Not all patients with end-stage renal failure (ESRF) will benefit from dialysis treatment. However, some may insist on commencing dialysis despite their expected life expectancy being 6 months or less. Others may be ambivalent about dialysis and opt for supportive care when they are not significantly symptomatic and revoke their decision at a later stage when they become symptomatic. Some patients will choose supportive care once the diagnosis of ESRF is confirmed. With the increasing age and increasing proportion of diabetes among incident patients, the number and severity of comorbidities have increased [1]. The provision of information to patients on the option of supportive management is important so that some of them do not embark on dialysis therapy that will not benefit them.

For patients with end-stage renal disease, it would be helpful if patients are given information on the pros and cons of dialysis therapies as well as on the option of conservative/supportive management. It would also be fruitful if advance care planning (ACP) is incorporated into the caring process so that multiple parties can be involved in the decision-making process. Patients can formulate the care plan that is best for themselves after discussion with their family members in close liaison with the clinical team.

In this issue of the Hong Kong Journal of Nephrology, Chan et al demonstrates the practice of ACP during the dialysis assessment process for ESRF patients [2]. Most of the patients who chose supportive management did not receive cardiopulmonary resuscitation, which has little benefit in their end-of-life care. Chan et al did not mention the use of advance directives in their article. A written advance directive may not be the most appropriate document for the acceptance or refusal of a therapeutic intervention like dialysis, especially when we encourage patients to live actively and positively even if they have chosen supportive care. ACP can be a method of preparing patients for end-of-life care, and as a means of strengthening interpersonal and intra-family relationships with patients maintaining control over their own life.

Renal physicians should initiate the discussion on ACP earlier rather than later. Appropriate communication skills and language is required in the process of shared decision-making centering the ACP process within the patient-family relationship. A team approach within the renal unit, including dialysis nurses and social workers, in the process of ACP may increase the chances of successfully planning care that is most appropriate for the patient, as the patient and their family generally trust the renal team as they have been caring for the patient since the early stage of chronic kidney disease.

ACP is especially important for patients who decide to withdraw from dialysis therapy when they experience difficulties in maintaining dialysis treatment or when continuation of dialysis translates into a continuation of suffering for themselves.

ACP by a process of shared decision-making involving the renal team, family members and the patient, with thorough appraisals of all the possible options, is a better approach in assisting our patients to make their own choice than the conventional physician-directed approach.

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REFERENCES