Fellows Corner

Dialysis Decision-Making: Can We Help Patients and Providers through the Process?

By Rob Rope

Millions of lives have been successfully prolonged through dialysis. However, the world of dialysis has changed since its inception. With time, our patient population has evolved from young and fit to old and sick. Belding Scribner, the father of chronic dialysis in the US, noted the need for a "deselection committee" just five years after the Medicare payment benefit for ESRD was established in response to his perception of the loosening of dialysis criteria (1). Notably, there is a growing body of literature indicating that dialysis does not meaningfully improve outcomes in many older and sicker patients, placing greater emphasis on dialysis decision-making in the outpatient setting (2,3). What are we to do in situations where dialysis may not be appropriate?

Ethically challenging situations rarely have a correct answer and it is important to remember that "death is as integral an aspect of human life as it is of all other biologic species."(4) In 2010, the Renal Physicians Association released updated guidelines to help providers and patients in dialysis decision-making (5). These can be downloaded free online and are worth reading. The guidelines give specific clinical instances where it is appropriate to either forgo dialysis outright, or consider forgoing (Table 1). The more common, and perhaps more challenging, cases tend to fall in the latter group.

The goal of providing dialysis to extend life while also maintaining an acceptable quality of life is a reasonable starting point when assessing if dialysis is an appropriate therapy. This goal involves identifying what patients want and what providers can deliver. This forms the basis of shared decision-making. Commonly articulated goals of care include: cure, prolonging life, improving or maintaining quality of life, comfort, and providing support for others (6). Dialysis cannot deliver all of these at the best of times and sometimes cannot deliver any. Without understanding why a patient may want to extend their life through the toxicity of dialysis (including fatigue, hypotension, cramping, etc.), it is impossible to have an adequate conversation about the risks and benefits. Providers need to understand a patient's motivations, and patients need to understand what symptoms dialysis will help, as well as what may be worsened.

While medicine has embraced "shared decision-making" as standard-of-care, providers must not view this as avoiding paternalism at all costs. Imagine the last time you went to a mechanic. Although you did not want to be led astray into an expensive repair just to pad the shop's bottom line, you probably also did not want a list of options without any guidance as to what might be appropriate based on your budget, your car's mileage, or its sentimental value. In the name of doing the "right thing" and avoiding paternalism, nephrologists may defer to family or other health care providers regarding whether or not to initiate dialysis. This can contribute to provider and patient regret in retrospect. Unfortunately, some data indicate that patients often regret initiating dialysis and may start dialysis based upon family or provider wishes rather than their own (7).

How might these discussions and outcomes be improved for providers and patients? One potential approach to these discussions is outlined in Table 2. The October 2016 edition of *CJASN* also provides several articles outlining supportive care and other end-of-life issues. In addition, training programs, like NephroTalk, can improve provider preparation for dialysis decision-making conversations and should be incorporated into fellowship curricula (8). These programs should be made available to practicing providers for CME. Providers need to feel comfortable discussing and providing options aside from traditional dialysis, including conservative care and referrals to hospice, otherwise options may be presented as "dialysis or death." As death is usually not a primary goal for patients, dialysis may seem like the only option and conversations may be unproductive. Lastly, an increased focus on conservative care programs nationwide, as well as increased nephrology training in dialysis decision-making and symptom management, could increase resources for patients and providers when dialysis is not the appropriate choice.

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Table 1
Renal Physicians Association guidelines on shared decision-making

Forgo Dialysis in Situations Where:	Consider Forgoing Dialysis in Situations Where:
• Patients, or surrogates, do not want dialysis. • Patients have "irreversible, profound, neurological impairment such that they lack signs of thought, sensation, purposeful behavior, and awareness of self and environment."	• Dialysis is unfeasible due to safety concerns (e.g., dementia, schizophrenia) or instability (e.g., hypotension) • Patients have a terminal illness aside from renal failure • Patients with advanced age (>75) with 2 or more of the following: ○ Answer of "No" to the question "Would you be surprised if the patient died in the next 12 months?" ○ High comorbidity score ○ Impaired functional status (e.g., Karnofsky score <40) ○ Chronic malnutrition (e.g., serum albumin <2.5 g/dL)

Table 2
Potential approach to discussions about starting/stopping dialysis in the elderly (6)

Assess patients' goals of care and place their prognosis within this context. Initiate advance care planning including advanced care directives and potentially physician orders for life-sustaining treatment (POLST).

1) Discuss individualized treatment options and likely outcomes (best case/worst case) with patients and families.
2) Make treatment recommendations to fit a patient's goals of care if the patient/family prefers or struggles with decisions.
3) Consider recommending against dialysis in patients with poor prognosis, contraindications, or safety concerns.
4) Consider time-limited trials with predefined goals that are measurable, reasonable, and obtainable within a specific time period. Document goals to facilitate future discussions.
5) Identify and treat burdensome symptoms. Consider palliative care consultation in challenging cases.
6) Periodically reassess patient willingness to continue dialysis and facilitate discontinuation when consistent with goals of care.

References

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