

BMJ Open Nephrologists' perspectives on the impact of COVID-19 on caring for patients undergoing dialysis in Latin America: a qualitative study

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ABSTRACT

Objective To describe the experiences of nephrologists on caring for patients undergoing in-centre haemodialysis during the COVID-19 pandemic in Latin America.

Design Twenty-five semistructured interviews were conducted by Zoom videoconference in English and Spanish languages during 2020 until data saturation. Using thematic analysis, we conducted line-by-line coding to inductively identify themes.

Setting 25 centres across nine countries in Latin America.

Participants Nephrologists (17 male and 8 female) were purposively sampled to include diverse demographic characteristics and clinical experience.

Results We identified five themes: shock and immediate mobilisation for preparedness (overwhelmed and distressed, expanding responsibilities to manage COVID-19 infection and united for workforce resilience); personal vulnerability (being infected with COVID-19 and fear of transmitting COVID-19 to family); infrastructural susceptibility of dialysis units (lacking resources and facilities for quarantine, struggling to prevent cross-contamination, and depletion of personal protective equipment and cleaning supplies); helplessness and moral distress (being forced to ration life-sustaining equipment and care, being concerned about delayed and shortened dialysis sessions, patient hesitancy to attend to dialysis sessions, being grieved by socioeconomic disparities, deterioration of patients with COVID-19, harms of isolation and inability to provide kidney replacement therapy); and fostering innovative delivery of care (expanding use of telehealth, increasing uptake of PD and shifting focus on preventing syndemics).

Conclusion Nephrologists felt personally and professionally vulnerable and reported feeling helpless and morally distressed because they doubted their capacity to provide safe care for patients undergoing dialysis. Better availability and mobilisation of resources and capacities to adapt models of care, including telehealth and home-based dialysis, are urgently needed.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ Semistructured interviews were conducted with nephrologists purposively sampled across nine countries to obtain in-depth and diverse data on their perspectives on the impact of COVID-19 on caring for patients undergoing dialysis in Latin America.

⇒ The range of perspectives and challenges obtained will inform the need to improve access to care during the COVID-19 pandemic.

⇒ All participants were from Latin America, and thus the transferability of the findings beyond this region is uncertain.

impeded access to treatment among individuals with chronic illness, including patients with kidney failure undergoing maintenance dialysis.¹ For patients undergoing long-term dialysis, their risk of acquiring COVID-19 is estimated to be five times higher, and they are four times more likely to die than the general population.²

The pandemic has seen major reconfiguration of care in many health institutions to manage the increased demand to care for people with COVID-19. Unfortunately, this has inadvertently shifted resources away from the care of patients with other medical conditions, including kidney disease. Dialysis units have been faced with unprecedented challenges. For patients undergoing in-centre haemodialysis (HD), physical distancing within the unit and during transportation can be difficult.³ Clinicians caring for patients undergoing dialysis have encountered a shortage of personal protective equipment (PPE) and could not access quarantine facilities for patients with infection.⁴ Preventing infection in dialysis facilities is particularly challenging in resource-limited settings. For



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INTRODUCTION

The SARS-CoV-2-related disease (COVID-19) pandemic has disrupted, delayed and

example, guidelines recommend against that the reuse of dialysis filters⁵; however, this remains to be common practice in some resource-limited settings, including in Latin America. Such regions also contend with an increased risk of SARS-CoV-2⁶ because of high-density housing and large socioeconomically disadvantaged communities.

However, little is known about nephrologists' experiences providing care to patients undergoing dialysis, particularly in low-resource settings with high rates of COVID-19 infection, including Latin America. This study aims to describe nephrologists' perspectives on providing care to patients undergoing dialysis during the COVID-19 pandemic to inform strategies for improving the quality and safety of care for patients undergoing dialysis.

METHODS

We used the Consolidated Criteria for Reporting Qualitative Health Research⁷ (online supplemental file 1).

Patient and public involvement

Patients were not involved in this study as this study aimed to describe the perspectives of clinicians.

Participant selection

Nephrologists caring for adults undergoing dialysis, including HD and peritoneal dialysis (PD), in Latin America, irrespective of years of clinical experience in dialysis settings, were eligible to participate. We used purposive sampling to include participants across a diverse range of ages, gender, years of clinical experience and countries. Nephrologists were identified through our professional networks (Sociedad Latinoamericana de Nefrología e Hipertensión) and invited by email to participate. Participants could nominate other colleagues to participate.

Data collection

The interview guide was developed based on the literature and discussion among the investigators (online supplemental file 2). Two authors (AMG and AH) conducted semistructured interviews in English or Spanish language (as preferred by the participant) by Zoom videoconference from June 2020 to November 2020 until data saturation. Author AMG, a PhD candidate with experience in qualitative studies, had practised as a dietitian in dialysis units in Chile. Her interest in the impact of COVID-19 and knowledge of the health system informed the conceptualisation of the research, design, data collection and analysis. The interviews were recorded and transcribed in English and Spanish.

Data analysis

Using inductive thematic analysis and drawing from the principles of grounded theory, AMG performed line-by-line coding of the transcripts, used constant comparison within and across transcripts, and inductively identified preliminary concepts. Similar concepts were grouped into themes and subthemes, and patterns were

identified among themes. The interview transcripts were imported into HyperRESEARCH V.4.0.1 (ResearchWare, Randolph, Massachusetts, USA). Investigators AH, EL, SC and AJ reviewed the themes to ensure that the analysis captured the full range and depth of the data obtained. We conducted member checking, whereby the preliminary findings were sent to participants for comment and any additional insights were integrated into the final analysis.

RESULTS

Participant characteristics

All 25 invited nephrologists (100% response rate) participated from 25 centres across nine countries (Chile, Colombia, Uruguay, Guatemala, Peru, Bolivia, Brazil, Argentina and Mexico) (table 1). Of the participants, 8 (55%) were women; 17 (59%) were from countries where English was not an official language; and 9 (18%) were from low-income and middle-income countries. The average duration of the interviews was 35 min (ranging from 30 min to 42 min). Nine participants responded to the preliminary findings and confirmed that the findings captured their perspectives.

Themes

We identified five themes: shock and immediate mobilisation for preparation, personal vulnerability, infrastructure susceptibility of the dialysis unit, helplessness and moral anguish, and promotion of innovative provision of care. The respective subthemes are described as follows, with illustrative quotations provided in table 2.

The conceptual links are shown in figure 1.

Shock and immediate mobilisation for preparedness

Overwhelmed and distressed

Participants were overwhelmed and unprepared for the sudden and severe consequences of COVID-19 and were distressed by the high mortality rates in patients undergoing dialysis. They faced 'chaos' and a 'tsunami of demands' in making rapid changes to minimise the risk of infection in the dialysis setting and to accommodate an unexpected increased 'demand' in the number of patients requiring acute dialysis. It was stressful and exhausting having to constantly remain 'alert' in facing such a medical emergency.

Expanding responsibilities to manage COVID-19 infection

Some took on additional responsibilities and cared for non-dialysis patients with COVID-19 and thus felt pressure to acquire high-level skills for treatment they were less familiar with, for example, oxygen therapy and mechanical ventilation: 'In hospitals, they throw you to the wolves without you knowing how to provide oxygen; they tell you: just do it'. For some, having to administer treatments for managing COVID-19 was 'new' and challenged their 'comfort zone'.

Table 1 Participant characteristics (N=25)

Characteristic	Number	%
Sex		
Female	8	32
Male	17	68
Age group (years)		
30–39	1	4
40–49	8	32
50–59	10	40
60 and over	6	24
Centre volume (number of patients undergoing dialysis)		
1–20	3	12
21–40	1	4
41–60	2	8
More than 60	19	76
Dialysis setting*		
Outpatient dialysis units	14	56
Hospital	16	64
Care for patients with confirmed COVID-19		
Yes	21	84
No	4	16
Tested for COVID-19		
Yes	12	48
No	13	52
COVID-19 test result		
Positive	1	4
Negative	24	96
Country*		
Chile	13	52
Colombia	3	12
Uruguay	2	8
Guatemala	2	8
Peru	1	4
Bolivia	1	4
Brazil	1	4
Argentina	1	4
Mexico	1	4

*Percentage may not equal to 100% as participants could have experience in multiple settings.

United for workforce resilience

Dialysis centres faced a critical shortage of staff; some nephrologists were unable to work because their older age placed them at increased risk for worse outcomes if infected with COVID-19, and other nephrologists were unavailable because they strived to work on 'the front line'. Younger participants were committed to help because they believed they had a lower risk of developing severe disease. Confronting the pandemic together

cultivated team solidarity, and they were conscious of supporting each other: 'Every day we would discuss, talk, and approach the health staff, with questions like how you are doing, how are you, or what you need?' Some chose to prioritise their clinical responsibility to patients over their own personal commitments: 'I put aside crucial personal things temporarily because this is my job'.

Personal vulnerability

Being infected with COVID-19

Participants were terrified about their own risk of being infected with COVID-19 and tried to stay healthy and said they were 'fighting and resisting' the virus. They stated, 'it was very uncertain, we are waiting to get sick, we don't want to expose ourselves'.

Fear of transmitting COVID-19 to their family

Some were worried about bringing the virus home and infecting family members. That was their 'primary concern' because they could not predict if their family would be exposed to severe illness and even death from COVID-19. Some noted their colleagues suspended clinic work because they had vulnerable family members, or those who continued to work chose to isolate themselves from their family: 'I sent my family away from Santiago these 5 months, because it was very intense'.

Infrastructural susceptibility of the dialysis unit

Lacking resources and facilities for quarantine

Participants despaired for patients who had COVID-19 as there were insufficient quarantine facilities in the dialysis unit to meet the demand. They could not isolate patients with COVID-19 from their family members. In some countries, participants felt helpless as dialysis units were 'running out of space and collapsed'. Participants were devastated as their patients could not access dialysis and died at home.

Struggling to prevent cross-contamination

At the onset of the pandemic, participants turned much of their attention and resources to preventing exposure to COVID-19. It was challenging to enforce social distancing, avoid 'crowds in the waiting room', and for staff and patients to wear PPE. Participants noted that patients took their masks off in the vehicle in which they were transported to and from the dialysis unit: 'if one patient becomes infected, he or she will infect the entire van because they spend more than an hour and a half or two hours being transported by the van in a closed space'. In some countries, reusing dialysis filters were no longer permitted: 'here we reuse the dialysis filters. That procedure had to be suspended also when patients had coronavirus'.

Depletion of PPE and cleaning supplies

Some faced an insufficient supply of PPE for patients and clinicians: 'you cannot give everything to everyone because there is a lack of resources'. It was stressful to ration supplies between patients and clinicians: 'we

Table 2 Selected illustrative quotations to support each theme

Theme	Quotations
Shock and immediate mobilisation for preparedness	
Overwhelmed and distressed	<p>We become in little machines to make decisions, with a high emotional cost. (Male, 40–49 age group, Chile)</p> <p>200 dead in one day, dam! there is a stab in the back. The distress of colleagues and the health professionals is enormous. (Male, 60–69 age group, Chile)</p> <p>It is shocking to see all the mortality. It has been painful for our patients and us. Every week they inform us:(patient A, B, C) did not survive and died. (Female, 50–59 age group, Chile)</p>
Expanding responsibilities to manage COVID-19 infection	<p>We went as a team, gaining experience, but at first, it was like a hit in my head. We did not know what we were up against. (Female, 50–59 age group, Chile)</p> <p>I have had to learn a lot about COVID, about acute kidney failure, about mechanical ventilation, because of this emergency. (Male, 40–49 age group, Chile)</p> <p>So, we have to adapt, study and collect others' experiences since nothing was known about this virus. Everything has been new. (Female, 30–39 age group, Chile)</p>
United for workforce resilience	<p>Everything has changed in my life. I was focused on being well to collaborate and being useful in the pandemic, putting aside personal projects because this is my vocation. I could not subtract myself, there was a spirit to serve, help, and resist. (Female, 30–39 age group, Chile)</p> <p>We had a very nice movement, lovely behaviour of the health workers, students. They proactively asked to help because they are young, and low risk. (Male, 47–49 age group, Brazil)</p> <p>During this COVID period, we have learned to work as a team, everyone giving his best. (Male, 40–43 age group Chile)</p>
Personal vulnerability	
Being infected with COVID-19	<p>It was very uncertain, waiting to get sick, exposing oneself, or hiding. I was scared. (Male, 40–49 age group, Chile)</p> <p>How to combat the fear of getting ill, first as a human being, and then as a member of a health team. How to prevent the infection from your patients, and it does not affect you. (Male, 60–69 age group, Chile)</p> <p>When the patients got infected, I checked their symptoms when I got home. "This hurts me, it hurts there". (Female, 60–60 age group, Chile)</p>
Fear of transmitting COVID-19 to family	<p>I am most concerned about spreading the virus to my family rather than getting sick myself. (Female, 50–59 age group, Chile)</p> <p>Old and young people have died, and you can be responsible for infecting your family members by bringing the virus home. (Male, 50–59 age group, Colombia)</p> <p>Health personnel with risk factors, or who fear infecting their family members, were absent. (Female, 30–39 age group, Chile)</p>
Infrastructural susceptibility of dialysis unit	
Lacking resources and facilities for quarantine	<p>Having no control during the pandemic has made it impossible for patients to access medicine. We are running out of space in the units because they have not been followed up on, have stage five and need dialysis urgently. (Male, 40–49 age group, Bolivia)</p> <p>Patients cannot eat anymore during the dialysis session, we have had to adapt the dialysis centres 24x7 with separations, so they have the minor contact possible. (Male, 40–49 age group, Chile)</p> <p>The dialysis access has been cut off. "We are trying to make our stage five patients endure as long as possible, medically and nutritionally, to prevent complications. (Female, 50–59 age group, Chile)</p>
Struggling to prevent cross-contamination	<p>Dialysis patients do not have a quarantine; it is an armchair and a different shift than usual. (Female, 50–59 age group, Chile)</p> <p>Some patients must take public transportation to go home... This is exactly the opposite of what we are trying to prevent cross-contamination in the units, to take care of them. (Male, 40–49 age group, Brazil)</p> <p>Some patients have bought biosecurity suits and wear them while walking in the street or while putting on gloves without washing their hands. (Male, 40–49 age group, Bolivia)</p>
Depletion of PPE (personal protective equipment) and cleaning supplies	<p>We wore shoe covers that, after a short time, were no longer available due to a lack of resources. So you place quaternary ammonium rubbers on the floor to clean feet. (Male, 60–69 age group, Chile)</p> <p>As opposed to using alcohol on hands, they put a hand wash at the entrance. "We were doing it due to lack of supplies, to protect them and ourselves. (Female, 40–49 age group, Chile)</p> <p>Our protections were not sufficient, so it was very scary. (Female, 30–39 age group, Chile)</p>
Helplessness and moral distress	

Continued

Table 2 Continued

Theme	Quotations
Forced to ration life-sustaining equipment and care	<p>The most severe problem is access to respirator treatment. There have been many such cases, and we have seen many deaths at home. (Male, 50–59 age group, Chile)</p> <p>They do not seem to take the patients into account much. They treat them like high-risk patients without recovery and don't put them on a ventilator. (Female, 60–69 group of age, Chile)</p> <p>I understood that the patient died from a lack of dialysis, not from severe organ failure. However, the patient died because of the lack of access to dialysis. (Male, 40–49 age group, Chile)</p>
Concerned about delayed and shortened dialysis sessions	<p>Patients did not receive an accurate dialysis because of all covid protocol measures you have to take. (Female, 50–59 age group, Chile)</p> <p>We reduced dialysis time because the hospitals and private units were overstretched. So dialysis is sometimes started late, or the dose is not adequate. (Male, 40–49 age group, Chile)</p> <p>We do not provide the best quality dialysis because we have less staff to dialyze people, and I have to dialyze people shorter. (Male, 40–49 age group, Chile)</p>
Patient refusal to attend dialysis sessions	<p>Some patients are afraid of going to the hospital. Other patients take medications on their own, to avoid going to the institution. (Male, 50–59 age group, Peru)</p> <p>Due to COVID, a patient decided to come only twice a week. A revolver cannot be held to his head to make him attend all three sessions. (Female, 60–69 age group, Uruguay)</p> <p>A fourth shift of dialyzing COVID-positive patients was started this morning at the largest public hospital. Therefore, patients staged a hunger strike at the entrance door. They were refusing to let patients in because they believed they would infect them. (Male, 40–49 age group, Bolivia)</p>
Grieved by socioeconomic disparities	<p>It is very difficult to realize that people who undergo dialysis are really sick and have no other alternatives. (Male, 40–49 age group, Chile)</p> <p>Many patients do not work and receive miserable pensions. They are also unable to go out and cannot afford food. (Male, 60–69 age group, Chile)</p> <p>The lack of access to hospital beds in sectors where the poorest are dialyzed is quite shocking. Consequently, many of them die. (Male, 40–49 age group, Chile)</p>
Deterioration of patients with COVID-19	<p>We have seen that people, both the staff and patients with positive covid, are very physically impaired. (Male, 60–69 age group, Chile)</p> <p>After the worst moment, we were left with many chronic patients, and what we deeply owed was rehabilitation. Sadly, these patients were wasted after spending two, three, or four weeks in the intensive care unit (ICU). (Male, 40–49 age group Chile)</p> <p>The medical community does not give much thought to rehabilitation. With the second wave, we must prepare for what is coming next, so we have little vision for the future. (Male, 40–49 age group, Chile)</p>
Harms of isolation	<p>Patients and professionals had to wear masks and glasses, so the patient didn't know who he was talking to. No one visited them at any time, and every day was the same for them. They felt very alone. (Male, 40–49 age group, Chile)</p> <p>There is much fear and uncertainty in the patients' faces about what is going to happen. Some of them are delivered to death, and they know they are going to die. Because some wanted to be accompanied, share with families, or talk, it was distressing. (Male, 40–49 age group, Chile)</p> <p>Many doctors bring in screens to help patients communicate, but the most important thing is that you arrive at the emergency room without knowing if you have covid positive relatives until a week or ten days later. The isolation is horrifying. (Female, 50–59 age group, Chile)</p>
Inability to provide kidney replacement therapy	<p>As a precaution, the living donor transplant was halted. The cadaver donor transplant was also stopped shortly after. By the time we realized we could resolve the issue, we no longer had beds because all of them were being used by COVID patients. (Male, 40–49 age group, Chile)</p> <p>Some transplant patients were infected with COVID, and one of them died. Thus, when someone appears to have a fever, we call them, monitor them, and hospitalize them if needed. (Male, 40–49 age group, Chile)</p> <p>CKD patients disappeared overnight. COVID ate them up. One does not know where they are, how they are. I am frightened of what will happen to them. (Male, 40–49 age group, Chile)</p>
Fostering innovative delivery of care	
Expanding use of telehealth	<p>Getting used to the fact that no by person consultation is required, getting used to telehealth. (Male, 40–49 age group, Bolivia)</p> <p>We have a chat group where our patients ask questions, and if something happens, I send a message and come right away. (Female, 60–69 age group, Uruguay)</p> <p>The prescription was sent to them via message, and they stay at home, sheltered, and come to the hospital as little as possible. (Male, 40–49 age group, Chile)</p>

Continued

Table 2 Continued

Theme	Quotations
Increasing uptake of peritoneal dialysis	COVID patients undergoing PD are managed as outpatients. It is better to leave them at home. PD patients do telehealth unless they have a special clinical situation. (Male, 40–49 age group, Colombia) We have much fewer complications in PD. (Female, 50–59 age group, Chile) Patients on PD dialyze at home without risk to other patients nearby. (Male, 40–49 age, Colombia)
Shifting focus on preventing syndemics	Two young patients with COVID are hospitalized, one of whom is obese. Obese patients have a lower chance of recovery than those with an abnormal BMI. (Female, 40–49 age group, Mexico) Chronic people are often at risk of developing complications from COVID. Unfortunately, no matter what the vaccine does, there may still be another virus next year. The world is treating the symptoms of this pandemic, but not the causes of this syndemic. (Male, 60–69 age group, Chile) The world has lost a considerable number of people. We have to lead a healthy lifestyle as we are more vulnerable than we think. (Male, 50–59 age group, Chile)

wanted to put masks on our patients but initially our hospital did not give us permission to do so because they were very afraid that they did not have enough supplies for everyone'.

Helplessness and moral distress

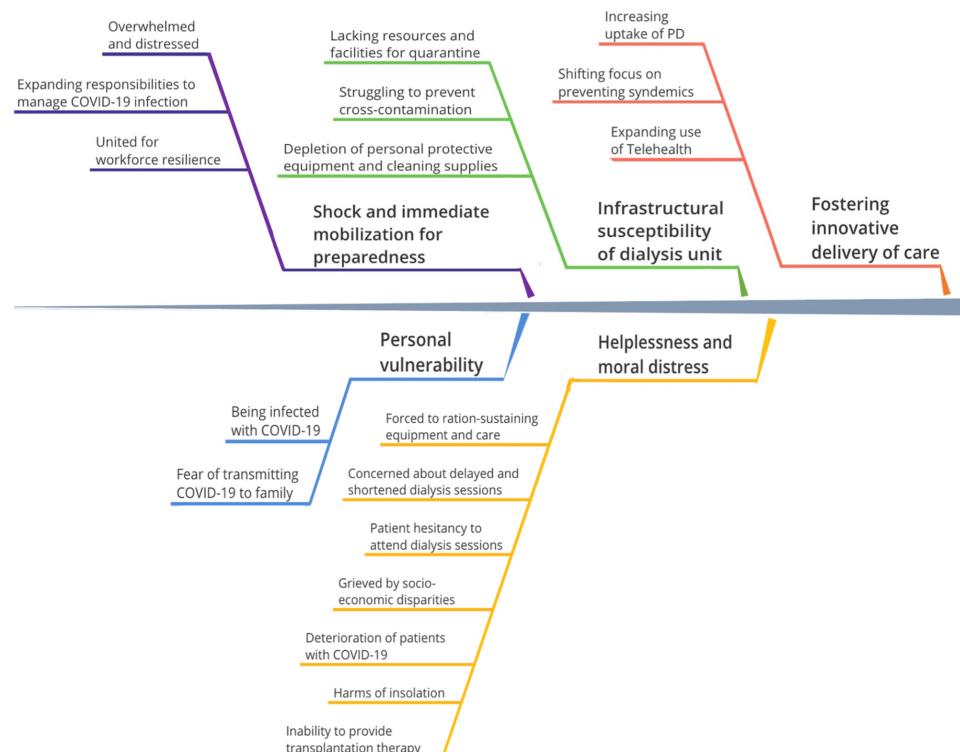
Forced to ration life-sustaining equipment and care

Some had to make harrowing decisions about rationing life-sustaining treatments, in particular dialysis and mechanical ventilation. One participant explained, 'I would have made the effort to offer dialysis to two critically ill patients with COVID, but I gave up on offering dialysis. They had no chance of receiving dialysis because there was no dialysis machine'. They were also forced to allocate ventilation to patients undergoing dialysis in

the hospital setting, who they judged to have a better prognosis. They had to do 'war medicine' and 'tried to distribute the few resources that were available as best as they could'. Some felt judged by others, and the dire consequences on patients caused anguish and guilt: 'The tremendous challenge of playing God, in the sense of who lives and who does not live, who has the right to be connected or not'.

Concerned about delayed and shortened dialysis sessions

Participants were concerned about having to reduce the dialysis prescription for patients to account for the increased time taken to implement strict cleaning protocols due to COVID-19, also to ensure that other patients could undergo dialysis: 'I had six patients who had to

**Figure 1** Thematic schema. PD, peritoneal dialysis.

dialyze, and you had only one machine, and there you had to cut dialysis time'. Dialysis units were understaffed because staff members had contracted COVID-19 or were unable to work: 'I have less staff to dialyze people, and I have to dialyze shorter'. Some tried to refer patients to private dialysis units, but those units could not accommodate additional patients.

Patient hesitancy to attend dialysis sessions

Participants explained about some hesitancy by patients to attend in-centre dialysis because of fear of being infected with COVID-19, which caused worry, helplessness and frustration: 'This morning, the largest public hospital adapted an area to dialyze COVID-positive patients on a fourth shift. Therefore, this morning patients went on a hunger strike at the entrance door. They were not letting patients enter because they said they were going to infect them'. They stated that patients were afraid of the possibility of dialysing near patients with COVID-19.

Grieved by socioeconomic disparities

Participants were saddened that patients from low socio-economic backgrounds were more disadvantaged because of COVID-19: 'many patients are do not work and receive miserable pensions. They cannot leave their home and they face difficulties accessing food'. They explained that 'where the poorest patients are dialyzed, it is shocking to see how patients arrive at the emergency room and cannot access a hospital bed, and many of them end up dying'.

Deterioration of patients with COVID-19

Some participants did not expect COVID-19 would have severe and ongoing symptoms and complications and observed how dialysis patients were in a severely weakened state after being infected, 'with much sarcopenia that caught my attention'. However, participants commented that 'rehabilitation is what we least think about now because we have to prepare for the waves that come next'.

Harms of isolation

Due to the COVID-19 protocols, the dialysis sessions were described as 'a bit depersonalised'. Health professionals had to wear a mask and glasses, and participants mentioned that patients 'had no idea with whom they were talking to'. Participants sought to provide emotional support because the 'patients were very alone', and for patients with COVID-19, 'there were no visits at any time, and every day for them was the same of others'. They noticed that patients were 'quite depressed' and that some patients 'knew they were going to die'.

Inability to provide transplantation therapy

In some countries, participants explained that their kidney transplantation programmes were suspended during the COVID-19 pandemic. Participants reported they did not have beds for transplantation because 'they were all used by COVID patients' and 'there is a long list of dialysis patients waiting for a transplant'. Likewise,

patients with kidney transplantation who come to be monitored with some frequency stopped attending hospitals or clinics. They noticed that patients stopped their following up: 'COVID-19 devoured them'. Participants highlighted having no idea about where their transplant patients are, how they are doing or if they have controlled their immune response: 'I have a considerable fear of what will happen to them'.

Fostering innovative delivery of care

Expanding the use of telehealth

Participants remarked that telehealth 'had to be implemented rapidly' because of the pandemic. Participants described how telehealth 'has allowed us to continue working remotely in hemodialysis's units. This is good because we can conduct nephrology consults during the COVID-19 pandemic'. Telemedicine provided them a safe, effective and efficient way of communication: 'patients send us messages when something happens, and don't have to travel more than 800 kilometers to see the doctor'.

Increasing uptake of PD

Some participants expected that there would be an increase in the number of patients who choose PD over HD during the pandemic: 'We see less complications with peritoneal dialysis than with hemodialysis'. They recognised that for patients undergoing PD, 'the risk is minimal' and could be managed through telemedicine.

Shifting focus on preventing syndemics

Participants explained that patients with comorbidities were at an increased risk of severe infection: 'patients with chronic disease, including those with kidney disease, suffer the most when developing complications from COVID-19 infection', and that these clustered within socially disadvantaged and vulnerable groups, and thus had concerns about inequity. They stated that 'a relatively large number of dialysis patients have died in the world, particularly in our Latino communities'. They urged for a focus on addressing the 'syndemic'; 'this world is treating the pandemic's symptoms, and they are not looking for the causes of this as a syndemic'; and called for a more comprehensive approach, encompassing education, employment, housing, food, and the environment – 'a comprehensive vision is needed if we are to protect the health of our communities.'

DISCUSSION

Nephrologists caring for patients undergoing in-centre HD in Latin America during the COVID-19 pandemic felt overwhelmed. They had to suddenly mobilise resources to prevent the dialysis patients' and others' exposure to COVID-19 and simultaneously manage individuals who were COVID-19 positive. A major challenge was contending with the susceptibility of dialysis units to cross-infection, particularly with the lack of resources

for quarantine and PPE supplies. They felt personally vulnerable in being exposed to COVID-19 infection, and the flow on risks to their own families. Having to ration life-sustaining treatment and being unable to provide adequate dialysis and witnessing the trauma of patients being isolated compounded a sense of helplessness and moral distress among nephrologists. The challenges provided an impetus for nephrologists to change the delivery of care with a focus on increasing the use of telehealth, home-based modalities, and preventing syndemics.

The findings were broadly consistent across participants. Nephrologists were concerned about the susceptibility of dialysis units including the lack of PPE, resources for quarantine, and cross-contamination. There appeared to be some differences in the availability of resources at the clinic in which they worked, which was determined by the resources, and the roles in which they had to take on. Due to the risk of infection, some participants reported suspending some procedures such as the reuse of filters, a common practice in dialysis centres in Latin America. They felt helpless about the socioeconomic disparities as patients in low resource areas faced substantial barriers to accessing healthcare and had worse outcomes.

While there are very few studies on nephrologists' perspectives on the care of patients undergoing dialysis during the COVID-19 pandemic, similar challenges have been identified across other medical disciplines. Clinicians have described the angst of having to ration⁸ and withhold treatment and experienced tremendous physical and psychological burden. In studies conducted across China, the USA, and Europe, clinicians have reported increased anxiety, depression, and symptoms of post-traumatic stress disorder.⁹ Studies in the United States have also identified that Latinx communities are severely disadvantaged in terms of accessing healthcare, and patients were afraid of unemployment, eviction, and inability to protect themselves from COVID-19 as they lived in high-density housing.¹⁰ However, specific to the context of dialysis, nephrologists were particularly concerned about patients undergoing inadequate dialysis due to the shortened sessions, patient hesitancy to attend dialysis, preventing infection in dialysis units, and suspension of transplantation programmes, further increasing the waiting lists in some Latin American countries.

Compared with the perspectives of clinicians, patients undergoing dialysis and caregivers have also reported feeling distressed and vulnerable in dialysis settings during the COVID-19 pandemic, particularly if they observed inadequacies and inconsistencies in infection control practices.¹¹ Patients undergoing dialysis reported that they were concerned about the cancellation of follow-up appointments as they could not monitor their blood results, missed dialysis sessions, and were anxious about risk of complications such as hyperkalaemia.^{12 13} However, patients have emphasised concerns about the potential loss of or delay in undergoing a kidney transplant.¹⁴

Our study generated comprehensive insights about nephrologists' perspectives on caring for patients undergoing dialysis during the COVID-19 pandemic. We conducted interviews until data saturation and used member checking and investigator triangulation to ensure that the findings captured the data collected. However, there are some potential limitations. The participants did not mention the impact on caregivers. Some findings suggest that family caregivers of patients undergoing in-centre HD should be considered by the dialysis team to develop educational and supportive interventions to meet family caregivers' needs, mitigate emotional distress, fears, and concerns, and prevent caregiver burden during the COVID-19 pandemic.¹⁵ All participants were from Latin America, and thus the transferability of the findings beyond this region is uncertain.

The prevention of "syndemics," defined as a synergistic interaction between multiple epidemics or disease clusters (ie, SARS-CoV-2 infection and non-communicable diseases)^{16 17} that exacerbate worse health outcomes, was also identified as a priority. Nephrologists recognised that the impact of the pandemic on patients with CKD and undergoing dialysis was intensified because of its diverse nexus of intertwined biological (including comorbidities) and socioecological factors. Therefore, they advocated the need for the health system not to have a single-disease focus but to ensure comprehensive whole-person care. It has been argued that the COVID-19 pandemic has escalated into a syndemic due to several driving factors: overcrowding, loneliness, uncertainty, poor nutrition and lack of access to health services; and consequently, depression, suicide, domestic violence and psychiatric illnesses have significantly increased.¹⁷ Social determinants of health, such as poverty, social inequality, social stigma and the environment where people live and work, significantly affect the intensity of the syndemic,¹⁸ which is apparent in the dialysis population particularly in resource-poor settings.

CONCLUSION

Nephrologists felt vulnerable, helpless and moral anguish because they were unable to provide access to quality and safe care for patients undergoing dialysis. In particular, they were concerned that patients were not receiving an adequate prescription of dialysis with many patients also refusing to attend dialysis sessions. They struggled with infection control measures due to the lack of resources for quarantine and PPE. They also encountered anguish and guilt from having to ration treatment. Better availability and mobilisation of resources and capacities to adapt models of care (ie, telehealth and home-based dialysis) are urgently needed. This may also help to prepare for future pandemics beyond COVID-19 to minimise the consequences on the care and outcomes of patients undergoing dialysis.

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