Advance Care Planning for Patients Approaching End-Stage Kidney Disease

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Summary: Patients with chronic kidney disease typically suffer a cascade of comorbid conditions, the magnitude of which have formidable impact on advance care planning (ACP). Complex health care decisions are complicated further by contextual issues that may change over time. A dynamic and evolving process, ACP ideally begins early in the continuum of chronic kidney disease, long before end-stage kidney disease is reached. Planning ahead for care is preparatory to making decisions about kidney replacement therapy and can make for a smooth transition in addition to preventing the start of dialysis by default. This article addresses the key components and unique aspects of ACP for patients approaching dialysis, highlighting the importance of shared decision making, and its effect on the execution of multiple aspects of transition.
Semin Nephrol 37:173-180
Keywords: Advance care planning, chronic kidney disease, shared decision making, palliative care, conservative care

Evidence that treatment intensity of patients with end-stage renal disease (ESRD) at the end of life exceeds that of other patients with end-stage organ disease[1] speaks to the propriety of initiating advance care planning (ACP) early to identify life goals, develop a care plan, and prepare for decision making that ultimately may be needed. Reports that some patients regret their decision to start dialysis underscore the importance of a patient-centered approach[2] and ACP as the context within which options for future care should be considered. Unique aspects of ACP for patients approaching ESRD include both the availability of a replacement therapy for a failing organ and the choice to accept or refuse its implementation. Such decisions are multifactorial in scope and may involve primary care and other specialist providers in addition to family members and nephrologists.[3] Advance care planning for patients with chronic kidney disease (CKD) focuses on broad goals of care and serves to guide discussions among patients, their families, and their health care providers.[4] A dynamic process, ACP must adapt to the changing health care status typical of CKD, allowing for intervention as needed when changes in physical, emotional, mental, or social milieu dictate.[5] Planning ahead for care is preparatory to making decisions about renal replacement therapy (RRT) and can facilitate a smooth transition to dialysis as well as optimize the chance that dialysis is not initiated solely because symptoms prompt an urgent decision. This article addresses the key components and unique aspects of ACP for patients approaching dialysis, highlighting the importance of shared decision making, and its effect on the execution of multiple aspects of transition.

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Financial disclosure and conflict of interest statements: none.
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0270-9295/ - see front matter

http://dx.doi.org/10.1016/j.semnephrol.2016.12.007

IMPACT OF ADVANCE CARE PLANNING ON TRANSITION

Early initiation of ACP provides time for thoughtful and deliberate consideration of the options available for RRT, their potential impact on a patient's day-to-day life, and time to contemplate and discuss the choices and preferences that best reflect a patient's values and life goals. Early and serial conversations allow time for providers to help guide their patient, and time for the transition to take place smoothly.[6] Patients with advanced CKD and decreasing kidney function face a manifold of challenges (Fig. 1), ranging from those of a physiological and medical nature to those invoking psychosocial and emotional stressors. The attendant complications of CKD and the comorbid conditions often associated with CKD are compounded further by expectations that patients choosing to pursue RRT be willing to undergo dialysis access surgery.

The decisions required of CKD patients transitioning to ESRD often require family member engagement in addition to time for contemplation, value clarification, reflection, and continued dialogue. Which of the available options for RRT are appropriate and worthy of discussion may vary with the patient's condition, wishes, and the time frame relative to CKD stage and prognosis for progression. For all modality options, education generally is recommended to commence when a patient reaches the intersection between stage 3 and 4 (estimated glomerular filtration rate [GFR], 30 mL/min). Advantages and disadvantages exist for both hemodialysis and peritoneal dialysis and, for some, the option to dialyze at home rather than in-center is an

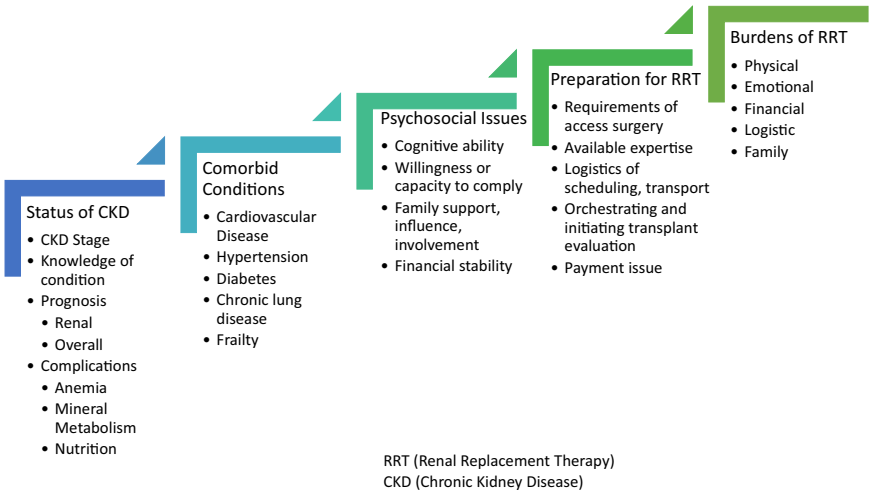

Figure 1. Challenges facing CKD patients poised for the transition to dialysis.

important consideration. The education aspects of ACP are key to the successful transition of CKD to ESRD no matter the modality or setting because both modalities require advance planning for dialysis access in the form of surgery for vascular access to the bloodstream or peritoneal access to the peritoneal cavity. For patients who are medically and otherwise eligible for kidney transplantation, pre-emptive transplantation is an option for which arrangements must be made in advance. With ACP, pretransplant evaluation needed for testing performed to establish dialysis candidacy and transplant listing can be arranged, and in cases in which a living donor is available, logistics and donor evaluation can be achieved before the need for dialysis.

Patients who start dialysis under urgent or even emergent circumstances lose out on the opportunity to deliberate and consider their options and may be less likely to change course or modality.[7] Others start under similar conditions because ACP is not offered, not understood, or even avoided by either the patient or the physician.[8] Still others do not wish to decide or acknowledge their potential for needing dialysis despite their physician's efforts to inform and enlighten them, coping with thoughts of the future through avoidance.[9] In the event that acute kidney injury is sustained and CKD reserve becomes low enough to prompt consideration of RRT, the presumption that death is imminent is likely to trump considerations of risks over benefits.[10] Although in many instances initiation of unplanned RRT is appropriate, patients for whom RRT otherwise may not have been considered a good option are faced with a decision of this magnitude when overwhelming symptoms and fear of death cloud objectivity. Advance care planning optimizes the chance that dialysis is not chosen under emergent circumstances and provides the opportunity for patients to consider the alternative path of palliative or conservative management.[11] Choosing to forego RRT by decision rather than by default allows for active nondialytic management to be instituted and the transition deliberately choreographed. The default of no decision (unless it is necessary) risks an emergency

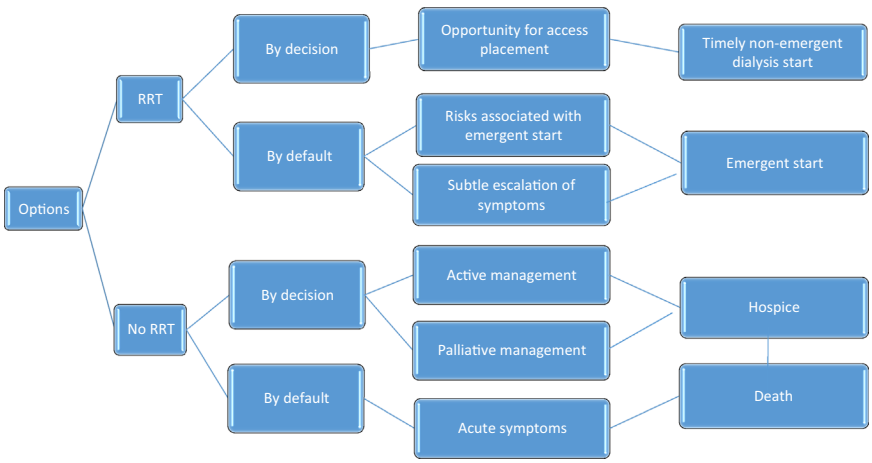

Figure 2. Advance care planning allows for deliberate decision making.