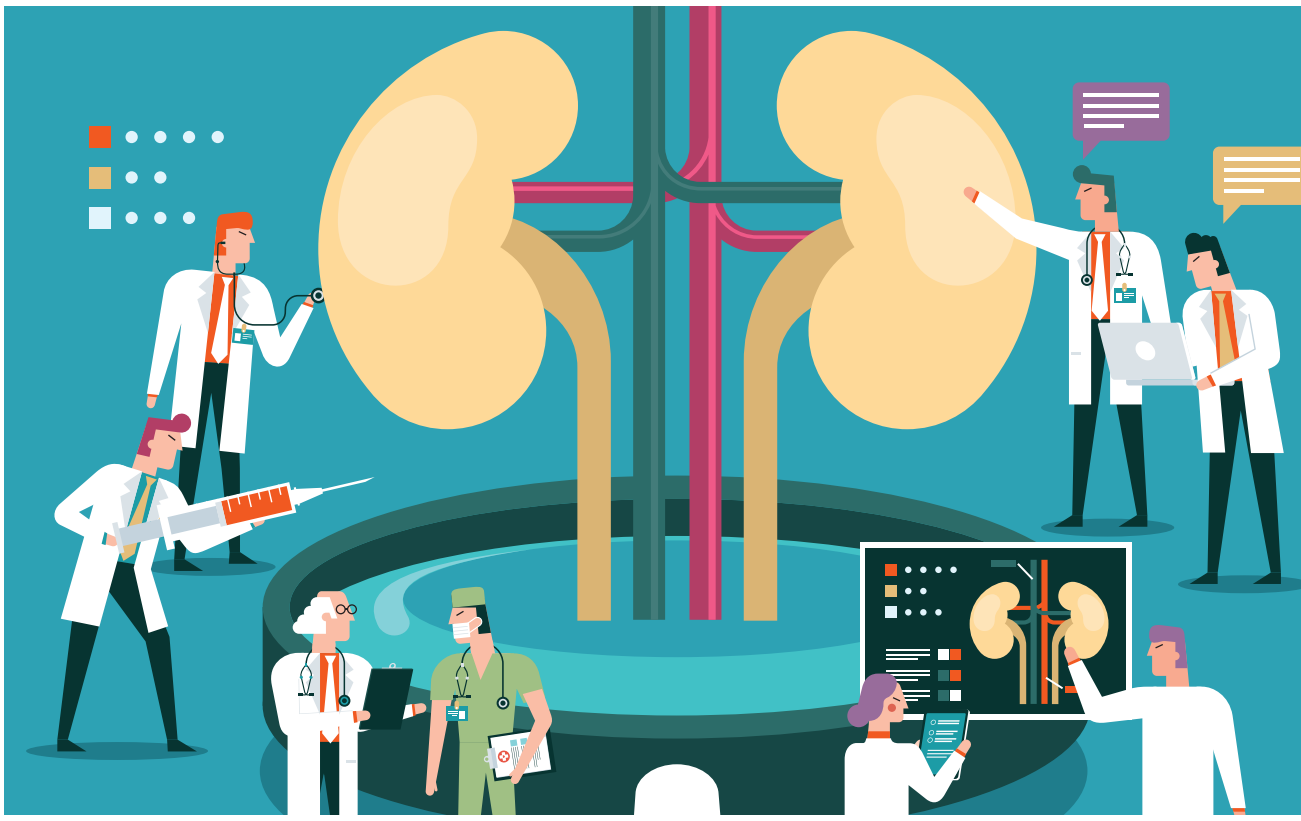
The First Phone Call

By Joseph Mattana and James Gavin



The Nephrology Match yielded disappointing results again this year.

At the same time, the current state of medical practice as a whole continues to suffer numerous problems, which are well described and largely obvious. Among them is a progressive degree of compartmentalization: Outpatient physicians are abandoning the hospital as a practice site, and hospitalists are quantitatively dominating inpatient medical care, with abandonment of the outpatient setting. This has afforded many efficiencies and advantages, including apparently favorable impacts on hospital metrics. It has also allowed for a form of subspecialization, a supporting argument being that this may better facilitate mastery and ongoing maintenance of competence in the increasingly complex domains of outpatient and inpatient practice.

From the perspective of many physicians, being limited to one or the other venue without additional responsibilities offers substantial quality-of-life advantages. Of course, this development is not without tradeoffs. From the standpoint of the patient it means discontinuity of care, with the hospitalized patient seeing a new and temporary physician, a hospitalist, who will ideally communicate regularly and effectively with the outpatient primary care physician and specialists. Such communications need to be bidirectionally effective. If these communications take place between a hospitalist and an outpatient internist who have never met (a not infrequent scenario now) and depend heavily on the faxing of voluminous and at times nearly incomprehensible templated printouts from electronic medical records, such communication is likely to suffer.

This compartmentalization has other consequences as well. The inpatient physician may lose touch with the outpatient domain of practice, especially the challenges faced by the outpatient physician, who receives the patient back after discharge and often scrambles to create an appointment while trying to determine what actually happened in the hospital and to come up with a plan after discharge. The outpatient physicians take on various risks as well, among them the potential for becoming somewhat distanced from some of the potential life-threatening sequelae of the conditions they see—a concern recently shared with me by a senior primary care colleague, who for many years had navigated the inpatient and outpatient settings and was now taking on a fresh residency graduate for full-time outpatient primary care practice.

Now comes the nephrologist, whose practice is in many ways the antithesis of these models.

As we all know, nephrology is truly one of the paradigms of medical practice. Nephrology is an ideal model of continuity, with nephrologists following up their patients in all domains including the inpatient unit, critical care unit, emergency department, and outpatient clinic. Nephrologists also oversee their patients' procedural care in all settings, including inpatient and outpatient dialysis. For patients who undergo transplantation, the nephrologist continues to care for them in all settings and through all transitions, with numerous patients staying under our care for many years with immeasurable personal satisfaction.

We have extensive interactions with multiple medical and surgical specialties. We manage pediatric-to-adult transitions for patients with complex conditions. We work closely with nurses, social workers, nutritionists, and others in both inpatient and outpatient settings. The dialysis model is unique in that it entails especially close follow-up of patients, with thrice-weekly encounters between nurses and physicians throughout each month. Finally, aside from the intellectual and personal satisfaction that a career as a nephrologist provides, nephrology also affords a robust experience with continuous quality improvement—a longstanding part of nephrology practice—and the development of skills in navigating a complex regulatory environment and various payment models: skills that may be of great value in other domains.

As we all also know, nephrology is inseparable from general internal medicine; hence, the nephrologist's scope is characteristically far beyond the kidney and typically includes taking ownership of many issues involving other organ systems. This is not lost among patients, who often see the nephrologist as their primary physician; hence, the nephrologist is in fact typically "the first phone call" for patients and other physicians when problems and questions arise. What should not be lost upon nephrologists is that this puts them in a remarkable position, including a vast spectrum of career options.

The structure of nephrology practice appears to be the ideal solution for much of what troubles us about current healthcare, including its fragmentation and discontinuity, and it also seems to have everything a physician would want in a career. However, this year's Match results remind us that despite all that nephrology has to offer for patients and nephrologists, these offerings do not appear to be resonating with students and residents. The preferences of trainees regarding work–home balance, income, job availability within a geographically desirable location, and other items, and the trainees' perception of various fields in how they align with those preferences, undoubtedly play a role in career choices for many. From this perspective, nephrology has fared less favorably for several years. The 2019 Nephrology Fellow Survey (1) reveals that these preferences hold true for nephrology trainees as well, with weekend call frequency, desired location, overnight call frequency, workday length, and compensation being among the dominant factors in the consideration of various employment options. Changes in practice and reimbursement models are needed, and they may be able to address some of these issues.

Although improvements in perceived quality of life and job opportunities undoubtedly affect career choice, no career is likely to lead to long-term satisfaction without excitement about that field's subject matter, including its intellectual challenge, the patients one cares for, the available therapeutic portfolio, and opportunities for growth in research, education, leadership, and other domains.

We must acknowledge that our field does have some current limitations, among them that after a half century dialysis remains the primary therapeutic modality for kidney failure. Nevertheless, rapid scientific advancement, new therapies for glomerular disease and for slowing the progression of chronic kidney disease, and advances in transplantation and many other areas hold great promise for improving care for our patients while providing great satisfaction for the nephrologist. Several residents have taken note of how the dearth of applicants for nephrology also provides a remarkable opportunity for a resident wishing to pursue a career in academic medicine to receive world-class training in nephrology as a pathway to that goal.

How can this excitement about all that nephrology has to offer be imparted to students and residents? Ongoing efforts by the American Society of Nephrology and the nephrology community will undoubtedly be essential to our success, but more is needed. Medical schools, department chairs, and internal medicine training program directors can help increase exposure to nephrologists not only as topical lecturers and consultants on innovative electives but also more often as medicine ward attendings and in other venues so that students and residents can better appreciate the vast scope of nephrology, its integration with all of internal medicine, and the vast spectrum of career pathways available to nephrologists.

With time, we can hope that many more students and residents will appreciate that nephrology is in many ways a paradigm of medical practice. Being the first phone call is something any physician should be proud of. ■

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Reference

1. Pivert K, et al. 2019 *Nephrology Fellow Survey—Results and Insight*s. Washington, DC, ASN Alliance for Kidney Health, 2019.