AJKD
In Practice

Communication Skills and Decision Making for Elderly Patients With Advanced Kidney Disease: A Guide for Nephrologists

Holly M. Koncicki, MD,[1] *and Jane O. Schell, MD*[2]

Elderly patients comprise the most rapidly growing population initiating dialysis therapy and may derive particular benefit from comprehensive assessment of geriatric syndromes, coexisting comorbid conditions, and overall prognosis. Palliative care is a philosophy that aims to improve quality of life and assist with treatment decision making for patients with serious illness such as kidney disease. Palliative skills for the nephrology provider can aid in the care of these patients. This review provides nephrology providers with 4 primary palliative care skills to guide treatment decision making: (1) use prognostic tools to identify patients who may benefit from conservative management, (2) disclose prognostic information to patients who may not do well with dialysis therapy, (3) incorporate patient goals and values to outline a treatment plan, and (4) prepare patients and families for transitions and end of life.
Am J Kidney Dis. 67(4):688-695.

INDEX WORDS: Elderly; dialysis; prognosis; prognostic tools; conservative management; nephrologist; treatment plan; end-of-life; end-stage renal disease; chronic kidney disease; geriatric care; communication; review.

CASE PRESENTATION

An 80-year-old woman with diabetes, hypertension, and coronary artery disease is referred to nephrology for evaluation of worsening chronic kidney disease (CKD). During the past 6 months, she has experienced multiple episodes of acute kidney injury in the setting of repeated hospitalizations. Her creatinine level has reached a plateau at 2.5 mg/dL, with an estimated glomerular filtration rate (eGFR) of 18 mL/min/1.73 m^2.

The patient notes decreased energy and appetite. She does not report nausea or vomiting, but notes a 10-lb unintentional weight loss over several months. On examination, she is alert and oriented, is mildly cachectic, and has peripheral edema. Aside from mild acidosis, electrolyte levels are normal.

The patient had previously lived independently; however, since her last admission, she has required the assistance of an aide.

The nephrologist shares with the patient that her kidney function has worsened to the point that management options should be discussed. The patient responds by asking: "How do patients like me do on dialysis? What can I expect if I don't choose dialysis? How will you ensure that I don't suffer?"

INTRODUCTION

This case represents a common clinical challenge for nephrologists caring for an increasingly older medically complex population. Coexisting conditions and geriatric syndromes complicate the care of these patients and may negatively affect the intended goals of dialysis therapy. The nephrologist must help patients decide whether to elect dialysis therapy or conservative management and help prepare them for future setbacks.

End-stage renal disease (ESRD) is associated with high mortality rates, nearly twice those of patients with other serious chronic diseases, including cancer, congestive heart failure (CHF), and stroke.[1] Survival may be extended with dialysis therapy; however, it does not restore normal life expectancy (Table 1). Five-year survival rates are estimated at 40% for all hemodialysis patients.[1] All-cause mortality rates are 6.1 to 7.8 times greater for dialysis patients than age-matched Medicare controls.[1] Additionally, patients with CKD and ESRD have high symptom needs that if left untreated, can impair quality of life and increase hospitalization and overall morbidity.[2,3]

Though often misconstrued as "end of life," palliative care is a philosophy that focuses on improving the quality of life of patients and families living with serious, complex, or life-limiting illness.[4] Patients who may benefit from palliative care services include those with chronic or life-limiting illness, uncontrolled symptoms, declining functional status, or clinical transitions that warrant reassessment of care goals.[5] The components of a comprehensive palliative care assessment are listed in Box 1.[5]

Incorporation of palliative care alongside standard of care has led to better symptom control, adjustment to illness, and preparation for end of life. It has also been associated with a survival benefit in

From the [1]*Division of Kidney Diseases and Hypertension, Hofstra North Shore-LIJ School of Medicine, North Shore LIJ Health Systems, Great Neck, NY; and* [2]*Section of Palliative Care and Medical Ethics, Renal-Electrolyte Division, University of Pittsburgh School of Medicine, University of Pittsburgh Medical Center, Pittsburgh, PA.*

Received June 2, 2015. Accepted in revised form September 18, 2015. Originally published online December 18, 2015.

Address correspondence to Holly M. Koncicki, MD, Hofstra North Shore-LIJ School of Medicine, Department of Medicine, Division of Kidney Diseases and Hypertension, 100 Community Dr, Great Neck, NY 11021. E-mail: hkoncicki@nshs.edu

0272-6386
http://dx.doi.org/10.1053/j.ajkd.2015.09.032

Table 1. Average Life Expectancy

Age, y	Prevalent Dialysis Population	General Population
65-69	4.6	15.5
70-74	3.9	12.1
75-79	3.3	9.1
80-84	2.7	6.5
>85	2.2	3.4

Data from Saran et al.[1]

some conditions, including CHF and lung and pancreatic cancer.[6,7] The demand for palliative care has grown in recent years following these well-recognized improvements. Attention has focused on how to promote the development of primary palliative care skills in subspecialties such as nephrology. These skills include management of symptoms, decision making around treatment choices, and preparation for end of life (Box 1). This review outlines 4 primary palliative care skills for nephrology providers to guide treatment decision making (Box 2).

PRIMARY PALLIATIVE CARE SKILLS FOR NEPHROLOGISTS

Skill 1: Use Prognostic Tools to Identify Patients Who May Benefit From Conservative Management

Importance of Prognosis

Prognostic understanding can affect the kinds of treatments a patient may choose and preparation for the future. Though patients value prognostic information that estimates survival benefit with a given treatment, as well as how the quality of this added time is experienced, these discussions occur infrequently.[8] In a discrete choice experiment, patients considering dialysis therapy initiation were willing to trade off survival time gained with dialysis in exchange for greater independence and less time interfaced with the health care system.[9] Prognostic information therefore serves as a starting place for patients to consider the risks and benefits of dialysis in terms of their overall care goals.

Box 1. Components of Palliative Care Assessment

1. Pain and symptom assessment (including physical and psychological)
2. Identification of social and spiritual concerns
3. Assess understanding of and education about current illness, prognosis, trajectories, and treatment options
4. Establishment of patient-centered goals of care and advance care planning
5. Identification and aiding at times of transitions of care

Source: Weissman and Meier.[5]

Box 2. Primary Palliative Care Skills for Nephrologists

1. Use prognostic tools to identify patients who may benefit from conservative management
2. Disclose prognostic information to patients who may not do well with dialysis
3. Incorporate patient goals and values to outline a treatment plan
4. Prepare patients and families for transitions and end of life

Patients with ESRD are less likely to have engaged in prognosis discussions compared with other patients with serious chronic conditions. A study compared seriously ill patients who were starting dialysis therapy and their nephrologists' perspectives on their prognosis.[10] Patients were more likely to overestimate prognosis. Those who were overly optimistic tended to prefer more aggressive therapies if they became seriously ill. By not engaging in prognosis discussions, patients with ESRD are less prepared to make treatment decisions for future setbacks and clinical decline. As a result, these patients tend to experience more intensive care at end of life and underutilize hospice. Patients who have discussed prognosis with their providers are more prepared for setbacks with fewer incidences of intensive therapies at end of life and a higher likelihood of receiving hospice services.[11]

Prognosis With Dialysis

Most patients elect dialysis therapy in hopes of living longer and better, yet older patients with advanced comorbid conditions may not meaningfully gain survival or improved quality of life. Understanding the available prognostic tools and markers can be helpful in making recommendations to patients regarding treatment options for their advanced CKD. The Renal Physicians Association guidelines suggest that patients with 2 or more of the following prognostic factors are at high risk for poor outcomes with dialysis therapy[12]: age older than 75 years, a high comorbidity score (eg, Charlson Comorbidity Index score $\geq$ 8), poor functional status or disability (eg, Karnofsky Performance Status $<$ 40; this includes patients who are unable to care for themselves and may require inpatient or special care and assistance), and severe chronic malnutrition (eg, serum albumin $<$ 2.5 g/dL).

In addition, a provider's clinical experience and judgment may identify patients at risk for poor outcomes with dialysis. In a study of 321 patients, 68 were recommended by providers for conservative management.[13] These patients were older, diabetic, and functionally impaired. When those who elected dialysis therapy despite the conservative management recommendation were compared with those who had pursued conservative therapy, the survival gained