Questions from the June 21, 2012 webinar

Does next of kin have any impact when there is no advance directive?

Depending on the state law, the next of kin might have the legal authority to make decisions in the absence of an advance directive. However, most states (>35) have health care surrogate laws which specify how the person is to be chosen to make decisions for a patient who lacks capacity and has not completed an advance directive. Next of kin may be vocal and potentially intimidating, so it is important that the health care team be knowledgeable about the laws that govern these situations in order to act with confidence when necessary.

In the example just used, what do you do if you system doesn't have a Palliative Care team? Would an ethics consult be appropriate?

Prior to the majority of hospitals having palliative care teams, most goals of care discussions were conducted by ethics consultants. An ethics consultation might have helped the sister in the decision-making process.

When and how are end-of-life issues discussed and with whom as a member of the interdisciplinary team with respect to a patient beginning dialysis?

Physicians, nurses, and/or social workers can discuss end-of-life issues with a dialysis patient. Frequently the job falls to the social worker, but it is ideal if all feel comfortable discussing the issues with patients pre-dialysis and once dialysis is started. An opportunity for discussion occurs during routine questioning of whether the patient has advance directives. Information is usually provided to the patient at this time and a request to discuss further in a week or so can accompany it. This will allow the patient an opportunity to review the information provided ahead of time. Normalizing the discussion is important for increasing the comfort of all involved. Healthcare providers are encouraged to complete their own advance directives so they can speak with experience and also model the behavior. Reminding patients that we can walk out the door and be hit by a bus might provide a comfortable introduction, or pointing out that most health care settings request this information now.

Is it not prudent to include an advance directive with a power of attorney for all dialysis patients at the initiation of dialysis?

Yes, it is best to have patients designate a person to make decisions for them in the event they lose decision-making capacity and to designate that person in a medical power of attorney.

Can the nephrologist determine that a patient is no longer capable of giving consent or does that require a psychiatric consult?

Physicians who have been trained how to assess decision-making capacity can determine that a patient is no longer able to give consent. It does not require a psychiatrist. Many physicians, though, do not feel comfortable making this assessment.

We have had in the last few months 2 elderly males dialysis patients commit suicide before the palliative care/and probably hospice was in progress to stop dialysis. Both gentlemen had been started on prozac a few weeks before the suicide. One used a gun and one hung himself with a cord. Can you comment on this; it seems to be more difficult to get elderly men to sign on to the stopping dialysis and the "dying"" process. Both families were very traumatized. Thank you

These are sad outcomes and difficult to comment on in retrospect. Depression is underdiagnosed in dialysis patients. Earlier palliative care consultation might have helped these gentlemen discuss their wishes with regard to continuing versus stopping dialysis. It is also uncommon for patients to be informed that no dialysis treatment remains a treatment option. Having this knowledge might increase such patient's likelihood of investigating it as an option, which could trigger a reevaluation of the depression.

What do you do with a patient who refuses to designate a decision maker?

Explain to the patient that it is likely that he may lose the ability to make decisions in the future and in the absence of his designation of a decision-maker state law will be applied to name a health care surrogate to make decisions for him. The person named according to the law may not be the person he would want. He can maintain control over future decisions made for him by naming a medical power of attorney in an advance directive.

I find that many patients do not understand that CPR in real life is not the same as CPR on television.

Very true. On television CPR works 75-100% of the time. In real life, only 10% or less of dialysis patients who have CPR survive to leave the hospital. This is an opportunity to assess a patient's understanding of CPR and provide education about the benefit of advance directives.

More information on difference between living wills and advance directives please.

Advance directives vary from state to state. In some states, a living will only states the patient's wish not to be kept alive on life support if he/she is dying or in a vegetative state and has lost decision-making capacity. In other states a living will includes this instruction plus the designation of a proxy decision maker. Here is a link to download advance directives specific for your state.
http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3289

What is the expectation of the Nephrologist in regards to hospice? I have a physician who is unwilling to refer a patient to hospice. He wants them to go through the PCP which delays the process.

There is no requirement that a nephrologist or any other physician refer a patient to hospice. A hospice referral by a physician is appropriate if the physician believes that the patient has 6 months to live or less if the disease takes its normal course. Some nephrologists are unwilling to estimate prognosis though it is clearly part of the physician's responsibility. See http://touchcalc.com/calculators/sq for an online tool to estimate dialysis patient prognosis. It may help to urge the nephrologist who is unwilling to refer a patient to hospice to request a palliative care consult. Patients can also call hospice directly and request an evaluation. Often the hospice medical director will certify the patient for hospice if the nephrologist will not.

Question with Comment: What do you think about consults to nephrology in the case of cascading system failure? The nephrologist is often the first provider to acknowledge that overall recovery is unlikely. As a hospital dialysis nurse I find an increase in cases where the 'acute' failure is actually a permanent failure, however the patient and/or family believe that dialysis will reverse all that is wrong.

Yes, nephrologists are often the ones to address the "big picture" and decline to dialyze the patient because it will not benefit the patient.

Comment: What is stunning to me here is the [need for] communication between the interdisciplinary staff. The goals have to be conveyed as a process as the patient's status may change, from initiation to treatment to a designated vulnerable phase. I think in many cases, this is a training in itself.