Executive Summary
The Renal Physicians Association (RPA) and the American Society of Nephrology (ASN) in conjunction with representatives from multiple disciplines and organizations in the dialysis community, kidney patients and family members, and internal medicine physicians as well as a bioethicist and a public policy expert comprised a working group that completed the Clinical Practice Guideline on Shared Decision-Making in the Appropriate Initiation of and Withdrawal from Dialysis late last year. The guideline presents recommendations concerning withholding or withdrawing dialysis in adult patients with either acute renal failure (ARF) or end-stage renal disease (ESRD).

These recommendations are based on the expert consensus opinion of the RPA/ASN Working Group. The members of the working group included:

- Alvin H. Moss, M.D., chair
- William F. Owen, Jr., M.D., vice chair
- Richard Albert, M.D.
- Eileen Brewer, M.D.
- Helen Danko, M.S., R.N.
- John H. Galla, M.D.
- Roman M. Hendrickson, M.D.
- Albert R. Jonsen, Ph.D.
- Judith Kari, M.S.W.
- Bertram Kasiske, M.D.
- Karren King, M.S.W.
- Jenny Kitsen
- John M. Newmann, Ph.D., M.P.H.
- Christy A. Price, R.N., M.S.N.
- Richard Rettig, Ph.D.
- Dale Singer, M.H.A.

Group members developed a priori analytic frameworks for decisions to withhold or withdraw dialysis in patients with ARF and ESRD. Systematic literature reviews were conducted to address pre-specified questions derived from the frameworks. In most instances, the relevant evidence that was identified was contextual in nature and only provided indirect support to the recommendations. The research evidence, case and statutory law, and ethical principles were used by the Working Group in the formulation of their recommendations. The recommendations are not mandatory, but rather flexible guidelines that may be tailored to a particular patient, provider, and geographic circumstance. They allow the renal care team to use discretion as they are applied to individual patients. They are intended for use by providers and patients (and their families or advisors) in the United States and its trust territories to aid in dialysis decision-making. They are not intended for use by regulatory agencies for reimbursement or other decisions.

The working group proposed and prioritized key questions related to the models using a combined nominal and modified Delphi process. Questions specified information that was either desirable or necessary to make informed and ethical decisions about withholding or withdrawing dialysis. Such questions were categorized as directly informative to the evidence model or as background and contextual in nature. These key questions guided analysis of the evidence.

Standard forms were used to abstract data from each study. Such data included information about study purposes and designs, participant descriptors, methodologic characteristics, outcome measures, and results.

Peer review of the guideline was obtained after development of the evidence model and selection of relevant literature to identify any major oversights in formulation of the evidence model and any seminal research evidence that was missed in the literature search. A second level of peer review was conducted when the draft guideline document and recommendations were completed. Peer reviewers were nominated by stakeholder organizations and other volunteers from the nephrology community. The final guideline was submitted to multiple organizations to request their endorsement.

At press time the following organizations had endorsed the guideline recommendations: Renal Physicians Association, American Society of Nephrology, American Society of Pediatric Nephrology, American Nephrology Nurses Association, National Kidney Foundation, American Association of Kidney Patients, National Renal Administrators Association, and Forum of End-Stage Renal Disease Networks.

The guideline includes nine recommendations that are listed below. The recommendations are supported by 15 prognostic tables and 302 references.

**Recommendations**

1. **Shared Decision-Making**. A patient-physician relationship that promotes shared decision-making is recom-
mended for all patients with either ARF or ESRD. Shared decision-making should involve at a minimum the patient and the physician. If a patient lacks decision-making capacity, decisions should involve the patient’s legal agent. With the patient’s consent, shared decision-making may include family members or friends and other members of the renal care team.

2. Informed Consent or Refusal. Physicians should fully explain diagnosis, prognosis, and all treatment options to each patient. The explanation of treatment options should include: (1) available dialysis modalities; (2) not starting dialysis and continuing conservative management which should include end-of-life care; (3) a time-limited trial of dialysis; and (4) stopping dialysis and receiving end-of-life care. Choices among options should be made by patients or, if patients lack decision-making capacity, their designated legal agents. Their decisions should be informed and voluntary. The renal care team, in conjunction with the primary care physician, should ensure that the patient or legal agent understands the consequences of the decision.

3. Estimating Prognosis. To facilitate informed decisions about starting dialysis for either ARF or ESRD, discussions should take place with the patient or legal agent about life expectancy and quality of life. Depending on the circumstances (e.g., availability of nephrologists), a primary care physician or nephrologist who is familiar with prognostic data should conduct these discussions. These discussions should be documented and dated. Chances for survival should be estimated for all patients requiring dialysis, with the realization that the ability to predict survival in the individual patient is difficult and imprecise. The estimates should be discussed with the patient or legal agent, the patient’s family, and the medical team. For patients with ESRD, these discussions should take place as early as possible in the course of the patient’s renal disease and continue as the disease progresses. For patients who encounter major complications that may substantially reduce survival or quality of life, it is appropriate to discuss and/or reassess treatment goals, and to consider withdrawing dialysis.

4. Conflict Resolution. A systematic approach for conflict resolution is recommended when disagreement exists regarding the benefits of dialysis between the patient or legal agent (and those supporting the patient’s position) and a member(s) of the renal care team. Conflicts may also occur within the renal care team or between the renal care team and other health care providers. This approach should review the shared decision-making process for the following potential sources of conflict: (1) miscommunication or misunderstanding about prognosis; (2) intrapersonal or interpersonal issues; and/or (3) values. If dialysis is indicated urgently, it should be provided while pursuing conflict resolution, provided the patient or legal agent requests dialysis.

5. Advance Directives. The renal care team should attempt to obtain written advance directives from all dialysis patients. These advance directives should be honored.

6. Withholding or Withdrawing Dialysis. It is appropriate to withhold or withdraw dialysis for patients with either ARF or ESRD for:

- Patients with decision-making capacity who, being fully informed and making voluntary choices, refuse dialysis or request that dialysis be discontinued.
- Patients who no longer possess decision-making capacity who have previously indicated refusal of dialysis in an oral or written advance directive.
- Patients who no longer possess decision-making capacity and whose properly appointed legal agents refuse dialysis or request that it be discontinued.
- Patients with irreversible, profound neurologic impairment such that they lack signs of thought, sensation, purposeful behavior, and awareness of self and environment.

7. Special Patient Groups. It is reasonable to consider not initiating or withdrawing dialysis for patients with ARF or ESRD who have a terminal illness from a nonrenal cause or whose medical condition precludes the technical process of dialysis.

8. Time-Limited Trials. For patients requiring dialysis, but who have an uncertain prognosis or for whom a consensus cannot be reached about providing dialysis, nephrologists should consider offering a time-limited trial of dialysis.

9. Palliative Care. All patients who decide to forego dialysis (or for whom such a decision is made) should receive continued palliative care. With the patient’s consent, those who have expertise in such care, such as hospice health care professionals, should be involved in managing the medical, psychosocial, and spiritual aspects of end-of-life care for these patients. Patients should be allowed to decide if they wish to die in a health care facility or at home with hospice care. Bereavement support should be offered to patients’ families.

Using selection criteria similar to those recommended by the Agency for Health Care Policy Research and the Institute of Medicine, RPA/ASN selected this topic based on the following conditions:

- Prevalence of the clinical problem,
- Burden of the illness associated with the problem,
- Significance of social, ethical, and legal considerations surrounding the problem,
- Unnecessary variability of clinical practice in managing the problem,
- Potential for the development of an evidence-based, clinical practice guideline to improve patient outcomes,
- Availability of scientific evidence to support a clinical practice guideline, and
- Financial implications of the clinical practice guideline.

In 1991, the Institute of Medicine recommended developing a clinical practice guideline “for evaluating patients for whom the burdens of renal replacement therapy may substantially outweigh the benefits.” Since then, nephrologists have reported being increasingly asked to dialyze patients for whom they perceive dialysis will be of marginal benefit. Not surprisingly, almost a decade later, this topic was given highest priority for guideline development because the renal professional community recognizes that the incident and prevalent ESRD population has changed substantially.
An increasing number of patients who are initiating renal replacement therapy are elderly and suffer from a variety of comorbid conditions that adversely affect the health-related quality of life. Furthermore, voluntary withdrawal from dialysis has become an increasingly common occurrence. Recent United States Renal Data System (USRDS) data show that approximately one of five patients voluntarily withdraws from dialysis.

External forces have raised awareness within the renal community of the need to address the issues of starting and stopping dialysis. Much public attention has focused on patients’ rights to discontinue medical therapies and the debate regarding the propriety of physicians actively assisting patients to end their lives. As a component of this public deliberation, increasing numbers of patients and their care providers have developed advance directives. Therefore, it is likely that the public will be interested in this guideline of patients’ rights and the use of palliative care.

In the context of an expanding American dialysis program that includes an increasing number of patients who have substantial comorbid conditions, the RPA/ASN leadership believe that an evidence-based clinical practice guideline that will assist patients, families, and the nephrology team in making decisions about initiating, continuing, and stopping dialysis will be timely and beneficial. This guideline will benefit patients and families by presenting more information about various options for the treatment of ESRD and by calling for their active participation in these decisions in recognition of their rights. Similarly, the evidence-based recommendations will help nephrologists and other members of the renal care team better inform and counsel patients and families about potential outcomes of acute renal failure and ESRD.

This guideline does not make explicit recommendations for pediatric patients, although many of the principles may apply to that population. In the pediatric setting, shared decision-making involves physicians and parents, unless the child has decision-making capacity. Shared decision-making is more difficult without adequate outcome data, and data on long-term outcomes for children treated with acute or chronic dialysis are sparse and do not address many quality of life issues or potentially long-term sequelae, especially for the infant. Parents have the legal authority to make decisions on behalf of their children, assuming that they act in the best interest of their child. Generally, parents give permission for the treatment of their children unless their legal authority has been removed and granted to others (e.g., the state). However, the American Academy of Pediatrics (AAP) emphasizes that physicians and parents should give great weight to clearly expressed views of child patients regarding life-sustaining medical treatment, regardless of the legal particulars. Child patients should participate in decision-making commensurate with their developmental capacity, and child assent should be sought whenever reasonable. In some states, adolescents under the age of 18 may be assessed to be sufficiently mature to make medical decisions for themselves. The AAP believes that the views of even younger children should be factored into end-of-life decisions.

Decisions to either withhold or withdraw dialysis are complex and depend on circumstances unique to individual patients and their providers. Although these recommendations are meant to aid in dialysis decision-making, they do not cover every possible contingency. Furthermore, the guideline recommendations do not cover the technical management of patients receiving dialysis or the selection of patients for renal transplantation.

The objectives of this guideline are to:

- Synthesize available research evidence on patients with ARF and ESRD as a basis for making recommendations about withholding and withdrawing dialysis,
- Enhance understanding of the principles and processes useful for and involved in making decisions to withhold or withdraw dialysis,
- Promote ethically as well as medically sound decision-making in individual cases,
- Recommend tools that can be used to promote shared decision-making in the care of patients with ARF or ESRD, and
- Offer an understandable and acceptable ethical framework for shared decision-making among health care providers, patients, and their families.

The primary target audience of this guideline is health care providers involved in the care of patients with either ARF or ESRD: nephrologists, intensivists, primary care physicians, nephrology nurses, advanced practice nurses, and nephrology social workers. It may also be useful to patients and their families, renal dietitians, dialysis technicians, renal administrators, clergy, and policy makers.

Copies of the clinical practice guideline may be purchased from the RPA by contacting rpa@renalmd.org or calling 301-468-3515.
Revised Dialysis Clinical Practice Guideline Promotes More Informed Decision-Making

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Over a decade ago, the Renal Physicians Association and the American Society of Nephrology published the clinical practice guideline, *Shared Decision-Making in the Appropriate Initiation of and Withdrawal from Dialysis*, to assist nephrologists, patients, and families in making decisions to initiate and withdraw dialysis. Since then, researchers have extensively studied dialysis decision-making, and there is a substantial body of new evidence with regard to 1) the poor prognosis of some elderly stage 4 and 5 chronic kidney disease patients, many of whom are likely to die before initiation of dialysis or for whom dialysis may not provide a survival advantage over medical management without dialysis; 2) the prevalence of cognitive impairment in dialysis patients and the need to periodically assess them for decision-making capacity; 3) the under-recognition and undertreatment of pain and other symptoms in dialysis patients; 4) the underutilization of hospice in dialysis patients; and 5) the distinctly different treatment goals of ESRD patients based on their overall condition and personal preferences. The Renal Physicians Association developed this second edition of the guideline to provide clinicians, patients, and families with 1) the most current evidence about the benefits and burdens of dialysis for patients with diverse conditions; 2) recommendations for quality in decision-making about treatment of patients with acute kidney injury, chronic kidney disease, and ESRD; and 3) practical strategies to help clinicians implement the guideline recommendations.


Accumulating evidence indicates that many elderly patients started on dialysis fare badly. In a study of >3000 nursing home residents who had a mean age of 73 years, by 12 months after the start of dialysis, 58% had died and all but 13% had experienced a substantial and sustained decline in functional status (1). Additionally, the evidence shows that there is significant regional variation in how elderly ESRD patients are treated. Elderly patients who received treatment in higher health care intensity regions at the end of life were less well prepared to start dialysis, less likely to have discontinued dialysis, less likely to have received hospice care, and more likely to have died in the hospital. These findings underline the importance of a comprehensive informed consent process before ESRD treatment based on the best available evidence and pertinent clinical practice guidelines (2).

Over a decade ago, the Renal Physicians Association and the American Society of Nephrology published the clinical practice guideline, *Shared Decision-Making in the Appropriate Initiation of and Withdrawal from Dialysis*, to assist nephrologists, patients, and families in making decisions in initiating and withdrawing dialysis (3). In the decade since the publication of this guideline, nephrologists have been challenged as they increasingly encounter an older population of patients with substantial comorbidities (4), and concurrently, researchers have extensively studied multiple aspects of dialysis decision-making for patients with acute kidney injury (AKI), chronic kidney disease (CKD), and ESRD.

**Guideline Goals**

In developing the second edition of this guideline, the Renal Physicians Association sought to provide clinicians, patients, and families with 1) the most current evidence about the benefits and burdens of dialysis for patients with diverse conditions; 2) recommendations for quality in decision-making about treatment of patients with AKI, CKD, and ESRD; and 3) practical strategies to help clinicians implement the guideline recommendations.

**New or Expanded Topic Areas in the Second Edition of the Guideline**

The second edition provides the following new or expanded topic areas that build on the evidence presented in the original guideline:

- The poor prognosis of some elderly stage 4 and 5 CKD patients, many of whom are likely to die before initiation of dialysis or for whom dialysis may not provide a survival advantage over medical management without dialysis.
- New evidence on estimating prognosis in ESRD patients including an integrated prognostic model that incorporates the patient’s age, serum albumin level, comorbidities, and clinician use of the “surprise” question—“Would I be surprised if this patient died in the next year?”—available at http://touchcalc.com/calculators/sq.
• The identification of distinctly different treatment goals for ESRD patients based on their overall condition and personal preferences: 1) patients who choose aggressive therapy with dialysis without limitations on other treatments; 2) patients with poor prognosis who choose dialysis but with limitations on treatments such as cardiopulmonary resuscitation, endotracheal intubation, and mechanical ventilation because they want to balance life prolongation and comfort; and 3) patients who decline dialysis and prefer that the primary goal of their care be their comfort.

• The frequent prevalence of cognitive impairment in dialysis patients and the need to periodically assess them for decision-making capacity.

• A recognition of the evidence that advance directives have failed to impact patient care and that advance care planning with a discussion of the patient's goals for care and completion of a Physician Orders for Life-Sustaining Treatment Paradigm form (only available in some states and regions) is the preferred approach for decision-making for patients who have lost or are likely to lose decision-making capacity over time.

• The under-recognition and undertreatment of pain and other symptoms in dialysis patients.

• The underutilization of hospice in dialysis patients.

• An understanding of the communication challenges in discussing prognosis and treatment options with CKD and ESRD patients and their families and a presentation of evidence-based strategies to assist nephrologists in this communication.

Methodology

The second edition uses the same two analytic frameworks that were developed for the original guideline: one for AKI and one for ESRD. These frameworks represent dynamic chronological sequences of decision-making that are informed by multiple factors such as patients’ preferences, prognosis, feasibility of dialysis, and quality of life. The San Antonio Evidence-based Practice Center and Veterans Administration Cochran Center developed the frameworks for the original guideline using methodology adapted from the Agency for Health Care Policy and Research Guideline process and the American Medical Association’s Attributes for Clinical Practice Guideline Development document.

For the second edition, pertinent adult and pediatric English language literature published from January 2003 to October 2009 was identified from an electronic literature search of PubMed, references from articles, recommendations from experts, and hand searches of medical and nephrology journals. In addition to the search terms used in the original guideline development (dialysis, end-stage renal disease, and acute renal failure), the search terms “palliative care” and “end-of-life care” were also included. In the second edition search, 4593 articles were identified, 3188 articles were excluded by title, 1405 articles abstracts were retrieved, 1144 articles were excluded by abstracts, 261 articles met selection criteria, and an additional 124 articles were added in the guideline development. As a result, in addition to the 300 studies in the original guideline, 385 new studies constituted the evidence base.

For the second edition, the article selection criteria, data abstraction process, levels of evidence, and formulation of recommendations were the same as used in the original guideline development process. More than 40 nephrology clinicians and intensivists, a bioethicist, and a pediatric psychologist were divided into eight workgroups and participated in the data abstraction process, with each article reviewed by two persons. If the two reviewers disagreed on whether an article should be included in the guideline evidence base, a third reviewer, usually the workgroup chair, broke the tie. To aid standardization of abstraction, the workgroups were assigned articles related to the specific thematic areas of the original guideline’s recommendations: shared decision-making, informed consent, and conflict resolution; prognosis of AKI; prognosis of ESRD; withholding and withdrawal of dialysis; advance directives and advance care planning; and palliative care.

The workgroups for adult patients reviewed the evidence and revised the recommendation and the rationale accordingly. Because of perceived need, two workgroups developed new recommendations and rationales for the second edition: communication of diagnosis and prognosis; and pediatric decision-making. The pediatric workgroup used the same methodology as the adult workgroups and developed recommendations for neonate, infant, child, and adolescent dialysis decision-making for AKI, CKD, and ESRD.

The rationales for each recommendation give the grade for the level of evidence. Level A evidence was the highest. For example, level A observational evidence was based either on multiple large studies or a single nationally representative study with a >80% response rate. The research evidence, case and statutory law, and ethical principles were used by the guideline workgroups in the formulation of the guideline recommendations and rationales.

Peer Review and Endorsement

Peer review of the guideline was solicited at multiple points. First, for the adult patient recommendations and rationales, peer review of the revisions suggested for each workgroup was performed within the workgroups. Second, the seven workgroup chairs for the adult recommendations reviewed all seven workgroups’ suggested changes. Each workgroup chair had previously been involved only in the literature review and revision of his or her assigned original guideline recommendation and rationale. Third, the adult recommendations and rationales were reviewed by a wide array of nephrologists, palliative care physicians, members of the kidney end-of-life coalition, representatives from the American Society of Nephrology, American Nephrology Nurses Association, American Association of Kidney Patients, and National Renal Administrators Association, and a health economist. Individuals or committees from the American Academy of Hospice and Palliative Medicine, American Association of Critical Care Nurses, American College of Nurse Practitioners, American Geriatric Society, Center to Advance Palliative Care, National Hospice and Palliative Care Organization, and Society of Critical Care...
Guideline Content
Figure 1 summarizes the recommendations for adult patients. A separate article for the pediatric literature is being written with the recommendations for pediatric patients. The content of the guideline is listed below in the bullets. In the guideline, boxes provide suggestions for specific action items to facilitate implementation of the recommendations.

- Scope, objectives, and target audience: Section 2 gives the scope of the guideline topic. Specific objectives are given and the intended target audience is described.
- Guideline development process: Section 3 details the methodology that was used to develop the guideline. Analytic frameworks and questions that were used to guide the entire process are presented. Literature searches, selection criteria, and methods of evidence critique and ratings are explained. Peer review processes and mechanisms for formulating final guideline recommendations are explicated.
- Guideline recommendations and their rationales for adult and pediatric patients: Sections 4 and 5 present the guideline recommendations, the principles, laws, and systematic reviews of evidence on which they were based. Ratings of the quality of evidence are provided.
- Prognostic data: Figures and tables with prognostic data for recommendation no. 3 are presented in the Appendix. They provide evidence-based information that may help health care professionals estimate prognosis for individual patients.
- Tool Kit-Useful instruments for implementing the guideline recommendations: Section 9 provides numerous validated tools that clinicians may use to implement the guideline recommendations. These include the Patient Health Questionnaire to screen for depression, the Trail Making Test Part B to test for cognitive impairment, the modified Charlson Comorbidity Index to calculate a comorbidity score, the French Renal Epidemiology and Information Network Registry Clinical Score to predict 6-month prognosis, the Karnofsky Performance Status Scale to assess functional status, and the Dialysis Symptom Index to assess symptom frequency and severity.

As an example, the following are practical suggestions from Box 3 in the guideline for implementing recommendation number 3, Fully inform AKI, stage 4 and 5 CKD, and ESRD patients about their diagnosis, prognosis, and all treatment options.

Establishing a Shared Decision-Making Relationship
Recommendation No. 1
Develop a physician-patient relationship for shared decision-making.
Informing Patients
Recommendation No. 2
Fully inform AKI, stage 4 and 5 CKD, and ESRD patients about their diagnosis, prognosis, and all treatment options.
Recommendation No. 3
Give all patients with AKI, stage 5 CKD, or ESRD an estimate of prognosis specific to their overall condition.
Facilitating Advance Care Planning
Recommendation No. 4
Institute advance care planning.
Making a Decision to Not Initiate or to Discontinue Dialysis
Recommendation No. 5
*If appropriate, forgo (withhold initiating or withdraw ongoing) dialysis for patients with AKI, CKD, or ESRD in certain, well-defined situations.

These situations include the following:
- Patients with decision-making capacity, who being fully informed and making voluntary choices, refuse dialysis or request that dialysis be discontinued.
- Patients who no longer possess decision-making capacity who have previously indicated refusal of dialysis in an oral or written advance directive.
- Patients who no longer possess decision-making capacity and whose properly appointed legal agents/surrogates refuse dialysis or request that it be discontinued.
- Patients with irreversible, profound neurological impairment such that they lack signs of thought, sensation, purposeful behavior, and awareness of self and environment.

*Medical management incorporating palliative care is an integral part of the decision to forgo dialysis in AKI, CKD, or ESRD, and attention to patient comfort and quality of life while dying should be addressed directly or managed by palliative care consultation and referral to a hospice program (see Recommendation No. 9 on palliative care services).

Recommendation No. 6
Consider foregoing dialysis for AKI, CKD, or ESRD patients who have a very poor prognosis or for whom dialysis cannot be provided safely.

Included in these categories of patients are the following:
- Those whose medical condition precludes the technical process of dialysis because the patient is unable to cooperate (e.g., advanced dementia patient who pulls out dialysis needles) or because the patient’s condition is too unstable (e.g., profound hypotension).
- Those who have a terminal illness from non-renal causes (acknowledging that some in this condition may perceive benefit from and choose to undergo dialysis).
- Those with stage 5 CKD older than age 75 years who meet two or more of the following statistically significant very poor prognosis criteria (see Recommendations No. 2 and 3): 1) clinicians’ response of “No, I would not be surprised” to the “surprise” question; 2) high comorbidity score; 3) significantly impaired functional status (e.g., Karnofsky Performance Status score less than 40); and 4) severe chronic malnutrition (i.e., serum albumin less than 2.5 g/dL using the bromocresol green method).

Resolving Conflicts about What Dialysis Decisions to Make
Recommendation No. 7
Consider a time-limited trial of dialysis for patients requiring dialysis, but who have an uncertain prognosis, or for whom a consensus cannot be reached about providing dialysis.

Recommendation No. 8
Establish a systematic due process approach for conflict resolution if there is disagreement about what decision should be made with regard to dialysis.

Providing Effective Palliative Care
Recommendation No. 9
To improve patient-centered outcomes, offer palliative care services and interventions to all AKI, CKD, and ESRD patients who suffer from burdens of their disease.

Recommendation No. 10
Use a systematic approach to communicate about diagnosis, prognosis, treatment options, and goals of care.

Figure 1. Summary of adult patient recommendations.

- For ESRD patients, estimate prognosis based on patient’s age, functional status, medical condition, including comorbidity and recent sentinel events, and the “surprise” question (Would I be surprised if this patient died in the next year?). The website http://touchcalc.com/calculators/sq provides a calculator for use of the “surprise” question response and
other variables to estimate prognosis in dialysis patients. The same degree of precision does not exist for tools that estimate prognosis for patients with AKI.

• Present the prognosis in a manner that is considerate of the patient’s emotional condition. Balance the patient’s desire for quality and quantity of life and provide reassurance that the physician has kept the patient’s best interest in mind. With the patient’s permission, strongly encourage the patient’s legal agent/family to participate in the discussion of prognosis and treatment options. See Recommendation No. 10 for suggested approaches to discussing prognosis, treatment options, and goals of care with AKI, CKD, and ESRD patients.

• Identify patient’s wishes and goals for treatment at onset of dialysis and again after any irreversible change in medical condition.

• For ESRD patients, reassess and communicate prognosis on at least an annual basis and more often as indicated by any major change in status.

• For CKD and ESRD patients, during each annual Comprehensive Assessment and Plan of Care discussion, communicate appropriate options based on the patient’s condition, prognosis, and goals for care. Regardless of choice, palliative care should be offered for pain and symptom management and advance care planning. Hospice referral is appropriate for ESRD patients stopping dialysis and for those continuing dialysis who have a predicted prognosis of <6 months.

• Provide recommendation to withhold/stop dialysis in patients who are not likely to benefit.

• If conflicts arise in shared decision-making, consider palliative care or ethics consultation (see Recommendation No. 8).

The guideline recommends shared decision-making—the process by which physicians and patients agree on a specific course of action based on a common understanding of the treatment goals and risks and benefits of the chosen course compared with reasonable alternatives. It notes, however, that there are limits to shared decision-making that protect the rights of patients and the professional integrity of health care professionals. The informed patient with decision-making capacity has the right to refuse dialysis even if the renal care team disagrees with the patient’s decision and wants the patient to undergo it. Similarly, even if the patient or family demands dialysis, the renal care team has the right to refuse to offer it when the expected benefits do not justify the risks. Recognizing that there are circumstances in which patients and renal care teams might disagree about decisions to start, continue, or stop dialysis, the guideline provides a recommendation and practical approaches for how to resolve such conflicts.

The true worth of the second edition of the guideline will be determined by the extent to which it is used and found helpful by clinicians, patients, and families making decisions to start or stop dialysis. U.S. and Canadian nephrologists who were aware of and used the original guideline reported themselves significantly more prepared to make end-of-life decisions with their dialysis patients than those who were not aware of the guideline (5).

This second edition of the clinical practice guideline is available for purchase through the Renal Physicians Association’s online store at www.renalmd.org.

Disclosures
None.

References