



California Health Care Foundation

HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

When Dialysis Is the Wrong Approach to End-Stage Kidney Disease

Vanessa Grubbs, Assistant Professor of Medicine, UCSF Zuckerberg San Francisco General Hospital

July 18, 2016



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The nurse practitioner exhaled completely as she plopped down next to me in the clinic workroom — as if she had used up her last bit of energy. She had spent the last hour with a 75-year-old man with severe chronic kidney disease. His kidneys were filtering about 4 teaspoons of his blood every minute when normal is 25 teaspoons.

I was the supervising nephrologist, so I asked her how things were going with the patient. She told me his basic medical history and then said, "So I just told him, 'If you don't start dialysis, you're going to die.'" She tilted her head and nodded in that way we clinicians do when we think we've summoned the courage to say what needed to be said. She went on to an exasperated, "Why does he keep coming back here if he doesn't want dialysis?"

Because she was new to nephrology and the care of patients approaching end-stage kidney disease, I shook my head in disappointment, thinking, "They got to her first."

They were the same ones who taught me.



Should physicians stop reflexively putting elderly kidney patients on dialysis?

They tell patients, "Start dialysis, or you'll be dead in two weeks" or "You have a responsibility to your grandchildren to be here." They even say, "Just try it, and if you don't like it you can stop," without offering a vision for what they hope dialysis can do and by when. They say it over and over again every time the patient comes to the clinic until he agrees — or stops coming back.

More Time, but at What Cost?

They never say, "Are you sure you want to start dialysis?" because they believe dialysis is always the appropriate response to kidney failure. Because they believe dialysis always prolongs life, and prolonging life is all that matters.

Experience has given me different lessons.

Dialysis may not be the best option for everyone with kidney failure. Several European studies have shown that dialysis does not guarantee a survival benefit for people over age 75 who have medical problems like dementia or ischemic heart disease in addition to end-stage kidney disease. In fact, it often worsens their quality of life. One study

found that elderly people who had dialysis lived on average a year longer than those who didn't — but almost all of this added time was spent in the hospital, traveling to and from dialysis, or undergoing dialysis treatments.

People with just a little bit of kidney function usually live much longer than two weeks — often months, sometimes years. People like Mrs. N, an 88-year-old woman whose kidneys filtered only *one* teaspoon of blood each minute when I met her. Many of my colleagues would have started her on dialysis, contributing to the fact that patients over 75 are the fastest-growing group starting dialysis, doubling over the last two decades. Mrs. N would have felt very tired after her dialysis treatments. She probably would have experienced lightheadedness or cramping during the treatments. And she likely would have needed procedures and even hospitalizations to keep doing them.

Instead, she died two years later — at home, pain-free, and surrounded by family. And without the rigors of dialysis.

Creating a Dialysis Alternative

It is for patients like Mrs. N that I have been working to create a conservative management program as part of the nephrology clinic at Zuckerberg San Francisco General Hospital. It would be an alternative to dialysis, managing patients' symptoms of progressive kidney failure with the goal of maximizing the quality of their remaining time without dialysis — when the risks of dialysis outweigh its benefits, as it often does for frail, elderly patients over 75. On average, this group survives less than six months after starting dialysis. One study of US nursing home patients found that 60% had either died or had decreased functional status (the ability to do things like walk, bathe, get dressed, get out of bed, and use the toilet) just three months after starting dialysis.

Such a program is sorely needed. **Outpatient palliative care is virtually nonexistent**, and hospice providers haven't figured out how to meet the needs of patients with kidney failure. For example, when hospice arrived for a first visit at Mrs. N's home, the first thing they asked about were funeral arrangements, which is what they tend to do for cancer patients, when all Mrs. N was feeling was a little nausea and fatigue. She was not unusual — patients with end-stage kidney disease tend to have few symptoms until death is imminent. Further, while anemia management is central to the care of our patients with advanced and end-stage kidney disease, medicines like Darbepoetin that treat anemia are not on hospice formularies because they are considered life-prolonging. Not only did this approach prompt Mrs. N's daughter to quickly show hospice folks the door and shut them out forever, it also caused her to haul the wheelchair-bound Mrs. N to clinic twice a month to get the shot that could have easily been given at home.

I know the cards are stacked against me beyond the walls of the clinic, but the nurse practitioner's words let me know that the odds are against me within the clinic walls too. A conservative management program is not possible if health care providers don't

believe it is the appropriate option, if we continue to try to convince and coerce — even bully and scare — people into believing that dialysis is the answer to kidney failure and that it can always prevent them from dying.

Many hearts and minds need to change. I started with the nurse practitioner.

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