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Shared Decision-Making for the Integrated Care of End-Stage Kidney Disease Patients

By Hajeong Lee

End-stage kidney disease (ESKD), which requires kidney replacement therapy (KRT) or comprehensive conservative management, burdens patients, their families and caregivers, and the healthcare system. The selection of the type of KRT for individual patients is therefore decided based on not only each patient's medical condition but also his or her family support, social and financial resources, and the healthcare resources he or she receives.

Most decisions regarding KRT have been based on physician- or healthcare system/stakeholder-centered determinations rather than "patient-centered" choices, and thus many patients with ESKD feel insufficiently involved in their treatment options. However, it is also important to improve a patient's sense of well-being by maintaining his or her daily life, both functionally and psychologically, which is not measured by any laboratory calculation.

Recently, the Kidney Disease: Improving Global Outcomes Controversies Conference recommended that patient-reported outcome measures (PROMs) should be implemented in clinical trials and registries of rare kidney diseases (1). The PROMs are tools that open a physician's ears to the patient and are good triggers to cultivate "shared decision-making." Shared decision-making implies that medical decisions are made collaboratively in accordance with the best available evidence provided by the clinician and the values and preferences of the patient. Furthermore, shared decision-making allows improved communication between physician and patient, enhancing the patient's compliance, motivating a patient's self-monitoring, and reducing emergency department utilization (2). However, remaining challenges should be overcome for PROMs to progress to shared decision-making and finally be incorporated into the healthcare system.

Barriers to the use of shared decision-making in caring for patients with ESKD are present at three levels.

1. From the clinician's view, barriers include limited time and resources, a lack of confidence in communication, and a lack of consensus on when and how to educate patients.
2. From the patient's view, barriers are a low level of health literacy, minimal awareness of kidney health, a low readiness to learn, different intellectual and socioeconomic levels, and complex co-morbidities.
3. From the healthcare system's view, there are problems to be solved, such as a limited budget for education or communication, a lack of standardized decision aids, and the absence of multidisciplinary team care with clear roles.

Fortunately, there has been a quality paradigm shift in the care of patients with kidney diseases to focus more on patient-reported outcomes, but all three levels of barriers should additively be conquered to accomplish true patient-centered care. The final goal for shared decision-making in caring for patients with ESKD is individualized care that allows patients to achieve the best outcomes from the viewpoint of patients themselves rather than the healthcare provider or system. As healthcare providers, let us make patient-centered care and shared decision-making priorities for nephrology in 2021. ■

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ERRATUM

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