Fellows Corner

We hope you, the reader, have been pleased with the reintroduction of the Fellows Corner column of Kidney News. Thanks to wonderful leadership from Robert Rope, MD, who has been serving as feature editor, we enjoyed broad participation and believe we have delivered some very informative, poignant, and reflective content. Rob will be stepping down as he completes his third year of fellowship at Stanford and joins the nephrology faculty at Oregon Health & Science University, where he started his medical training. He looks forward to continuing his work with fellows and to bolstering interest in nephrology and education.

We are excited to announce that two terrific contributors will be stepping in as co-editors of Fellows Corner. Please welcome Devika Nair, MD, a fellow at Vanderbilt University, and Daniel Edmonston, MD, a fellow at Duke University. I am confident they will do a terrific job, and together with the rest of the team at Kidney News, look forward to ongoing reader contributions to Fellows Corner in the future.

—ASN Kidney News Editor Richard Lafayette, MD

Time-Limited Trials of Dialysis in the Intensive Care Unit: Are We Timing Dialysis Initiation Appropriately?

By Arjun Sekar, MD

Nephrologists are often consulted for renal replacement therapy (RRT) in critically ill patients in whom the overall prognosis is poor and the benefit of RRT is questionable (mortality in these scenarios is 50% or higher) (1). Initiating RRT can lead to worsened morbidity, extra suffering, and increased health care costs. Time-limited trials (TLTs) in these scenarios offer a potential bridge between conflicting providers or family members. The "technological imperative" is an imperative of possibility in health care: If it is possible, it has to be done. With the availability of continuous RRT, dialysis can be done more safely, even in critically ill patients. As a consultant in the intensive care unit, the nephrologist often rounds separately, which can lead to fragmented messages delivered to patients and families. Alternatively, the primary team might have already discussed dialysis as a "life-saving" intervention, creating expectations from patients and families. The intensive care unit is a highly stressful environment for families and staff, and fragmented communication can augment difficulties. Within this environment, the technological imperative and cultures of care can mean that starting a patient on dialysis might be easier than withholding it, even when nephrologists might disagree (2).

These scenarios can lead to interpersonal conflict among staff and to clinician unease. Providers’ unexamined emotional responses can lead to burnout, cynicism, frustration, and ultimately, poor patient care (3). I describe some scenarios below where TLTs of dialysis can set clear treatment goals for the primary team and the nephrologist.

When the overall prognosis or clinical benefit of RRT is uncertain, TLTs of dialysis must be considered. TLTs are goal-directed trials of RRT limited by predetermined outcomes evaluated at planned intervals. The emphasis must be on clearly defining and documenting the goals of care with an understanding that the intervention must be stopped if goals are not achieved (4).

There are potential benefits of a TLT of dialysis. It allows the nephrologist to assess the reversibility of acute kidney injury, the response to RRT, and changes in the patient's overall prognosis. TLTs can allow families to come to terms with the guarded prognosis without a sense of abandonment (Tables 1 and 2).

The guidelines of the Renal Physicians Association on shared decision-making are a useful tool for nephrologists in these ethical situations. There are guidelines specific to the acute setting as well, with step-by-step details on sharing prognosis, communication tools, and TLTs. One very specific recommendation is to offer RRT in critically ill patients when there is ongoing conflict between medical staff and the patient. Dialysis can be provided while pursuing conflict resolution, provided that the patient or legal agent requests it. Physicians familiar with these tools were more comfortable applying these guidelines clinically than those who were not (3).

The decision to initiate RRT in a critically ill patient is tough when the overall prognosis is unclear. Nephrologists in practice and training should familiarize themselves with the Renal Physicians Association guidelines to assist with realistic decision-making and communication with patient surrogates. Establishing clear indications for TLTs in dialysis and studies that assess outcomes, including morbidity, can help us be better at predicting prognosis and communicating with families in these scenarios.

From a personal perspective as a fellow, having these conversations with families and explaining the prognosis helped develop a relationship of trust with the families, which has been very rewarding.

Information in the Clinical Journal of the American Society of Nephrology ethics series (5) can help guide us regarding TLTs in dialysis.

Arjun Sekar, MD, is a fellow at the Cleveland Clinic.

Table 1: Examples of potential clinical scenarios in which time-limited trials may be of use

- In advanced heart failure with hypervolemia where transplant or LVAD therapies are not available, a TLT could allow assessment of patient response to inotropes and medical management
- Medical optimization before a potentially life-saving high-risk procedure
- Relief of dyspnea in a hypervolemic patient being transferred to hospice care
- Continuing RRT until the arrival of a family member

Abbreviations: LVAD, left ventricular assist device; RRT = renal replacement therapy; TLT = time-limited trial.
### Table 2: Steps in the process of a time-limited trial of dialysis

**Preparation**
- Gather information regarding context of overall prognosis, severity, and prognosis of AKI, and discussions with other providers to obtain consensus
- Identify short- and long-term clinical milestones to assess for progress (or decline)
- Consider palliative care consult for assistance

**Communication**
- Explore patient/family values and goals of care
- Share prognosis with family
- Discuss the milestones to be achieved with RRT in accordance with a patient’s values and goals
- Share the anticipated timeframe of the trial (this can be variable)
- Document all discussions and goals clearly

**After initiating a TLT**
- Meet with family and providers regularly
- Communicate with providers before and after meetings to maintain a unified message
- Consider available choices, including hospice, at the predetermined end of the TLT if the patient has not met the goals

Abbreviations: AKI = acute kidney injury; RRT = renal replacement therapy; TLT = time-limited trial. Adapted with permission of Scherer and Holley (5).

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### Health Care Legislation Moves to Senate

By David L. White

Efforts to dismantle the Affordable Care Act (ACA) continue in Washington on several fronts. On March 7, 2017, Health and Human Services Secretary Tom Price, MD, explained the three phases of ACA repeal: repeal legislation; regulatory review; and subsequent legislation that cannot be included in the first repeal effort due to Senate rules on the budget reconciliation process (see box). Action is occurring on all three phases.

#### Phase One

The American Health Care Act (AHCA), legislation to repeal the ACA, narrowly passed the House last month after the bill was amended to address concerns raised by the first Congressional Budget Office (CBO) score of the bill that estimated AHCA would leave 14 million more people uninsured next year than under President Obama’s health law—and 24 million more in 2026. However, on May 25, the CBO released the updated CBO score for the House-passed version of AHCA. This second estimate was required by Senate rules before the chamber could take up the bill.

The second estimate projects that the bill will save $119 billion over 10 years, $32 billion less than the previous scored version of the bill, and approximately $220 billion less in savings than the initial bill, and was projected to erode coverage by 23 million by 2026.

Here are some highlights from the new CBO score. CBO stressed the uncertainty of its estimates, given that it is hard to know which states would take up the chance to opt out of certain key parts of the ACA. All figures are for the decade spanning 2017 to 2026 unless otherwise specified.

- **23 million fewer will be insured in 10 years.**
- **AHCA would cut spending on Medicaid, the joint federal-state health program for low-income people, by $834 billion.** The program would cover 14 million fewer people.
- **Premiums will go up in 2018 and 2019.** After that, there will be significant variation depending on whether someone lives in a state that opts out of key ACA insurance rules.
- **One out of 6 Americans will live in an area with an unstable insurance market in 2020 where sick people could have trouble finding coverage.**
- **Poor, older Americans would be hit especially hard.** The average 64-year-old earning just above the poverty line would have to pay about 9 times more in premiums.
- **In 2026, 51 million people under age 65 would be uninsured—almost twice as many as the 28 million who would have lacked coverage under the ACA.**
- **The bill will save $119 billion, which is $32 billion less than a previous version of AHCA.**
- **It repeals $664 billion worth of taxes and fees that had financed the ACA.**

The path forward for the bill in the Senate is unclear. The next step is for the Senate parliamentarian to determine which provisions of the bill can pass through reconciliation, which is important even if the Senate plans to largely start from scratch.

Continued on page 18