

“Enhancing Care in the Dialysis Setting: Motivation, Communication, and Simulation”

Module 1: “Dialysis in ESRD: Toward a More Patient-Centered Approach”

Introduction

The world population is experiencing a significant increase in end stage renal disease (ESRD) requiring renal replacement therapy (RRT). With an estimated annual growth of 4%, the ESRD population is projected to continue to grow in the US, and in terms of workload and clinical decision-making, this has led to significant challenges for caregivers managing ESRD in clinical practice.¹⁻²

“The issue is not who places the access but who does it right, every time, to everyone, and everywhere.”

I. Davidson, MD²

Unfortunately, controversy has continued to surround proper planning in the clinical care of patients requiring RRT. Treatment challenges may surround dialysis access placement, type, and timing; short- and long-term best practices for management, and who actually places the access. Along with rapidly developing and improving technologies, vast differences in clinical and professional experience, and socio-economic factors, the difficulty of performing randomized analyses in heterogeneous ESRD populations has contributed to making ESRD treatment complex and varied between institutions.²

In 2007, Dr. Ingemar Davidson suggested that, “Rather than emphasizing the doctrine of one modality fitting all, doing the right thing for each patient, each time, is ethically and morally the better model.” To this point, clinical outcomes must be driven by the patient’s individual set of symptoms, characteristics, and circumstances.² In his paper on patient-centered decision-making in dialysis access, Dr. Davidson built the following mission statement for making sure that we, as clinicians “do the right thing” in dialysis access for our patients with ESRD:

GLOBAL MISSION STATEMENT FOR THE DIALYSIS ACCESS TEAM²

- To do the right thing for your fellow human
- At the right time,
- In the right amount,
- For the right reason,
- Within the framework of your conscience, skills, and knowledge,
- Modeled by the culture and society laws, in which you live.

What follows elaborates on each of these parameters in the hopes that clinicians managing dialysis will choose the most individualized methods – the patient-centered approach – for their patients on dialysis.

To do the right thing for your fellow human...

All health care workers need to ask themselves a simple question. “What motivates me in this line of work?” Gratitude from patients? Money? Career advancement? Power? Recognition by colleagues? A better lifestyle? Many of us feel that if we do a better job, we’ll receive something good from it – a higher salary; a better job; recognition; status; awards; etc.³ What sometimes gets lost are the patient-centered reasons for why we chose our line of work. Ultimately, medicine is a service-based industry in

which we provide a service for our fellow human beings. We possess the knowledge, attributes, and ability to offer medical answers and treatment when they, themselves, cannot.

In terms of dialysis access, positive outcomes depend on the individual efforts and motivations of all stakeholders involved.⁴ However, some doctors appear to be more effective and/or successful than others. What could be the reasons for this? Education?

Luck? The people surrounding them? Or, is it something else that makes some people more successful than others? In many, if not most cases, these “accomplished individuals” are integral elements within a greater system of teamwork that serves the dual function of optimizing patient care while maximizing individual success.⁴ This interdependent mindset characterized by a continuous flow of information between individuals and departments will improve procedural effectiveness and ultimately, patient outcomes.⁵⁻⁶ The clinical centers that routinely achieve stronger patient outcomes are the by-product of this collaboration and communication.⁴ Unfortunately, in many areas, including dialysis access, various members of the care team are trained in isolation from each other.³ This has the unfortunate effect of causing fragmenting of care and inconsistent treatment within the ESRD delivery system and among the individual caregivers.³

“...we may hypothesize that when people work in concerted synergy as a team, safety and quality improve, and so several experts have created “Centers of Excellence.”

I. Davidson, MD⁴

As humans and caregivers, we naturally assume a leader or follower role depending on specific circumstances and interactions. Typically, physicians are most often leaders, while patients are mostly followers. In order to optimize care of these individuals, we must remember that one of our primary underlying motivations should be just that – to provide care for our fellow humans that is timely, appropriate, and in their best interest. Helping, curing, fixing, treating – these should ultimately be why we do what we do.³

At the right time, in the right amount...

When trying to maximize clinical outcomes and minimize adverse events in the dialysis care of patients with ESRD, there are several confounding factors that warrant attention. For example, the timing and choice of dialysis modality will certainly impact longevity. As mentioned above, there is a great deal of variability in dialysis practices and outcomes both in this country and abroad.^{3, 7-8} For example, there is an inappropriately low prevalence of peritoneal dialysis (PD) in Western countries, which has implications to access placement in the pre-dialysis stage, and there is an excessively high use of central venous catheters in incident and prevalent dialysis patients.⁹ For years, the transplant community has recognized these variations in treatment; though it remains unclear which specific clinical and individual-based factors preclude the most optimal outcomes.

Another example of this variability is the difference of treatment modality in a large university or research institution (perhaps participating in clinical studies) compared to that seen in a community hospital. Further, options for dialysis in a rural setting may be limited compared to those in a large urban area.² One must also consider the patient’s current stage of CKD. Pre-dialysis? Stable? Rapidly progressing?

Within this category is the growing concept of “PD-first,” which implies that in most cases PD should be the first-line dialysis modality when appropriate. The reasons for this are that in the majority of patients, PD offers a survival benefit for the first several years after initiation of dialysis.¹⁰⁻¹² In addition, transplant patients on PD have better long- and short-term transplant outcomes than those on hemodialysis prior

to kidney transplant,¹³⁻¹⁴ and while a patient is on PD, clinicians can make plans to place a native vein AV fistula.²

In order to prevent serious complications, avoid dialysis catheters, and improve patient outcomes, proper planning surrounding dialysis type, timing, and duration is essential for patients in need of RRT. In addition, RRT planning must begin in CKD stage IV to allow patients and their families to understand treatment options and make the most effective decisions, thereby allowing orderly planned initiation of dialysis with an appropriate access.^{2, 15} As clinicians we must be willing to take a leadership role in determining these aspects of care.

For the right reason (our motivations)...

Along the same lines as doing the right thing for your fellow man, we must look internally in order to determine the reasons why we are treating patients and why we've chosen our particular field. We need to ask ourselves the following questions:^{3, 16}

- What drives us?
- Why do we do anything at all?
- What has really motivated us to become good at our work?
- Does it matter if we teach residents and fellows to be accessible and responsive?
- Should we reassure trainees not to worry about uncontrollable ebbs and flows of medicine, such as case-by-case reimbursement, loss of certain procedures to other clinicians ("turf"), legal fears, etc.?
- How important is profit motive in how we practice medicine?
- What provides the "drive" for our trainees to move forward in their careers?

To help answer some of these questions, Daniel Pink, in his book "Drive: The Surprising Truth about What Motivates Us" has outlined three types of motivation, each of which affects our clinical decision-making differently (Table 1).

Table 1: Occupational Motivations¹⁶

Type	Primary Characteristic	Explanation
<i>Motivation 1.0:</i>	The motivation to survive.	We do our jobs so we can eat. While this motivation is strong, most of us rarely call upon this system, and it plays a non-essential role in our day-to-day professional lives.
<i>Motivation 2.0:</i>	Reward or punishment.	In this type of motivation, we see that doing a better job leads to getting something good – higher pay, a better job, etc. However, making mistakes or treating patients improperly may lead to loss of a job, medico-legal issues, loss of respect, etc.
<i>Motivation 3.0:</i>	Higher level motivation based on autonomy, mastery, and purpose.	These are the intrinsic rewards – the sense of accomplishment and importance – not extrinsic rewards like money or reputation.

On a base level, the simple goal of doing a better job and getting an extrinsic reward in return (money, better job, etc.) seems logical. However, when pressured to perform for these tangible rewards, the pressure to produce reduces creative cognitive function. Unfortunately, clinicians who face the greatest challenges will likely come from the Motivation 2.0 group, since both money and status (both extrinsic rewards) are less now than ever.¹⁶ Problem-solving, facing challenges, addressing controversy – these

are the characteristics that lead to the higher level motivations of autonomy, mastery, and purpose. Again, it goes back to doing what's right for our fellow man. Mastery of one's craft, particularly in medicine, can lead to better outcomes and a sense of purpose and autonomy characterized by Motivation 3.0. This type of motivation has the potential to facilitate better care for those with ESRD.^{3, 16}

Within the framework of your conscience, skills, and knowledge...

In terms of dialysis access, ESRD, surgery, and interventional procedures, a specific set of highly technical skills and knowledge are necessary to perform the most appropriate procedures.⁴ While the motivations behind treating patients on a day-to-day basis cannot be ignored, the skills and knowledge required to do the job are also an inherent necessity.

Typically in the medical field, when a clinician makes a mistake, he/she is given additional training from several possible areas: mentors, continuing medical education, and hospital or clinic administrators, for example. The idea is that the clinician will learn what was done incorrectly and be able to prevent the same mistake in the future. However, in many, if not most cases, a medical mistake is based on a lack of communication. In fact, it could be argued that in most people, the vast majority of their lives are based on communication, while knowledge and skills represents a smaller, but no less important piece.

In the past, medical training has largely been based on training team members in isolation: physicians with physicians, nurses with nurses, etc.³ This is also true for training of various aspects of dialysis access. Unfortunately, since the team doesn't typically train together, they are unprepared for deviations from what is to be expected. As a result, patients suffer. However, when the work of each leader is coordinated with the team, each participant is able to bring their own set of skills and knowledge to the table, thus maintaining autonomy and improving work efficiency and outcomes.³

"...when an individual feels pressure to perform for extrinsic rewards, such as a situation where more output equates to more money, then the pressure to produce reduces creative cognitive function. The greater the reward, the more likely that the flow of creative thought will be impaired and performance will be degraded."

D. Pink¹⁶

"...healthcare delivery in a less hierarchic structure, while still being able to respond to a coordinating body, enables the various leaders to move in and out of action more effectively and as needed."

I. Davidson, MD³

In the Dreyfus Model of Skill Acquisition, Dreyfus maintains that an expert, as opposed to a novice or beginner, no longer needs to rely on rules or guidelines. He/she has an analytic grasp of a situation – a vision of what is possible – and he/she consequently makes intuitive decisions.¹⁷ Thus, what we do in clinical practice depends heavily on our level of expertise. Within this context, all team members have to use their expertise, knowledge, and conscience to do the many "rights" to make their center a more efficient place to work and a safer center for optimized patient care.

Modeled by the culture and society laws, in which you live.

The term "culture" represents a set of assumptions, values, and similar behavior among a specific population of people. It can mean many things, including the country in which you live, your individual cultural boundaries, your religious beliefs, the particular hospital in which you work, the local laws governing how you practice medicine, and several others.² Ultimately, a clinician makes decisions/selections for patients within the limitations of these rules. In medicine, the culture in which we work has a strong influence on the way we practice, both positively and negatively.³

Of course, “doing the right thing” in one culture may not be identical to another culture. In the example discussed above, a treatment modality for dialysis access in a university may differ from that seen in a community hospital. However, in both cases, the perception may be that the clinician is still “doing the right thing.” The differing cultural setting is what allows treatment differences to be seen.

A trait that is present in any culture is trust, which is the basic unit of “social glue” that facilitates people working together in an effective way. In the medical field, trust is built by mutual respect, and from a clinician standpoint, it requires that we protect other people and show them that we care for them on an individual and personal level. It also means managing commitments and keeping promises.³

Changing a culture in any situation is a monumental task since it occurs slowly over time. Changing a culture to optimize patient benefit is perhaps more likely in a facility with an interdependent mindset that focuses on intrinsic rewards – autonomy, purpose – rather than extrinsic rewards such as money.^{3, 16} Any culture needs to address the fine balance between safety and accountability. In this case, mistakes or near misses are shared interdepartmentally, and the information is used for improvement purposes, as opposed to the prevailing blame and punishment “business model”.³

Conclusion

The strategies described require a coordinated teamwork approach that involves continuous care along the spectrum of ESRD. To overcome controversies surrounding proper planning for patients requiring RRT, clinicians need to look at their internal motivations and use communication and individual skill to optimize patient treatment. By emphasizing a doctrine of “doing the right thing” for the right reasons for each individual patient, we have an opportunity to expand our standards of care in these patient populations.

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