



The generalist, the specialist, and the patient with chronic kidney disease

A key part of medical practice is managing professional relationships. This includes effective communication with each other: primary care provider, specialist, and patient in all permutations. I have previously written about how technologic advances both facilitate and hamper interphysician communication. But as payment models morph, as health systems become more complex and insulated, and as the medicine subspecialty workforce changes, the relationship between generalist and nonprocedural specialist will continue to evolve. I can offer personal testimony to the enormous value of sharing our electronic medical record with my nephrology colleagues within the institution; online (nondisruptive) management “conversation” is common in real time while I am with a patient in the office.

Gone is the time when referral was a necessary mechanism to build a practice, when a primary care physician would send everyone with an elevated alkaline phosphatase to the neighboring gastroenterologist, who in turn would send everyone without a primary care doctor to him or her. But there has always been the potential for professional, ego-based tension between primary care and nonprocedural specialist physicians, although this tension is rarely discussed. When does referral to a specialist by a general internist imply a lack of appropriate knowledge or an unwillingness to do an appropriate literature review? When should a specialist be concerned about “interfering” in primary care—by initiating more aggressive blood pressure control, or by giving the patient a needed vaccination? And what should be done if the patient decides to change the captain of the medical team? Maybe in the new medical care arena we will indeed function and be judged as a team, physician communication and transitions will be seamless, and all that matters will be the patient. Time will tell.

For now, the comanagement of patients with a chronic disease is often a challenge. The discussion by Sakhuja et al (page 289) of patients with chronic kidney disease (CKD) highlights important clinical issues faced by primary care providers and nephrologists. With the increased diagnosis of early CKD, there may not be enough consulting nephrologists to see all these patients. And when CKD is diagnosed at an early stage, not all patients may warrant a specialist consultation. Yet the gaps in clinical care are clear. Too many patients with “a little” proteinuria or microhematuria do not get an adequate microscopic urinalysis to look for a treatable inflammatory renal disorder. Too many patients with a “slightly” elevated creatinine and blood pressure do not have their pressure aggressively treated, despite evidence that a systolic blood pressure in the high 130s is associated with more rapid progression of CKD. Should we establish expectations for ourselves, or should we just take a step back and refer all these patients to a nephrologist and await guidance? This is where I believe that a few clearly written and widely disseminated guidelines would help. Knowledge of appropriate and basic guidelines for diagnosing and managing common disorders (not just CKD) should be the focus of continuing medical

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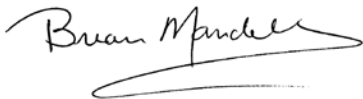
education and should be required for maintaining certification for *all* internists, including specialists. But, as always, guidelines often need to be tailored for the patient in our examining room.

There are nuances in the care of patients with CKD that, as a nonspecialist, I will not automatically know need to be implemented. As an internist, I should know the value of starting inhibition of the angiotensin pathway in patients with proteinuria, but as CKD progresses in a specific patient, should this be decreased? Should I initiate urate-lowering therapy,¹ hoping to slow the rate of my patient's renal demise?

When do we know enough to know that we do not need to ask for a specialist's input? How well do we self-assess our clinical knowledge and skills? How can we achieve the right balance between referral and self-management? We try to save our patient the cost of the time and the copayment to see a specialist, and with bundled care we try to minimize consultant fees and time. But in the meantime, are we ordering unnecessary tests or delaying appropriate therapy?

As we think about the comanagement of patients with CKD, we need to recognize and utilize the nuanced improvements in care that our nephrology colleagues can provide. As non-nephrologists, we should be able to start a thoughtful diagnostic evaluation. For example, an antinuclear antibody test in the absence of evidence of glomerulonephritis is not likely to be informative in determining the cause of an isolated elevated creatinine; a urinalysis is. We should be able to recognize potential renal injury (proteinuria, decreased glomerular filtration rate, microhematuria, hypertension), and initiate aggressive mitigation of factors that are known to enhance progression of the CKD (proteinuria, hypertension) and contribute to the significant morbidity and mortality of CKD-associated cardiovascular disease.

We should already be managing hypertension, diabetes, and hyperlipidemia, but CKD should be a red flag, driving us to more aggressively control these comorbidities, and driving us to do better than control only the estimated 46.4% of hypertensive patients in 2009 and 2010 whose hypertension was adequately controlled.² There is no reason for us to step back and wait for direction in addressing these most common issues. And our specialist colleagues will be there to efficiently assist in refining the nuances of care.



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■ REFERENCES

1. Levy GD, Rashid N, Niu F, Cheetham TC. Effect of urate-lowering therapies on renal disease progression in patients with hyperuricemia. *J Rheumatol* 2014; Apr 1, doi: 10.3899/jrheum.131159. Epub ahead of print.
2. Guo F, He D, Zhang W, Walton RG. Trends in prevalence, awareness, management, and control of hypertension among United States adults, 1999 to 2010. *J Am Coll Cardiol* 2012; 60:599–606.