ETHICAL ASPECTS OF THE TERMINATION OR INITIATION OF DIALYSIS THERAPY

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INTRODUCTION

With the demographic ageing and poly-morbidity of the dialysed population, the replacement of renal function has become a treatment that exposes some ethical problems. More frequently than in the past, the dialysis centre encounters the problems of conservative treatment, which means the non-initiation or termination of dialysis. This is the exact opposite of what we learned as health care professionals at the university.

AIM

The aim of this work is to clarify the issues of the non-initiation or termination of dialysis and to share our own experiences in this area, as the conservative treatment used to be rather rare in our country.

METHODOLOGY

Dialysis treatment is now available to all patients who are indicated for it and have agreed to the proposed treatment. All patients are informed of all treatment options and are a part of the decision-making process. The non-initiation or termination of a dialysis programme is usually associated with a very low quality of life, unresolved complications, the low functional fitness of the patient, and psychosocial problems. Conservative treatment without the initiation of dialysis is considered for patients who, in addition to kidney failure, have very serious and/or unresolved complications, or whose condition prevents dialysis. Patients, where dialysis is not initiated or is terminated, are transitioned to palliative care. After the transition to palliative care, we do not terminate our medical care, but we work with physicians of various specialities, nursing staff, hospices, families, and other experts.

There are general recommendations for the non-inclusion or exclusion of patients from the dialysis programme (the Code of Ethics of the Czech Medical Chamber, Recommendation No. 1/2010 of the Czech Medical Chamber) as well as statutory regulations (formerly stated as a living will request, which is regulated by Act No. 372/2012 Coll.), which generally determine how we will proceed.

RESULTS

In our dialysis centre, we have terminated dialysis for only four patients in recent years, and we present one case report as an example.

The patient was an 84-year-old man who had been in a chronic dialysis programme for 15 months. Following severe deterioration, the patient was hospitalised in the anaesthetic and resuscitation department where he suffered an epileptic paroxysm; he was unconscious, connected to artificial pulmonary ventilation, needed pressure support, and a CT scan showed a chronic subdural haematoma (SDH) with a fresh haemorrhage in the right hemisphere and a tiny recent SDH in the left hemisphere. According to neurosurgeons, no surgical solution was possible. Unfavorable prognosis. On the 14th day of hospitalisation in the anaesthetic and resuscitation department, despite intensive medical care, the condition of the patient deteriorated with the further significant progression of CT scan findings. After repeated medical team discussions with the family, the family agreed to discontinue dialysis. Death occurred ten days after the termination of dialysis.

CONCLUSION

The non-initiation or termination of dialysis and a transition to palliative care is a joint decision of the medical team, the patient, and his/her family. The question of non-inclusion or exclusion is not easy and is the subject of many discussions in which medical, nursing, psychosocial, ethical, legislative, and economic factors are reflected. Our experience has shown that dialysis centre staff are trained to perform renal replacement therapy but do not have extensive experience with conservative or palliative care. The increasing age and morbidity of our dialysis patients suggest that we will confront this issue more frequently in the future. In the future, local renal nursing standards covering this issue and advanced staff training on ethical issues will be needed more than ever.