

Chapter 18: Ethics of RRT, Initiation, and Withdrawal in Cancer Patients

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Malignancies are common in CKD patients, and the incidence is higher than in the general age-matched population. Because cardiovascular disease and infection are so prevalent in CKD, especially ESRD patients, the mortality rate from cancer in ESRD patients is lower than the age-matched general population due to these competing influences. Thus, the relative risk of mortality from cancer is increased in the younger ESRD population and then declines with age (1,2).

Patients with cancer and a need for RRT present very difficult scenarios for making clinical decisions, and an approach grounded in medical ethical principles can be helpful (3–7). Medical ethics reflect the culture and time that we are living in and also include a religious perspective. This chapter will focus on a US perspective that reflects the generally accepted values of our society at the present time. The United States has a wide representation of cultural and religious values, with many patients who are new immigrants from many countries. A discussion of the different medical ethical approaches from these societies is beyond the scope of this discussion, but the clinician should always inquire from the patient and family how they want prognosis, goals of care, and end-of-life issues discussed with them. This discussion will rely heavily on the national clinical practice guideline *Shared Decision-Making in the Appropriate Initiation of and Withdrawal from Dialysis*, 2nd Ed. (SDMG), in particular the section “Ethical Considerations in Dialysis Decision-Making” (8). Six ethical principles should be strongly considered for patients with cancer when discussing RRT (Table 1).

Conflicts between respect for patient autonomy and beneficence/nonmaleficence often can occur with these patients. There are four scenarios where the ethical issues of cancer and RRT intersect: 1) patients with ESRD who develop a terminal malignancy; 2) patients with a terminal malignancy who develop ESRD; 3) patients with a terminal malignancy who develop AKI (AKI can be caused by the treatment of the malignancy, obstruction or invasion of the

kidney by the malignancy, or surgical removal of the kidney to remove the malignancy); and 4) a renal transplant patient with a terminal malignancy.

In the first scenario, withdrawal of dialysis (9–11) is often the ethical question. In the second and third scenarios, withholding of dialysis or withdrawal may be the ethical issue. An important ethical aspect is the ethical imperative of the clinician to “first, do no harm.” The clinician has the right and duty not to order a treatment that will do more harm than good. Nephrologists often find themselves in the position of being asked to provide dialysis, by a patient, family, or other clinicians, when dialysis may not be in the patient’s best interest. Many clinicians feel they are required to provide dialysis treatment when the patient or health care provider (HCP) requests it. The SDMG (recommendations 5 and 6) clearly state that the clinician has no such obligation. The clinician should document these discussions and make it clear that the patient/HCP has the right to transfer care to another clinician. Clinicians should not fear medical–legal concerns in this scenario; in reality, these rarely, if ever, occur, especially if the SDMG is followed.

Instead, shared decision-making is the preferred process where the clinician/care team (SDMG recommendation 1) and the patient/family/HCP make a care plan for the patient. The first step in this process is for the care team to ask, listen, and understand the patient’s understanding of his or her condition and values and goals in life. With the patient’s explicit permission, the care team then explains from their expert perspective the patient’s condition, prognosis, and the risks and benefits of the treatment options. Recent qualitative studies have shown that CKD patients want to know their prognosis. However, our experience is such that patients often do not want a numerical estimate, such

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Table 1. Six medical ethics principles (http://en.wikipedia.org/wiki/Medical_ethics#Values_in_medical_ethics)

- 1) Respect for autonomy: The patient has the right to refuse or choose their treatment (*voluntas aegroti suprema lex*).
- 2) Beneficence: A practitioner should act in the best interest of the patient (*salus aegroti suprema lex*).
- 3) Nonmaleficence: “First, do no harm” (*primum non nocere*).
- 4) Justice: Concerns the distribution of scarce health resources and the decision of who gets what treatment (fairness and equality).
- 5) Respect for persons: The patient (and the person treating the patient) has the right to be treated with dignity.
- 6) Truthfulness and honesty: The concept of informed consent

as how many months of life they may have remaining. Rather, they prefer a general statement about overall prognosis (SDMG recommendations 2 and 3).

Through the process of consensus building, a shared decision and treatment plan is agreed on (SDMG recommendation 4). In a consensus, each party may not get the plan they originally favored, but they may be convinced by hearing the perspectives put forth by others that a different plan is preferred. Sometimes the party may not like the consensus plan but agrees to accept it. I have seen this in situations where the HCP may want to initiate or continue dialysis in a patient who clearly is getting no benefit (or even suffering harm), but the nephrologist has decided that he or she cannot ethically order the dialysis treatment. After offering to transfer care to another nephrologist, invariably the HCP will accept the clinician’s decision. For this to work, the clinician must show respect for the alternative point of view, listen carefully, and validate the person’s views. If the views are based on religious objections, then it is sensible to involve a clergy person who may help explain the religion’s positions. A time-limited trial of RRT (7) can be undertaken in certain defined situations such as when the benefit to be achieved by dialysis is uncertain or a consensus about the benefit of dialysis cannot be reached (SDMG recommendation 7).

When consensus cannot be reached, the SDMG suggests conflict resolution (SDMG recommendation 8; “resolving conflicts about what dialysis decision to make”; Box 1 and Figure 1). The SDMG suggests a practical ethical approach to decision-making. The patient’s case is analyzed from these perspectives (Table 2).

Each perspective is viewed through the six ethical principles in Table 1. The SDMG then recommends the following process for ethical decision-making (Table 3). Although the SDMG recommends that patients with a terminal prognosis (<6 months) should not receive dialysis, the guidelines recognize that “palliative dialysis” (12) is an option for those who require more time to finish their life goals. Such goals include activities for significant events like a wedding, birth, or graduation. Palliative dialysis allows the patient to transition to a more comfort-oriented care. The patient may shorten their dialysis treatment time, restrict further hospitalizations or procedures, and, when appropriate, receive hospice services (SDMG recommendation 9).

Box 1. Suggested steps for implementing recommendation 8 (reproduced with permission)

- Extended conversation
 - Why does the patient or legal agent desire dialysis when it is not recommended by the renal care team?
 - Why does the patient or legal agent refuse dialysis when it is recommended by the renal care team?
 - Does the patient or legal agent misunderstand the diagnosis, prognosis, and treatment alternatives?
 - Does the nephrologist misunderstand the patient’s or legal agent’s reasons for requesting dialysis?
 - Does the nephrologist understand the psychosocial, cultural, or spiritual concerns and values the patient or legal agent have?
 - Has the nephrologist consulted a psychologist, social worker, or chaplain for assistance in fully understanding the concerns of the patient or legal agent family?
- Consultation with other physicians
 - Do other physicians agree or disagree with the attending physician’s recommendation to withhold or withdraw dialysis?
 - Is the request for dialysis by the patient or legal agent medically appropriate?
- Consultation with ethics committee or ethics consultants.
 - Has the patient or legal agent been informed that the purpose of the ethics consult is to clarify issues of disagreement, and ideally, to enable resolution?
 - Has the patient or legal agent met with the ethics committee or ethics consultants to explain their perspective and reasoning behind their request for dialysis?
 - Can the ethics committee identify the reasons why the patient or legal agent is resistant to the physician’s recommendation to forgo dialysis?
 - Can the ethics committee identify the reasons why the health care provider is resistant to the patient’s or legal agent’s desire to begin or continue dialysis?
 - Has the ethics committee explained in understandable terms to the patient or legal agent its conclusions and the reasoning behind them?
 - Can the impasse be resolved with accommodation, negotiation, or mediation?
- Documentation
 - The physician must document the medical facts and his/her reasons for the recommendation to forgo dialysis and the decision not to agree to the request by the patient or legal agent.
 - The consultants should also document their assessment of the patient’s diagnosis, prognosis, and their recommendations in the chart.
- An attempt to transfer the patient’s care
 - If reconciliation is not achieved through the above procedure and the physician in good conscience cannot agree to the patient or legal agent’s request, the physician is ethically and legally obligated to attempt to transfer the care of the patient to another physician.
 - Another physician and/or institution may not be found who is willing to accept the patient under the terms of the family’s request. Physicians and institutions that refuse to accept the patient in transfer and their reasons should also be documented in the medical record.
 - Consider consultation with a mediator, extramural ethics committee, or the ESRD Network in the region.

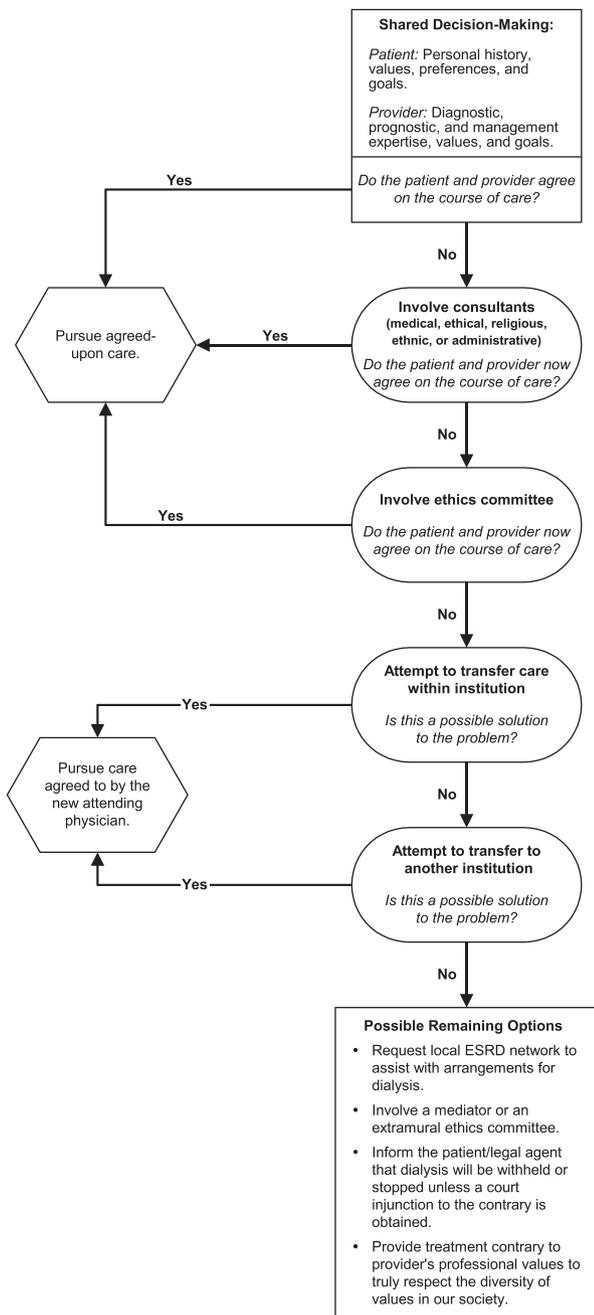


Figure 1. Systematic approach to resolving conflict between patient and renal care team.

Finally, an effective process depends on excellent clinician–patient/family communication (13–15) (SDMG recommendation 10). To have these discussions, appropriate systems must be in place in the nephrology practice and dialysis units to facilitate the process (Table 4,) (16–18).

There are excellent resources to help the health care team to accomplish these goals and tasks. Offering meticulous end-of-life care, including hospice, is mandatory for all of our patients with a <6-month prognosis (17–19). It is important for patients and families to understand that palliative care and hospice do not

Table 2. Perspectives to consider in ethical decision-making*

- 1) Medical indications, the diagnosis, prognosis, and treatment
- 2) Patient preferences
- 3) Quality of life
- 4) Contextual features (social, economic, legal, and administrative)

*Adapted from reference 8 with permission from the Renal Physicians Association

Table 3. The seven-step process of ethical decision-making in patient care*

- 1) What are the ethical questions
- 2) What are the clinically relevant facts
- 3) What are the values at stake
- 4) List options (what could you do)
- 5) What should you do (choice the best option from the ethical point of view balancing all the above factors)
- 6) Justify your choice based on the ethical principles
- 7) How could this ethical issue have been prevented

*Adapted from reference 8 with permission from the Renal Physicians Association.

Table 4. Systems approach to American College of Physicians in nephrology practice and the dialysis unit

- 1) Normalize the conversation: start discussions of EOL issues early in the patient’s interaction with the nephrology team.
- 2) Involve all members of the care team. In the office, this depends on human resources available. In the dialysis unit, train and utilize the dietician, technicians, social worker, and nurses.
- 3) Have a champion. Without this, likely there will be little buy-in or progress. Although the nephrologist does not have to be the champion, the nephrologist leader (*i.e.*, medical director in the dialysis unit) needs to show strong support.
- 4) Teach all staff members simple communication techniques.
- 5) Integrate ACP into the workflow.
- 6) Do continuous quality improvement on the process.
- 7) There are resources available to learn from established successful programs .

result in a shortened survival (20). Patients are not harmed, and they appreciate honest communication of bad news (21). It is important to recognize that our patients want to know their prognosis, and there are validated tools available for the clinician to utilize when having this discussion (22,23).

In the end, the goal of the communication between the patient (and family or other preferred surrogate decision-maker) and the kidney care team is shared decision-making. Shared decision-making is the recognized preferred model for medical decision-making because it addresses the ethical need to fully inform patients about the risks and benefits of treatments, as well as the need to ensure that patients’ values and preferences play a prominent role (8). Shared decision-making has been referred to as the “pinnacle” of patient-centered care (24). Patient-centered care has been one of the six specific aims for improvement for health care since the Institute

Table 5. List of resources

- 1) RPA SDM Toolkit: <https://itunes.apple.com/us/app/rpa-sdm-toolkit/id843971920?mt=8>
- 2) ACP DECISIONS: <http://www.acpdecisions.org>
- 3) Coalition for Kidney Supportive Care: <http://www.kidneysupportivecare.org/Home.aspx>
- 4) *Supportive Care for the Renal Patient*, edited by Chambers, Brown, Germain, 2nd Ed., London, UK, Oxford Press, 2010
- 5) RPA SDM Guidelines, 2nd Ed., 2010: <http://www.renalmd.org/catalogue-item.aspx?id=682>
- 6) Five Wishes: <https://www.agingwithdignity.org>
- 7) Alberta's Conversations Matter: <http://www.albertahealthservices.ca/9098.asp>
- 8) ASN Geriatric Curriculum: <http://asn-online.org/education/distancelearning/curricula/geriatrics/>
- 9) KDIGO Renal Supportive Care Initiative: <http://kdigo.org/home/conferences/supportivecare/>
- 10) Vital Talk communication techniques: <http://vitaltalk.org/sites/default/files/quick-guides/NURSEforVitaltalkV1.0.pdf>
- 11) <https://www.prepareforyourcare.org/>
- 12) <http://www.ihl.org/Engage/Initiatives/ConversationProject/Pages/default.aspx>
- 13) <http://www.gundersenhealth.org/respecting-choices>
- 14) Six-month mortality predictor: Under nephrology/HD, <http://www.qxmd.com/apps/calculate-by-qxmd>
- 15) Breaking Bad News SPIKE: <https://depts.washington.edu/bioethx/topics/badnws.html>

of Medicine (IOM) issued its 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (25). The IOM noted that the US health care delivery system does not provide consistent, high-quality medical care to all people. The IOM defined patient-centered as “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.” Since the publication of the IOM report, there has been growing national interest in more individualized patient-centered models of care. These models focus on what matters most to individual patients and less on what might matter to providers or health systems (26). A recent qualitative study suggests that patients want to discuss ACP with the nephrologist (27). When effectively done, it can increase use of hospice and provide a “good death” (28). A recent review emphasizes the ethical principles involved in these discussion with the elderly CKD patient (29). This chapter has sought to explain how high-quality, ethical care can be delivered to patients with advanced kidney disease and cancer.

TAKE HOME POINTS

- The ethics of RRT in cancer balances the principles of respect for patient autonomy with nonmaleficence.
- In some cases, palliative dialysis may be an option for these patients.
- Good communication skills are the key to shared decision-making and patient-centered care.

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REVIEW QUESTIONS

1. A long-term dialysis patient presents with metastatic sarcoma that is not treatable, and the prognosis is poor. What are the relevant medical ethical principles to consider in this patient?
 - a. Autonomy
 - b. Nonmaleficence
 - c. Beneficence
 - d. Respect for person
 - e. Truth and honesty
 - f. All of the above
 - g. None of the above

Answer: f is correct. Patient autonomy, nonmaleficence (avoiding the harms of RRT), beneficence, respect for person, truth, and honesty.

2. The family requests that you withhold the cancer diagnosis/prognosis information from this patient. What is the ethical principle that would guide your decision?
 - a. Nonmaleficence: The information would be harmful to the patient
 - b. Truth and honesty.
 - c. Beneficence

Answer: b is correct. In our society, it is not ethical to withhold this information. In some cultures, it is left to the doctor to decide if it would be “harmful” to the patient to give them bad news. If a family asks that you not give bad news to the patient, it is acceptable to ask the patient if they prefer that

these discussions take place with a family member or HCP instead of with them; this is a common scenario for some cultures in the United States (Native American, some Asian cultures).

3. The patient’s health deteriorates rapidly, and she is in pain whenever she is moved, such as transportation to and from dialysis. She is very lethargic and not communicative. The clinician feels that dialysis is doing more harm than good for the patient. When this is discussed with the family, they insist that dialysis be continued. They believe that in their religion withdrawing dialysis is a sin. Attempts at shared decision making and involving their pastor have not resulted in a resolution of the conflict. The correct approach is to:
 - a. Continue dialysis
 - b. Seek a court order to withdraw dialysis
 - c. Explain to the family that you understand and respect their point of view; explain that you have an ethical duty to do no harm by the treatments that you order for your patients, and at this point, dialysis is doing more harm than good; and you will be discontinuing your order for dialysis and the family can seek another clinician to take over care if they wish

Answer: c is correct. After following an shared decision making process and conflict resolution, if there is still no consensus, then the clinician has the right and ethical duty to not order RRT if the principle of nonmaleficence and justice outweighs the principle of autonomy. The patient has the right to refuse a treatment but not to demand a treatment.