"Given: Concern for the mental outlook of the chronic dialysis patient.

Question: Explain the outlook your team wishes to develop in the patient, how this is accomplished by the medical personnel, and the effect upon the patients."

It is universally recognized that the aim of a chronic hemodialysis program is the physical, social, and mental rehabilitation of the patient with irreversible renal failure. How well such rehabilitation is accomplished depends on many factors and varies with each patient. Physical rehabilitation results from adequate dialysis—that is, a sufficient number of hours per week to keep symptoms of uremia under control. Added to dialysis therapy are certain drugs, a controlled diet, etc. Social rehabilitation usually follows physical well-being, and the patient can work and be self-supporting.

Perhaps the most complex and least understood aspect of dialysis dependency is the patient’s mental and emotional adjustment to his disease and to the program. Only a trained psychiatrist or psychologist could really delve into these problems; unfortunately such expert help is not always readily available. Thus it becomes the lot of the nephrologist and the dialysis staff to listen to, understand, counsel, and advise these patients. To narrow this down even further, it is the nurse who is with the patient for several hours two or three times a week, and she is seldom sufficiently trained to effectively minister to his mental and emotional needs.

A common factor in hospital dialysis units is lack of space, with several beds and “kidneys” in a relatively small room. Thus there is little or no privacy for the patients and no opportunity for them to talk over concerns or problems confidentially with either nurses or doctors. The tendency in our Unit is for patients to discuss these problems with each other; in many cases this can be helpful, in others it can be dangerous. A well-adjusted patient can be a great help to a new, frightened patient just starting on the program. However, a poorly-adjusted patient who boasts of dietary indiscretions, his large welfare or unemployment benefits, or his complications, is a real hazard to those around him.

Our Unit employs seven registered nurses, none of whom have had more than elementary psychiatric training. Over the months we become extremely well acquainted with our patients, and we have many opportunities to watch them, talk with them, and try to help them. But we are frequently at a loss as to how to handle a crisis, or even how to answer everyday questions from worried patients. The tendency of the mass media to dramatize such subjects as dialysis and transplantation, for example, raises many concerns in patients’ minds. And the removal of a patient from the program, either through transplantation or death, can arouse feelings of sympathy, envy, fear, or hostility in those who remain dialysis-dependent.

Thus, to answer the original Question: our aim is to help all our patients adjust to the stresses of chronic dialysis therapy and to make trips to the Unit a routine part of their weekly living. Although the initial explanations of the illness and the dialysis program are given by the nephrologists, the day-to-day relationships are between patients and the nurses. Only serious problems or conflicts are referred to the medical staff. The immediate effect of our comments, answers and attitudes is often obvious, but the degree of mental rehabilitation in each individual patient can only be evaluated over a period of months or years.

I personally feel that some of our patients have adjusted quite well to their program, while others have many psychological problems. Perhaps it is unrealistic to expect complete adaption to dependency of a machine for the maintenance of life. If the patient can come to terms with his illness and make dialysis a “normal” part of his weekly routine, we would probably consider him mentally rehabilitated.

Perhaps this psychological dilemma is best illustrated by briefly describing two of our patients, representing opposite extremes. Mrs. S., with chronic pyelonephritis, has been on dialysis once a week for almost five years. At age 50, she is married and the mother of two adopted teen-age girls. After several episodes of cannula problems, she was given an A-V fistula, thus removing a real source of stress. She seems to have an excellent understanding of her physical condition and good rapport with the doctors and nurses. She maintains her home and is extremely active socially. Dialysis day is her “day of rest”, and she arrives prepared to read, relax, and sleep. Symptoms such as bone pain, pseudo-fractures, and unusual gait do not seem to cause undue anxiety or self-concern.

Mr. T. is a 36-year-old bachelor, on dialysis for just over a year. He is an anephric. Following removal of a rejected transplant, and requires thrice weekly dialysis. Since starting on the program, he has had no incentive to work, living with his mother and drawing a disability pension. His “I.Q.” level appears below normal, he has poor manners, and he has no real comprehension of his disease or health status. Frequent dietary indiscretions lead to excessive weight gains and consistently high serum potassium levels. He shows no interest in reading or watching TV during dialysis and makes small jokes and frequent demands. Obviously he is not rehabilitated in any sense of the word.

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