

A Country Doctor Writes:

Meaningful Us

Meaningful Use was a vision for EMRs that in many ways turned out to be a joke. Consider my list of Meaningful Us for medical professionals instead.

When electronic medical records became mandatory, federal monies were showered over the companies that make them by way of inexperienced, ill-prepared practices rushing to pick their system before the looming deadline for the subsidies.

The feds tried to impose some minimum standards for what EMRs should be able to do and for what practices needed to use them.

The collection of requirements was called meaningful use, and by many of us, nicknamed “meaningless use.” Well-meaning bureaucrats with little understanding of medical practice wildly overestimated what software vendors—many of them startups—could deliver to such a well-established sector as healthcare.

For example, the feds thought these startups could produce or incorporate high-quality patient information that we could generate via the EMR, when we have all built our own repositories over many years of practice from Harvard, the Mayo Clinic, and the like or purchased expensive subscriptions like UpToDate. As I have described before, I would print the hokey EMR handouts for the meaningful use credit and throw them in the trash and give my patients the real stuff from UpToDate, for example.

I'd like to introduce an alternative set of standards, borrowing the hackneyed phrase, with a twist.
Meaningful Us for Medical Professionals:

Unbiased, Understanding, Unflappable, Unhurried

Like the software meaningful use items, these may be hard to attain, but especially in today's healthcare environment, they seem worthy of striving for.

UNBIASED

Able to fairly represent alternative approaches to allow patients to make up their own mind about their care.

UNDERSTANDING

Able to listen to patients' concerns and reflect back that you “get it” and will work to help address them.

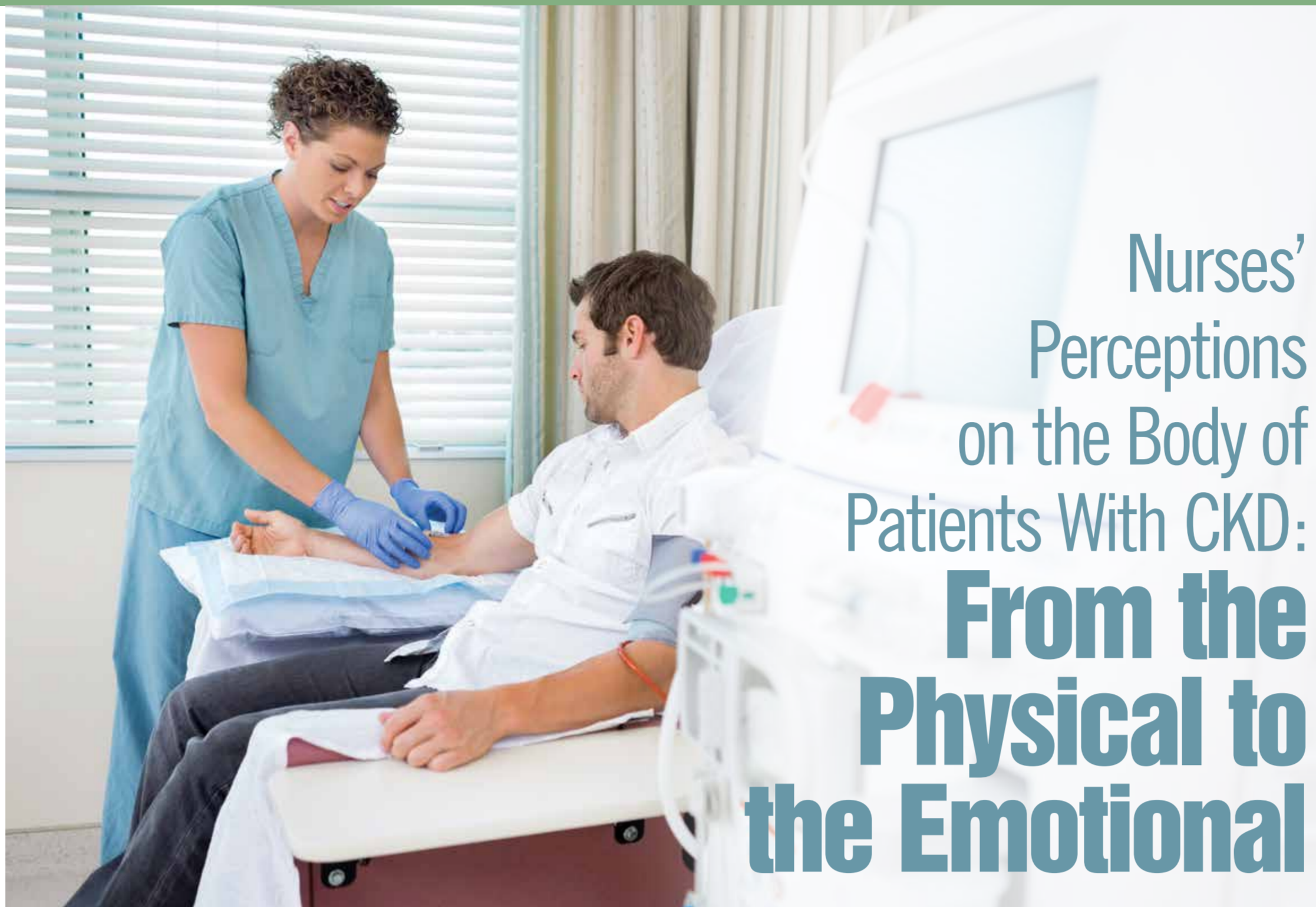
UNFLAPPABLE

Able to, in Osler's words, maintain equanimity in the face of the challenges of medical practice.

UNHURRIED

Able to use time wisely, therapeutically, without frenzy, to make the most of the most valuable resource we all have.

Now, isn't that more inspiring?



Nurses' Perceptions on the Body of Patients With CKD: From the Physical to the Emotional



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While the connection between physical and emotional changes among patients with chronic kidney disease (CKD) through their disease process may seem obvious, few studies have reported results on the alterations or limitations caused by CKD in the body image of individuals in this patient population. Fewer still report results from the perception of nurses who live daily with patients with this pathology, explains Guillermo Pedreira-Robles, RN, BScN, MSN. He adds that understanding these perceptions provides significant power and a large knowledge base for the profession.

Exploring Nurses' Perceptions

For a study published in the *Journal of Renal Care*, Pedreira-Robles and Mariela Patricia Aguayo-González sought to explore nurses' perceptions of the changes occurring in the bodies of patients with CKD throughout their disease process. “Using scientific methodology to expose these perceptions strengthens the basis for continuing to improve the care provided to patients with CKD,” says Pedreira-Robles. “Because we sought to expose knowledge based on experience, we conducted a qualitative study that could collect this information with the highest methodological and scientific quality.”

Data were collected by semi-structured, face-to-face, 40-to-60-minute interviews, carried out in a closed office in the workplace, with nurses from the nephrology service of a university hospital between April and May 2018. “Participants were different ages and had a great deal of professional experience caring for patients with CKD,” notes Pedreira-Robles. During the interviews, open questions were asked, based on a literature review conducted prior to the study on the physical symptom and body image impacts of CKD. Interviews were transcribed and analyzed using the seven phases of Colazzi, a process that provides a rigorous analysis and is closely based on the data, resulting in a concise description of the phenomenon under study that is validated by the participants.

All of the seven subthemes have a special importance to explain the nurses' perceptions of the changes occurring in the bodies of persons with CKD throughout their disease process:

- 1 STIGMA CREATED BY THE NEED FOR DIALYSIS:** Nurses reported that patients with CKD were differentiated from others by their permanent dialysis access, identified as a physical mark, an aesthetic scar, and a mechanical device that was visible and notably marked by the body.
- 2 DYSFUNCTIONALITY ACCOMPANIED BY PAIN:** Nurses reported that patients with access dysfunction thought constantly about it and the treatment, and thus, pain or physical complications were accompanied by emotional pain outside treatment hours.
- 3 THE FEELING OF SLAVERY:** The constant repetition of treatment (daily for peritoneal dialysis or every 2 days for hemodialysis) and the understanding that it could continue for life could, according to the nurses' perceptions, lead patients with CKD to have a feeling of slavery.
- 4 LACK OF PATIENT INFORMATION:** Nurses reported that patients with CKD were often not informed of certain aspects of the disease and its treatment and, consequently, failed to understand important issues related to their emotional well-being.
- 5 THE SILENCE OF TABOO:** Nurses reported a taboo on discussing sexual problems, effects of CKD, treatment impact, implications for social life, physical appearance, self-esteem, etc.
- 6 LACK OF RESOURCES:** Nurses felt they did not have all the necessary skills and resources needed to address patients' emotions, mourning, losses, etc., due to the great magnitude that these problems represent.
- 7 HOPE FOR IMPROVEMENT:** Abdominal scars left by kidney transplant were experienced positively as signs of a release from the slavery of dialysis, and therefore, hope of getting better.

Coexistence of Physical & Emotional Pain

With participating nurses believing there was a close relationship between the physical and emotional impacts of CKD—identifying elements intervening and coexisting in patients' bodies—a central theme of “from physical to emotional pain in the body of persons with CKD” emerged from the data. “This is the most important finding of the study, and the one that best defines the entire content of the study,” explains Pedreira-Robles. “Everything that happens physically on the body (punctures, bruises, surgical wounds, catheters) has an equal impact on the emotional part of the person.

“Going through the identified problems, nurses are able to dive into them, fully understanding that they must be perceived as opportunities for change and improvement in the care provided.” The solutions come proposed through the identified problems or gaps. We are not just

trying to analyze the problems, but to bring changes and describe clear benefits.”

A Complex Whole

Pedreira-Robles suggests that the main evidence derived indirectly from the study is the need to continue understanding the person with chronic pathology as a complex whole: “All its parts are equally affected by the disease and each must have efficient and effective responses,” he says. “While keeping patients alive is crucial, we must consider what life patients lead, their quality of life, and the bodily harm and related problems derived from carrying a catheter, having a scar, being punctured over and over, having problems with the access for dialysis, etc. The need to provide professional emotional support and the need to establish continuous health education routines were identified as key points for improvement. These results must be directed to management systems and governments to achieve a paradigm shift.” ■

QA
 WITH DR. MEDLAW

Underlying Principles of Payment

The COVID-19 crisis has put many practices under great stress as far as payments as patients lose insurance coverage or cannot cover bills. However, it is essential to remember that the underlying principles in these situations have not changed. Let's look at a few questions that came in before the crisis to reinforce these basic points.

Q: *I converted my family practice to all-cash last year and it has worked out well in most cases - I offer very competitive pricing and the time I don't spend dealing with paperwork I can spend with my patients. However, I have one patient who is always behind, and this has continued even on a \$20 per month payment plan. I see him at least every 3 months to follow his diabetes, so this is really backing up. He is actually a great patient otherwise, but this non-payment cannot just continue. Can I terminate him now just for non-payment? Can I make payment a requirement for a new appointment?*

Yes, to your first question but no to your second. The situation in which a patient is under active care that cannot be suddenly discontinued, which would be what most doctors understand to be abandonment, does not apply here. With enough notice, termination is possible. As long as you do not breach your fiduciary duty to not abandon your patient, you may withdraw for any reason. However, keeping him in your practice but refusing to see him until he pays is “internal abandonment”—the patient is kept on the rolls of the practice but gets no care. If you keep him on, he is to be treated as any patient would be, regardless of payment status.

Q: *As a small-town doctor, I have always been lenient on collecting co-pays and dealing with deductibles when patients really cannot afford them. I put a note in the chart of any patient I don't collect on explaining the circumstances. However, I have colleagues who say that it is fraud.*

This can be very risky for you. While AMA Opinion 6.12 says that when the share the patient is responsible for “is a barrier to needed care because of financial hardship, physicians should forgive or waive” it, that is an aspirational ethics statement, and you are still bound by the payor relationships that you have that bind you to collect. If you waive a co-pay, correct your billing to reflect it. There is also the problem of violation of the Anti-Kickback Statute if you do not collect co-pays or apply deductibles to patients in federal healthcare programs. Following the rules with both private and governmental payors should let you keep on helping your patients without risk to yourself.

Q: *How come a hospital can get a patient set up with Medicaid so they can get paid, but I can't pay a premium on a patient's insurance so that it doesn't lapse so that I can get paid?*

You cannot pay for a policy under which you will benefit by the insurer paying you. The hospital, by contrast, is not making a payment and is just assisting the patient to obtain access to what they are eligible for.

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

Decision Regret Increased for Those Who Choose Dialysis to Please Others

Patients who report choosing dialysis to please doctors or family members more often report decisional regret, according to a study published in the *Clinical Journal of the American Society of Nephrology*. Researchers administered a 41-item questionnaire to adult patients receiving maintenance dialysis in seven units located in Cleveland. Predictors of regret were identified. Of the 397 respondents, 21% reported decisional regret. No significant demographic correlates of regret were identified. When patients reported choosing dialysis to please doctors or family members, regret was more common (odds ratio [OR], 2.34). The likelihood of reporting regret with dialysis initiation was lower for patients who reported having a prognostic discussion about life expectancy with their doctors and for those who completed a living will (ORs, 0.42 and 0.48, respectively). “Patients might be less likely to experience regret if nephrology fellows and nephrologists receive training in primary palliative care skills, including goals-of-care communication, prognostic discussions, shared decision-making, and documentation of end-of-life wishes,” the authors write. “Future research, should examine how interventions targeting risk factors for dialysis regret might mitigate regret by enhancing patient participation in decisions about whether and when to initiate dialysis.”

Allopurinol Does Not Affect eGFR in Chronic Kidney Disease

Allopurinol does not affect estimated glomerular filtration rate (eGFR) in patients with chronic kidney disease (CKD) and does not result in a clinically meaningful benefit in kidney outcomes from serum urate reduction among patients with type 1 diabetes and early-to-moderate diabetic kidney disease, according to two studies published in the *New England Journal of Medicine*. Study investigators randomly assigned adults with stage 3 or 4 chronic kidney disease at risk for progression to receive allopurinol or placebo. Due to slow recruitment, enrollment was stopped after 369 of 620 intended patients were randomly assigned to allopurinol (185 patients) or placebo (184 patients). Three patients withdrew immediately from each group. The researchers found that the change in eGFR rate did not differ significantly for the allopurinol and placebo groups (-3.33 versus -3.23 mL/min/1.73 m² per year; mean difference, -0.10 mL/min/1.73 m²). In the other study, researchers randomly assigned participants with type 1 diabetes and early-to-moderate diabetic kidney disease to receive allopurinol (267 patients) or placebo (263 patients). The mean serum urate level decreased from 6.1 to 3.9 mg/dL with allopurinol and was unchanged at 6.1 mg/dL with placebo. After 3 years of treatment plus a 2-month washout period, the between-group difference in the mean iohexol-based GFR was 0.001 mL/min/1.73 m². “As is often the conclusion in clinical research, more high-quality randomized, controlled trials are needed,” write the authors of an accompanying editorial. ■

COVID-19 RESOURCE CENTER

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