

Geriatric Dialysis: Understanding of Effectiveness and Appropriateness Continues to Evolve

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Editor's Note – This article is a review of the articles listed below regarding geriatric dialysis with the assistance of Lori-Ashmore Ruppel, CHA mission program and research associate.

- Akbar, Sana and Alvin H. Moss. “The Ethics of Offering Dialysis for AKI to the Older Patient: Time to Re-Evaluate?” *Clinical Journal of American Society of Nephrology* 9 (2014)
- Bebem, Tomasz and Dena E. Rifkin. “The Elderly are Different: Initiating Dialysis in Frail Geriatric Patients.” 28, no. 3 (May-June 2015)
- Farragher, Janine and Sarbjit Vanita Jassal. “Rehabilitation of the Geriatric Dialysis Patient.” *Seminars in Dialysis* 25, no. 6 (November-December 2012)
- Dannelke, Lenora. “Dialysis: A Forever Decision.” *Aging Well* (Winter 2011).
- Polinder-Bos, H.A. and others. “High Fall Incidence and Fracture Rate in Elderly Dialysis Patients.” *The Netherlands Journal of Medicine* 72, no. 10 (December 2014)
- “Clinical Practice Guidelines on Shared Decision-Making in the Appropriate Initiation and Withdrawal from Dialysis,” Renal Physicians’ Association (2010)
- Ross, William, M.D. “God Panels and the History of Hemodialysis in America: A Cautionary Tale.” *Virtual Mentor, AMA Journal of Ethics* 14, no. 11 (Nov 2012):: 890-896.
- Shum, Chen Keung. “Outcomes in Older Adults with Stage 5 Chronic Kidney Disease: Comparison of Peritoneal Dialysis and Conservative Management.” *Journals of Gerontology: Medical Sciences* 69, no. 3 (March 2014)
- Shandna, Shultz, et al., “Is There a Rationale For Rationing Chronic Dialysis?” *BMJ* 1999 (318:7178): 217-23.
- Singh, Pooja and others. “The Elderly Patient on Dialysis: Geriatric Considerations.” *Nephrology Dialysis Transplantation* 29 (2014)
- Tamura, Kurella, et al., “Functional Status of Elderly Adults Before and After Initiation of Dialysis.” *NEJM* 361 (2009): 1539-47.
- Treit, Kathryn and others. “Timing of Dialysis Initiation in the Geriatric Population: Toward a Patient-centered Approach.” *Seminars in Dialysis* 26, no. 6 (November-December 2013)
- Van Loo, I.N. and others. “A National Survey on the Decision-making Process of Dialysis Initiation in Elderly Patients.” *The Netherlands Journal of Medicine* 73, no. 5 (June 2015)

Introduction

The use of dialysis on a broad basis began in 1962 when the Artificial Kidney Center in Seattle developed an allocation system for dialysis based on “social worth.” This was quickly abandoned, and Congressional action in 1972 (ESRD) made dialysis available to virtually anyone under 75 who was eligible for Social Security. This was clearly a moment of naïveté. No one imagined that the 10,000 patients receiving dialysis when it started would expand to the 320,000 who receive it today at an annual cost of \$39.5 billion or 8 percent of Medicare costs. It has, in the words of one nephrologist, become “an unsustainable behemoth.” What’s more, the fastest growing number of new patients are over 75. Dialysis is just one case study of the effect that growing longevity will have on health care costs in the future.

There have also been questions about the effectiveness of ESRD for geriatric patients, about criteria for decision-making, and about the proper moral agency. Who makes the decision to begin or terminate dialysis, and on what basis? Do poor outcomes and high cost justify initiation of dialysis for the frail elderly, especially when “conservative management” may work just as well? These questions, as well as the relationship of ESRD to the emerging field of palliative care, are the core of the several articles cited above.

Criteria for Decision Making

Initially, not that many people qualified for dialysis, especially those over a certain age. Gradually, the age restriction was dropped. Today most nephrologists agree that it is not the absolute age that matters, but other factors such as co-morbidities, dementia, falls and fractures -- conditions that occur more frequently among the elderly. In addition, research seems to indicate that the benefit of dialysis for patients over 85 is limited (Romano et al, 2014, 235). “There have

been changes in the attitudes of nephrologists,” says Dr. Michael Germain. “Recent studies have shown the very, very poor outcomes for patients with renal failure once they’ve gotten into long-term care” (Yard). Another says that there is a “growing realization that dialysis does not suit all patients (Mutha, 2717); yet another says that dialysis “does not confer a statistically significant survival advantage of non-aggressive, conservative renal care” (Ross 892), and that in many cases conservative management of kidney disease is just as effective as dialysis (Shum et al., p. 308). They also note that conservative management is not simply “no dialysis.” Rather, “it shifts the focus from efforts to prolong life to those that focus on symptom control, quality of life and care support by a multidisciplinary team (Shum, 313). Shandna and Shulz note that predicting survival on dialysis depended more on the level of co-morbidity and functional isolation than on the age of the patient.”

Very recently, one researcher said that “little is known” about what nephrologists consider when they face a decision about initiating dialysis for elderly patients. There is evidence that patient preference, co-morbidities, dementia and poor physical functioning were taken into account. But it is not clear whether “mood disturbances, ADL impairment, frailty and cognitive impairment figured in (vanLoon et al., 228). One French study suggested that psychological and physical deteriorating were principle factors in decisions to refuse or discontinue treatment, but that the decision is deemed legitimate only if dialysis results in a major loss of autonomy or isolation from the family or society.”

There have been several attempts to establish better criteria and a better process for assessing an elderly patient’s suitability for dialysis. A number of authors referred to “Guidelines to Assist Decision Making” taken from the American Society of Nephrology and the United States Renal Physicians. These guidelines

list shared decision making, informed consent, estimating prognosis, conflict resolution, advance directives, withholding or withdrawing dialysis, special patient groups, time-limited trials, and palliative care. (Full text of their guidelines can be found at www.aacn.org). A “Recommended Approach to Starting and Discontinuing Dialysis in the Elderly” is found in Thorsteinsdottir et al. (2097).

Who Decides?

We’ve come a long way from the days when decisions about dialysis were made by a panel, who based their decisions on social value! All researchers placed high priority on patient autonomy, or at least participation, but few felt that was adequate. Most suggested some form of “shared decision making,” that took into account clinical and social factors as well as patient preference. One study noted that in France patients’ refusal to continue treatment is not taken into account. The physician seeks the patient’s opinion, but makes the final decision (Clement et al., 2450). A U.S. nephrologist said that about half of his colleagues decide whether to even raise the issue of initiating dialysis, opting instead to make a unilateral decision that it is not appropriate.

Muthalagappan et al. distinguish among the “fully autonomous” model, which risks overwhelming individuals; a paternalistic model, and a “shared decision-making model.” They note that “difficulties in predicting” prognosis sometimes leave patients with a sense of uncertainty that hinders their involvement. In the end, they say, “the best choice is defined by what matters most to patients, especially when outcomes are variable.” (2720).

Still, “it is hard to identify clear decision points for patients and their families,” says Dannelke. She cites one physician who said, “Older folks in the predialysis clinic would say very routinely, ‘Nope, not for me. Never.’ ...And the next time I saw those folks it

would be in the maintenance unit and they’d be on dialysis...How did that happen?” (26).

Thorsteinsdottir and colleagues note that even if shared decision making is desirable, “nephrologists report that they feel ill-prepared to have” the discussions necessary for such decision-making, that patients often do not feel they have adequate information; that physicians bring their own biases, and families tend to be overly optimistic. They also note the danger of falling into a binary approach, where it is either “dialysis or nothing.” Sekarrie et al not the disadvantage of late referral, and say that primary physicians need more education about referral, and that nephrologists need more education about ethics and the law of discontinuing dialysis and about planning for advance directives (470).

Conservative Management and Palliative Care

A number of authors mention palliative care; three address it at some length. Yard notes that palliative care is an option that is the result of refocusing from increasing survival to enhancing quality of life. Romano, writing from Brazil, promotes a shared decision-making model, but says that foregoing dialysis is only possible in places where there is “a good palliative care program,” to provide other care. Brennan discusses holistic palliative care; he is the only author to take explicit account of the spiritual and religious needs of patients, an important aspect of care in Catholic hospitals.

Dialysis, Economics and Justice

Several writers note the economic aspect of dialysis. William Ross says clearly that it is time for the government to decide whether it is time to phase out the subsidization of care to all patients with ESRD and let patients under 65 seek coverage from third party payers. This would have a dramatic economic impact. Thorsteinsdottir and colleagues note that in the U.S., dialysis is the only specific medical

treatment that gets universal coverage. He maintains this is “discrimination by diagnosis.”

Ross suggests that we should look to the “quality-adjusted life-year” (QALY), the number of years of improved quality of life patients stand to gain from dialysis, as one way to bring the benefits vs. economic burdens calculation into focus. He also says that while he sees Congressional action as unlikely, he thinks it may be time to consider phasing out subsidization of care for all patients on ESRD and let patients under 65 seek coverage from third party payers (893).

Several things are clear from this brief literature review. First, the unique payment arrangement for dialysis has probably contributed to over-use. Second, dialysis is not the best option for all patients, especially those who are elderly and have multiple comorbidities. Third, even if shared decision making is the ideal, patients need more information, and physicians need better ways to lead discussions of options. Fourth, dialysis should not retain its privileged place in funding; other health care needs are equally important. Finally, the time seems right to merge decisions about dialysis with the rapidly growing discipline of palliative care so that it becomes part of an overall strategy for the patient’s good.