Difficult Communication in Nephrology

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Effective communication is necessary when providing medical care but can prove challenging when attempting to match patients' values to therapies. Nephrologists often participate in difficult conversations with patients and their families, most commonly involving dialysis in patients with chronic kidney disease (CKD) and ESRD. Despite this, most nephrologists and nephrology fellows do not feel prepared for these difficult conversations (1–3).

In recent years, there has been an increasing focus on goals of care and utilization of a palliative approach in advanced CKD and dialysis care. The aim is to address the symptoms, pain, and stress of advanced kidney disease to improve quality of life. To accomplish these goals, nephrology care providers need to discuss prognosis and goals of care with their patients. There are few specific resources available to help guide nephrologists in these difficult conversations. These include journal articles, a 4-hour communication skills workshop geared toward nephrology fellows (Nephrotalk), and the Renal Physicians Association Clinical Practice Guidelines on Shared Decision-Making in Dialysis & Toolkit (1–5).

Trainees and practicing nephrologists should increase their efforts to use the resources available to help them tackle these discussions with their patients. Although the tendency might be to avoid these conversations due to discomfort or fear of upsetting patients, it has been shown that the majority of patients find it important to be informed about their medical condition, including prognosis (6). As a result, building skills in having difficult discussions will not only improve physician comfort and create more effective communication for future interactions but also meet important patient needs. The techniques taught in the 4-hour workshop provide basic skills for these discussions, including assessing understanding, giving information, responding to emotion, and matching patient values to treatment options. When it comes to giving bad news or assessing goals of care, the physician should start with open-ended questions, use a communication framework, and use the individual skills where appropriate (2).

Late-stage CKD: discussing whether to start dialysis

"Doctor, I know my kidneys aren't working well, but are you sure dialysis is my only option?" One of the most common scenarios that the nephrologist will encounter is whether to start dialysis in an elderly or debilitated patient. Presenting dialysis as a choice rather than the definitive next step in medical care should be discussed with all patients who have advanced CKD, but it is arguably most relevant in elderly patients and those with high levels of comorbidity. Data suggest that, although dialysis can prolong life in individuals older than 75, much of this time is spent either on dialysis or hospitalized, leading to a poor quality of life (7). In patients with high comorbidity scores and especially, ischemic heart disease, the survival advantage with dialysis might disappear (8). This prognostic information needs to be presented to patients to help guide decision-making regarding dialysis, but it is rarely discussed (3).

In addition to physician discomfort, insufficient time is likely contributing to this lack of communication between patients and their nephrologists. When a patient has progressive CKD, he or she is usually referred to classes to learn about kidney disease and dialysis when the nephrologist does not have sufficient time to accomplish this in the clinic. Unfortunately, these classes do not adequately address the option of conservative care for ESRD. Instead, they focus on hemodialysis, peritoneal dialysis, and renal transplant as the three options for patients with worsening kidney disease (9). Thus, if the physician does not mention conservative management, which can include palliative care or hospice care, then the patient may never know that it is an option. Many nephrologists might assume that dialysis education classes discuss the options of conservative management and do not realize the missed opportunity.

Nephrologists should discuss prognosis and conservative management, especially with those over 75 years old or with high comorbidity, during their clinic visit. Although lack of time might seem too great a barrier, both experience and use of various tools (Table 1) can lead to more succinct discussions. In addition, nephrologists should remember that they may be able to use time-based advance care planning codes (99497 and 99498) to be reimbursed for these discussions.

ESRD: Stopping dialysis, including what to expect afterward

"Doctor, my mother is so tired. She only gets out of the house to go to dialysis. I am not sure she wants to continue doing all this." The majority of dialysis patients are unaware of their prognosis, have not completed an advance directive, and have not discussed goals of care with their nephrologists (3). Given their high mortality rates, however, every patient on dialysis would benefit from a discussion regarding goals of care and should complete an advance directive with guidance from the medical team.

The impediments to having discussions about stopping dialysis are similar to those encountered when discussing dialysis initiation. In addition, physician uncertainty regarding both prognosis and life after dialysis cessation may also limit communication regarding stopping dialysis. Patients on dialysis with a poor 6-month survival can be identified with an online prognostic model (10). Alternatively, simply using the surprise question ("Would I be surprised if this patient died within the next year?") can identify patients at risk for higher mortality who would benefit from advance care planning (11). Discussing what life looks like after dialysis, including possible symptoms and their palliative management, likely prognosis, and access to supportive services, including hospice, may be challenging for nephrologists if they have not been trained in end-of-life management for renal patients.

Conclusion

Physician discomfort, insufficient time, lack of training, and medical uncertainty are roadblocks to effective communication with patients and can prevent difficult discussions from taking place. These obstacles may be lessened with education and curricular emphasis during nephrology fellowship programs in addition to meaningful continuing education for practicing nephrologists. Nephrologists should be empowered to discuss prognosis along with goals of care in patients with advanced CKD and ESRD. With skills acquisition and practice as well as utilization of the tools available to guide discussions and determine prognosis, nephrologists can help their patients improve their quality of life.

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Table 1. Tips for discussing prognosis and goals of care in the clinic

- Discuss GOCs with all high-risk patients instead of select patients with challenging cases
- Have conversations about GOCs and prognosis over multiple visits
- Use the EMR to create a GOC template to guide the discussion using specific questions
- Use interactive software to document wishes regarding spiritual beliefs, medical care, and finances
- Have patients watch advance care planning videos to provide framework for further discussions

Abbreviations: EMR = electronic medical record; GOC = goal of care.