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Ethics and End-Stage Renal Disease

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On October 30, 1972, Congress passed legislation authorizing end-stage renal disease (ESRD) treatment under Medicare. The number of patients who will consider or need renal replacement therapy continues to increase dramatically as diabetes and obesity reach epidemic proportions. Cardiovascular disease and infectious diseases are the 2 leading causes of death in the United States. Currently, the third leading cause of death is withdrawal of maintenance dialysis, accounting for up to 25% of all yearly deaths.

Apart from situations in which patients make their own decisions under the principle of autonomy and the right of self-determination, physicians are frequently placed in the position of making the decision to stop renal replacement therapy. Physicians often address this challenge by incorporating their personal beliefs and faith systems. Because the decision to discontinue renal replacement therapy can be disconcerting, it is usually best to assemble a multidisciplinary decision team that includes the social worker, dialysis nurse, and primary care/attending physician, as well as assistance from clergy.

In general, after a shared decision-making environment is created and the patient and family are fully informed, end-of-life care discussions can begin and decisions can be made. According to the few studies that have evaluated it, the time until death in a patient with minimal renal function is usually not more than a week after cessation of renal replacement therapy, and an exceedingly low percentage is alive by 30 days. If a patient has residual renal function, other variables come into play and the time until death will have a greater range.

Several steps must be taken to ensure that all concerned parties have a complete understanding of the decision to withdraw or withhold dialysis in adults. After the physician-patient relationship is established, the patient and family must be fully informed of the diagnosis, prognosis, and treatment options. Then advance care planning is discussed, and any active advance directives are reviewed.

If consensus is not reached after these steps have been taken, a time-limited trial of dialysis can be offered to patients who have an uncertain diagnosis with unclear direction. Finally, palliative care options should be explored. Dialysis can be offered to someone in hospice as long as ESRD is not the diagnosis used to justify the hospice care.

In the 1960s, before it became more widespread and available in practice, hemodialysis was routinely withheld. At that time, an anonymous lay committee decided who received chronic hemodialysis and who did not. These committees were known as "God committees" as chronicled in *Life* magazine in November 1962.

Recently, the Independent Payment Advisory Board created by the Patient Protection and Affordable Care Act has been accused of being a reincarnation of these committees. In England, the National Institute for Health and Clinical Excellence limits technology and medication usage based on cost to the system. As the percentage of Medicare expenditures related to ESRD services increases, this issue will be a developing topic of discussion as government payors attempt to control costs. Because of this reality, providers will need to become more aware of these issues.

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