers explored the transition from CVC to AVF or AVG among a Medicare-eligible population who started hemodialysis on a CVC between 2010 and 2013 in order to determine any sex or racial disparities in these dialysis access quality metrics. An examination of longitudinal measures of CVC access was followed by a competing-risk model.

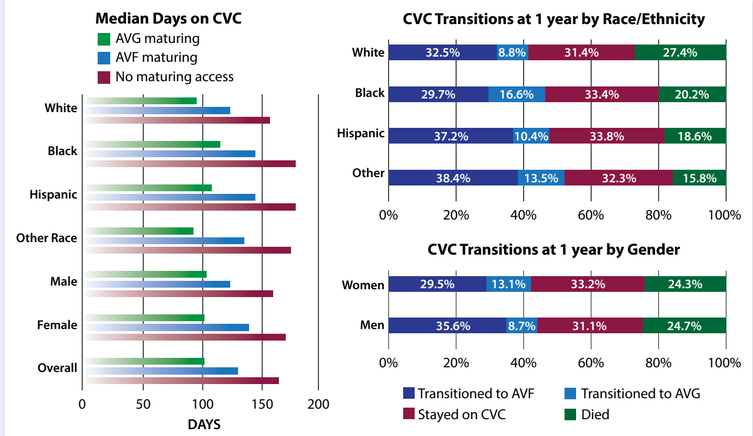
"We found that the average patient in the US waited approximately 7 months on dialysis with a CVC before transitioning to a permanent access," says Dr. Arya (Figure). "At 1 year after hemodialysis initiation, 32.7% of patients had transitioned to AVF and 10.8% to AVG, while 32.1% stayed on a CVC and one-quarter had died." Women spent significantly longer on CVC than did men, as did patients who were black, Hispanic, or of another racial/ethnicity minority when compared with white patients. "Overall, more patients transitioned to AVF than AVG, even when stratified by sex and race/ethnicity," Dr. George adds. "At 1-year follow-up, a higher percentage of women had transitioned to AVG compared with men, and there were similar rates of both death and continued CVC use among men and women. Similarly, double the proportion of black patients transitioned to AVG compared with white patients. Interestingly, 1-year mortality was higher in whites compared with blacks, Hispanics, and other ethnicities, so the differences are not entirely explained by concerns for durability of dialysis access."

As expected, proactive placement of a permanent access decreased the median time patients underwent hemodialysis through a CVC. "What is more surprising," says Dr. George, "are the racial, ethnic and gender disparities in length of time on a CVC despite having an access site in place. Specifically, women had 2-3 weeks longer transition time regardless of whether there was permanent access in place at the time of hemodialysis initiation, and black patients spent, on average, approximately 40 more days on CVC compared with white patients."

Continuing to Fall Short

With the study results demonstrating racial/ethnic and sex differences in AVF prevalence and more than 70% of participants failing to transition off CVC over 90 days, Dr. Arya says "we continue to fall significantly short" on main goals of the FFCL. "There is an urgent need for clinicians and policymakers to shift focus to minimizing catheter use for patients starting hemodialysis through CVC," she adds. "Special outreach and intervention strategies focused on women and minority patients may be needed to facilitate quicker transition. Future work should focus on understanding the system level and process mechanisms behind the prolonged CVC use in the United States and re-evaluating strategies to decrease time on CVC, especially in these patient populations."

Figure Outcomes



Abbreviations: AVF, arteriovenous fistula; AVG, arteriovenous graft; CVC, central venous catheter.

Source: Adapted from: Arya S, et al. *J Am Soc Nephrol*. 2020;31(3):625-636.

Dealing With Non-Compliant Patients: Using Facts in Your Defense

The following is a continuation of the MedLaw column in the January issue.

If, despite your best efforts, your patient suffers a poor outcome and you are being sued for malpractice, you would ideally like to stop the process before it reaches the courtroom. To that end, your attorney would file a Motion for Summary Judgment, asking the judge to dismiss the case as a matter of law because the plaintiff cannot meet their burden of proof. The plaintiff would be required to "lay bare their proof" that it was actually your conduct that was the proximate cause of the harm.

The judge may decide the Motion on papers alone or may hold a hearing at which the attorneys can offer argument, but there will not be any witnesses called. Your "witness" will, therefore, be the medical record. Courts generally loathe to deny a plaintiff their day in court, and so the record must be very clear as to the patient's resistance to your efforts to work with them and your informing them of the serious consequences of their non-compliance and of the likelihood that it would cause the very harm that they then suffered.

If this Motion fails and the matter proceeds to trial, you still have strong defenses to raise based on the patient's non-compliance:

- Contributory negligence is an archaic defense that is still retained in few jurisdictions. It holds that a plaintiff who has any fault at all in their injuries may not recover damages for those injuries. If you are in one of those jurisdictions, your ability to demonstrate that patient non-compliance contributed at all to the claimed harm will bar any recovery against you.
- Comparative negligence does exactly what its name implies: it compares the level of fault for each side. In some jurisdictions, no amount of plaintiff fault bars recovery, and in others, there is a cut-off beyond which the plaintiff is barred. If a case goes through, any recovery will be offset by the proportion of the plaintiff's fault. In any comparative negligence jurisdiction, patient non-compliance will be a critical issue, because even if the case is not barred and the patient wins, damages will be reduced.

The plaintiff's duty of mitigation applies to the conduct of the patient after a harm has been recognized. Plaintiffs must show that they did what they reasonably could to minimize the effect that the negligence for which they are suing had on them. Even if you do have actionable liability for an error of your own, a patient non-compliant with well-advised recommendations for correction comes into evidence and acts as a damages offset.

When dealing with a persistently non-compliant patient, think ahead to how you would counter a malpractice claim when you create the record. A clear contemporaneous record of the patient's ongoing non-compliant conduct despite your efforts to have them act in a medically responsible way is the key to a solid defense.

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

In Case You Missed It

Most Kidney Patients OK With Getting Text Reminders on Care

Adults living with kidney failure are receptive to using mobile devices to help with their care, according to a study published the *Clinical Journal of the American Society of Nephrology*. Mobile health can provide many benefits for patients, especially for those whose care is complicated and who have dietary restrictions. Whether people on dialysis are ready to incorporate mobile technology into their care would be a limiting factor. "Importantly, mobile technology has been used to improve treatment adherence; address patient-reported symptoms in real time; improve nutrition, activity and mental health; assist in empowering patients to reverse the predominantly one-way care delivery system, and place the patient at the center of their own health care," said the lead author. Among 949 dialysis patients surveyed for the study, approximately 80% owned smartphones or other Internet-capable devices, such as tablets. About 72% said they use the Internet, and 70% had intermediate or advanced proficiency in mobile health. The main reasons for using mobile health were making appointments, communicating with healthcare personnel, and obtaining lab results. The main concerns with mobile health were privacy and security. Older patients, those who were Hispanic, and those with less than a college education were less adept with mobile health, while employment was associated with higher proficiency. "Mobile health can be utilized to bring a number of interventions that can help people on dialysis manage their health and improve independence," said the lead author, adding the findings should encourage healthcare providers and tech developers to invest in mobile health innovations.

Stress From Not Achieving Goals Tied to Worse Kidney Disease

Stress related to not achieving goals is associated with a greater risk for rapid kidney function decline (RKFD) in African Americans, according to a study published in the *Journal of Investigative Medicine*. Investigators explored the association between goal-striving stress (GSS) and RKFD among 2,630 African Americans using data from the Jackson Heart Study (2000 to 2004 and 2009 to 2013). The incidence of RKFD in this sample was 7.34% during a mean 8.06 years of follow-up. The mean GSS was 3.80, with the total GSS score ranging from 0 to 36. After full adjustment, those who reported high versus low GSS scores were more likely to experience RKFD (incidence rate ratio, 1.60). When adding cortisol to the model, those who reported high GSS had 1.58 times the rate of RKFD as participants reporting low GSS scores (incidence rate ratio, 1.58). "Researchers and clinicians should continue to explore nontraditional risk factors in an effort to explain and prevent racial disparities in kidney disease," the study authors write.