

student well-being: students seeking professional psychiatric treatment and being treated with prescription antidepressant medications. Obviously, this being a sensitive issue, it too would be vulnerable to reporting bias.

Dyrbye et al reported rating scores for various coping strategies used by the 538 survey respondents. They included the use of alcohol among the coping strategies but omitted the use of illicit substances. Alcohol and other substance abuse is a problem among medical students^{4,5} and should not be taken for granted.

Despite the difficult-to-avoid limitations of response and reporting bias, Dyrbye et al should be congratulated on an informative study of a challenging topic. Their findings and conclusions are intriguing and serve as a reminder that reported rates of depression and burnout among medical students may very well represent only the tip of the iceberg. Teachers of the art of medicine need to be observant of, and sensitive to, students who may be faltering.

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2. Givens JL, Tjia J. Depressed medical students' use of mental health services and barriers to use. *Acad Med.* 2002;77:918-921.
3. Tjia J, Givens JL, Shea JA. Factors associated with undertreatment of medical student depression. *J Am Coll Health.* 2005;53:219-224.
4. Newbury-Birch D, White M, Kamali F. Factors influencing alcohol and illicit drug use amongst medical students. *Drug Alcohol Depend.* 2000;59:125-130.
5. Newbury-Birch D, Walshaw D, Kamali F. Drink and drugs: from medical students to doctors. *Drug Alcohol Depend.* 2001;64:265-270.

In reply: Response bias is a concern with survey studies. We do not know if depressed students are more apathetic and less likely to fill out surveys on QOL and depression or if, on the other hand, they are more likely to complete such surveys because the survey content is more relevant to their circumstances. As pointed out by Drs Khoo and Tan, there may be other factors as well that impede minority students from filling out survey forms. As we pointed out in the discussion, minority students may feel that their anonymity is threatened because there are few minority students like them. Specifically, survey forms that seek information on age, sex, and ethnic groups may be perceived as being unduly revealing. Further research is needed to explore these issues and other possible barriers to participating in survey research.

Although not reported, the survey did ask students if they were currently being treated for depression or anxiety. There was no difference by minority group in response to this question (6% minority vs 11% nonminority; $P=.17$). We agree that this question is sensitive and vulnerable to reporting bias.

The survey instrument did include questions about the use of illicit substances (marijuana, methylenedioxymethamphetamine [XTC, ecstasy], amphetamines, and other sub-

stances). As expected, the prevalence of students using such illicit substances was exceedingly low, and thus we did not analyze the data by minority status.

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Timely Referral Alone May Not Be Enough for Patients With Chronic Kidney Disease

To the Editor: We read with great interest the review article on late referral (LR) of patients with chronic kidney disease (CKD) by Sprangers et al.¹ As the authors pointed out, educating primary care physicians (PCPs) about optimal referral guidelines is important in preventing LR. However, what is equally important is PCPs' management of CKD itself. Late referral rates range from 10.5% to 83.0% of patients,¹ and almost 40% of LRs are due to the reluctance of patients to visit a nephrologist.² With an increasing incidence and prevalence of CKD, patients encounter long waiting times for nephrology consultation. Thus, PCPs should be familiar with and adhere to predialysis CKD management principles as proposed in the National Kidney Foundation Kidney Disease Outcomes Quality Initiative guidelines to enhance the quality of prereferral care.³

To investigate the quality of prereferral care of patients with CKD, we conducted a retrospective analysis of 204 patients who began dialysis for CKD between March 2003 and March 2005 in 2 community hospitals in Rochester, NY. Patients who had stage 3 and stage 4 CKD at referral were identified, and relevant clinical and laboratory data were obtained from the initial nephrology consultation notes. We used hemoglobin (>11 g/dL), serum calcium (8.4-10.2 mg/dL), and serum phosphorus (2.7-4.6 mg/dL) levels; calcium-phosphorus product (<55 mg²/dL²); and use of erythropoietic agents and angiotensin-converting enzyme inhibitors as measures for assessing the quality of predialysis care (values in parentheses indicate adequate care). Of the 204 patients who began dialysis treatment for CKD during the study period, 45 had stage 3 and 100 had stage 4 CKD at referral. In both groups, predialysis control of blood pressure; maintenance of hemoglobin, calcium, and phosphorus levels; and use of renoprotective agents and erythropoietic agents were suboptimal (Table 1). Thus, even though these patients were appropriately referred to nephrologists as specified by National Kidney Foundation guidelines (in stages 3 and 4), a large proportion had received suboptimal prereferral care that could impact long-term outcomes.

Approximately 4% of the US adult population has moderate to severe CKD⁴ (estimated glomerular filtration rate <60 mL/min per 1.73 m² but not requiring dialysis), and PCPs have a key role in their management. With the widespread availability of guidelines and the emphasis given by insurance companies, PCPs' quality of care of patients with coronary