

Conservative Kidney Management in the United States: What It Is and What It Could Be

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It is challenging to conduct research on conservative kidney management (CKM) in a country where it hardly exists. First, there is an issue of vocabulary; CKM is often misunderstood as a synonym for “not doing dialysis,” or,

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worse, a euphemism for “doing nothing.” In reality, the CKM offered by the most successful programs around the globe is intensive, proactive, and highly customized to the values, preferences, and goals of individual patients. It is much more than the absence of dialysis – CKM equals active medical management of symptoms, active preservation of residual kidney function, and active communication to ensure that patients and their loved ones are informed and supported over time. The benefits of this type of intensive CKM, including months-years survival¹, symptom improvement², preserved functional status³, decreased treatment burden⁴, and extremely low rates (<2%) of patients changing their minds and starting dialysis⁵, are what make it a valid care option. These results can hardly be expected if CKM operates as a code word for “no care.”

The second major challenge for CKM research in the United States is that the skills necessary for both offering and providing CKM are not routinely taught in nephrology fellowship training programs. Most nephrologists are never explicitly taught how to assess prognosis or conduct a family meeting about treatment options.⁶ Most educational materials for patients with advanced chronic kidney disease do not mention CKM.⁷ Unsurprisingly, qualitative data show that most patients with kidney failure feel that they had no choice about starting dialysis.⁸

In this issue of *Kidney Medicine*, Scherer et al⁸ navigate the imperfect and imprecise landscape of CKM in the United States in their analysis of patient factors, provider perspectives, and clinical resources related to CKM. They examined data from the Chronic Kidney Disease Outcomes and Practice Patterns Study database, including chart-abstracted patient characteristics, patient surveys about decision-making discussions, and provider surveys about CKM delivery and resources from 26 geographically diverse nephrology practices in the United States.

Based on chart data interpreted by the study coordinators, 7% of patients with estimated glomerular filtration rates <30 mL/min/1.73 m² were identified as “choosing CKM” in advance of the development of kidney failure. As outlined above, the terms “CKM” and “choice” need to be carefully understood within the confines of this study, in which CKM was defined narrowly as the absence

of dialysis or transplantation; accordingly, the presence of an actual choice seems unlikely given that only a minority of patients (18%) reported discussing the option of forgoing dialysis with their provider (Fig 1b). In contrast, 100% of surveyed clinicians reported that the clinicians in their practice “typically discuss CKM as a treatment option for kidney failure,” with 58% indicating that they “usually or always” offer the option of CKM to patients over 75 years (Table 3). These disparities between patients’ and providers’ reports echo prior findings of the chasms that exist between what nephrologists feel they are communicating and what patients understand about their illness and treatment options.⁹⁻¹¹ Another notable chasm is that 100% of nephrologists reported offering CKM; however, none of the nephrology practices surveyed had an established CKM protocol or guideline, a designated CKM clinical champion, or a dedicated CKM clinic. Limitations in the generalizability or reproducibility of the findings in this study are also significant due to unlinked data and variable vocabulary, as acknowledged by the authors.

The most remarkable and instructive findings in the analysis are displayed in Figure 2. Zero nephrologists reported that patient preference, functional status, or comorbid conditions would strongly influence their sense of the potential suitability of CKM. Based on international clinical expertise and research in CKM, these are precisely the factors that should be most central in shared decision-making about dialysis versus CKM for patients who are seriously ill. Furthermore, it is notable that “frailty” had the greatest influence on providers’ perception of the suitability of CKM. It follows that a concerted effort should be made to equip nephrologists with the skills needed to assess frailty objectively. Without these skills, the chance that unconscious bias may color nephrologists’ subjective or “gestalt”-based frailty assessments is high. It is an ethical imperative that CKM be offered equitably to patients who are seriously ill and not be unduly influenced by age, functional ability, race, sex, or personal values of physicians.

The authors conclude that further research is needed to develop CKM implementation in the United States. A fundamental frameshift may also be necessary – illness should not be defined by its treatment. Cancer is still cancer even without chemotherapy. Defining kidney failure as the illness state that requires dialysis or transplantation has effectively excluded CKM from epidemiologic registries and payment models that allow us to study, standardize, and track trends and outcomes over time. Concurrent initiatives to 1) educate patients and clinicians about CKM; 2) generate evidence-based best

practices and CKM guidelines; and 3) import successful CKM care models from abroad that incorporate social work, dietetics, spiritual care, and specialty palliative care will all be necessary to establish CKM in the United States as what it should be – a robust and proactive care option, a holistic and humane pathway, and an equitable and informed choice.

ARTICLE INFORMATION

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