Conservative Care for Kidney Failure—The Other Side of the Coin

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Shared decision making, the process by which patients express their values and preferences and clinicians describe treatment options and their risks and benefits, is heralded as the pinnacle of patient-centered care.1 For older patients with advanced chronic kidney disease (CKD) who are facing possible kidney failure, the decision to initiate dialysis or focus on active alleviation of symptoms, known as conservative care or conservative kidney management, is likely one of the most consequential decisions they will face. Guidelines recommend that patients should receive information about all treatment options for kidney failure.2,3 However, evidence suggests that current practice falls short of shared decision making ideals. In reality, dialysis is viewed as the default treatment for kidney failure, and the option to forgo dialysis treatment is often not explicitly discussed.4

Many countries, including the US, maintain a national registry of patients who receive kidney replacement therapy with dialysis and/or kidney transplant. The comprehensive information these registries provide regarding the incidence and prevalence of kidney failure and the costs and quality of kidney replacement therapy exert a powerful influence on health care policy.5 However, these registries have a notable blind spot: they do not systematically collect data from patients who receive conservative care for kidney failure. This important knowledge gap impedes the ability of patients, families, and clinicians to engage with the information needed for this consequential decision.

In JAMA Network Open, Wong et al6 performed a systematic review of cohort studies documenting the survival, quality of life, and/or use of health care resources among persons with advanced CKD undergoing conservative treatment of kidney failure. Their review included all English language studies through December 3, 2021, of adults in whom there was an explicit decision not to pursue maintenance dialysis. They found 41 relevant publications, representing 5102 patients, with most of the studies conducted in Europe, the United Kingdom, or Asia. Twelve studies described patients in formal conservative care programs with dedicated staff and/or clinicians trained in palliative care, whereas the remaining studies described patients in usual nephrology care settings or did not specify the approach to conservative care. The heterogeneity of studies precluded a meta-analysis, thus the authors conducted a systematic narrative review. Of the 34 studies that reported survival, the authors found that median survival ranged from 1 to 41 months, as measured from a mean estimated glomerular filtration rate of 7 to 19 mL/min/1.73 m². Of the 8 studies that described quality of life during a follow-up period ranging from 8 to 24 months, mental well-being improved over time, and physical well-being and overall quality of life were maintained until near the end of life.

Ladin et al7 found that nephrologists hesitate to discuss conservative care for kidney failure because they see maintaining hope as a part of their duty to patients and their families. The work by Wong et al6 dispels the notion that conservative care for kidney failure means a grim and near-immediate death. Considered against available data on the survival and quality of life provided by dialysis, the study advances the idea that a conservative care approach can provide time and sustain quality of life to support patients’ life goals.

Despite limiting the systematic review to studies in which there was an explicit decision for conservative care, the authors also found that use of health care resources remained high. In the 14 studies that described end-of-life health care, 4% to 47% of patients underwent an invasive procedure in the final month of life, and rates of hospice enrollment (20%-76%) and in-hospital death (27%-68%) were wide ranging.

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The inclusion of contemporary cohorts and outcomes that are relevant to patients, families, and clinicians are key strengths of the study. Perhaps the most important limitation in applying these findings to clinical practice is the heterogeneity of the studies and selective nature of the patients who were studied. Describing the best, worst, and most likely outcomes of different treatment options is one way to provide meaningful prognostic information while acknowledging the uncertainties that exist. Clinicians can also situate prognostic conversations in broader discussions about patient goals and priorities to understand what patients are and are not willing to endure.

The study by Wong et al also raises a larger question. If professional societies have endorsed shared decision making for kidney failure and recognize that conservative kidney care can be appropriate patient-centered treatment, why do we lack information systems to monitor the outcomes of conservative care? It seems fundamental that quality, safety, and costs of kidney failure therapy cannot be fully understood by examining only one side of the coin.

We believe it is time to broaden the scope of kidney replacement therapy registries to include persons who receive conservative treatment of kidney failure. Population-level data on conservative kidney care paralleling those currently available for dialysis would further understanding of the population’s use of health care resources and disparities in access to care, guide the establishment of quality metrics, and be a step toward fostering fair reimbursement for kidney failure treatment. Such data could also facilitate pragmatic clinical trials of decision aids and symptom management in kidney failure.

Wong et al have conducted a laudable evidence synthesis that deepens our understanding about prognosis and quality of life with a conservative approach toward the management of kidney failure. Their work is a reminder that to optimally support shared decision making and the dissemination of best practices, we need to address the conservative care information gap so that lack of awareness is no longer a barrier to informed decision making.

ARTICLE INFORMATION
Published: March 14, 2022. doi:10.1001/jamanetworkopen.2022.2252
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Conflict of Interest Disclosures: Dr Kurella Tamura reported receiving personal fees from American Federation for Aging Research outside the submitted work. No other disclosures were reported.
Disclaimer: The views expressed are those of the authors and not necessarily those of the US Department of Veterans Affairs.

REFERENCES
