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Education in Palliative Care during Nephrology Fellowship: Where Are We?

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Patients with advanced kidney disease are increasingly older with multiple comorbidities and cognitive and functional impairments and have a limited life expectancy (1). They experience high symptom burden and recurrent hospitalizations and undergo aggressive medical interventions at the end of life with high inpatient mortality and low utilization of hospice services (2). Palliative care, which focuses on the optimization of quality of life, can be delivered alongside chronic kidney disease care. Primary palliative care skills that all nephrology providers should use (2−4) include the following:

1. Education of overall medical condition,
2. Evaluation and communication of prognosis,
3. Basic goals of care discussions that elicit values and medical wishes to guide consistent treatment plans,
4. Advance care planning,
5. Identification and management of physical and psychological symptoms, and
6. Identification of clinical changes near the end of life.

Nephrology palliative care is a developing subspecialty of nephrology that addresses the complex needs of patients with advanced kidney disease, including managing complex symptoms, difficult conversations, and discourse over treatment preferences among patients, families, or other providers. There are several barriers in providing nephrology palliative care, ranging from broad misconceptions about the field to healthcare policies limiting feasibility of this care (5, 6). Strikingly, the most fundamental barriers are (5) inconsistent general nephrology education in primary palliative care skills and (2) limited nephrology palliative care specialists. Online nationwide survey-based studies conducted in 2012 and 2015 on second- and third-year nephrology fellows highlighted the lack of primary palliative care training in US nephrology fellowship programs. The majority of nephrology fellows expressed discomfort with primary palliative care due to their lack of educational exposure and felt they would benefit from formal palliative care rotations with a structured curriculum during fellowship (7, 8).

The integration of primary palliative care in general nephrology fellowships is in development. Formal curriculum or palliative care electives have been created in some institutions through collaboration with palliative care, geriatric, and nephrology faculty and are taught by interprofessional (physicians, social workers, and pharmacists) teams (9). There are also several online and in-person training programs including NephroTalk Consensus Care Curriculum, VitalTalk, Center to Advance Palliative Care (CAPC) Clinical Training, Stanford Palliative Care Training Portal, and Coalitions for Supportive Care of Kidney Disease webinar series (10, 11). We believe that institution-based nephrology palliative care curriculums should be incorporated into general nephrology fellowship training programs. An ideal curriculum includes the following: 1) didactics on fundamental concepts of nephrology palliative care, 2) interactive serious illness communication workshops, 3) individualized exposure through active participation and rounding with palliative care teams, and 4) guided implementation of conservative kidney care.

To subspecialize in nephrology palliative care, there are several pathways to obtain dual board eligibility. Currently, there are several 3-year integrated nephrology and hospice and palliative medicine (HPM) fellowship programs, including Mount Sinai Hospital and Stanford University. Starting in July 2021, the University of Pennsylvania, Yale University, and The University of North Carolina are initiating an Accreditation Council for Graduate Medical Education (ACGME) combined 2-year nephrology and HPM fellowship program. Last, the option to pursue an independent HPM fellowship following completion of general nephrology fellowship is in development. Formal curriculums for nephrology fellows are in development. The role of the nephrologist is evolving. In order to adapt into this new role, education in nephrology palliative care must continue to grow through awareness, integration into general nephrology fellowships, research, and most important, the willingness to step out of our comfort zones and have difficult conversations.

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References