**Scenario 7: Nephrology**

You are an intern doing your Nephrology elective. You have just finished three months of inpatient medicine and are glad for some elective time. Your first morning on service you are called by your attending to see a new inpatient consult. You go to see the patient. She is a 65 yo woman transferred the previous night for somnolence and confusion. She has a history of hypertension and diabetes, neither of which have been under good control as best you can tell from her outside records. Her exam is remarkable for a BP of 160/90, HR of 88, RR of 20, O2 saturation of 92% on 50% face mask. Her JVP is elevated at 10 cm, lungs have crackles 1/3 of the way up bilaterally and dullness to percussion at both bases. Cardiac and abdominal exams are unremarkable. Her legs have 3+ edema bilaterally to the knees. Lab work is significant for a potassium of 5.0, BUN of 110, creatinine of 7.2; CBC, LFT’s and cardiac enzymes are negative. A chest x-ray that shows bilateral pleural effusions and an ECG shows no ischemic changes.

Your assessment of the patient is that she is in renal failure and is fluid overloaded with a modest oxygen requirement. You feel she needs dialysis to improve her clinical condition. You review this with your attending who agrees. Together you go to the dialysis unit to make arrangements for an acute dialysis treatment. You discuss this with the dialysis staff just before rounding on the patients in the unit. The news of needing to add a patient on to the schedule is met with frustration, as the schedule is already full and staffing is short. Arrangements are made for that patient to be dialyzed acutely that evening.

Next, you round with your attending on the patients receiving dialysis. Each patient is reviewed at the bedside with the nurse overseeing the dialysis treatment. Data are reviewed on a flowsheet, but may of the values are missing. In many cases, the nurse caring for the patient doesn’t know specifics about the patient’s current condition or pertinent data about the medical history. This information is not readily available in the paper chart or on the computerized record. Time is required to update the sheets and to decide on any changes that need to be made to the plan of care. There is an opportunity to answer patients’ questions and discuss any concerns.

As you finish rounds and head to lunch, you ask your attending if that was a typical morning on the rotation. You are excited about all of the things you have been included in, but also wonder if there might be a different way to approach caring for this population of patients.