End Stage Renal Disease by patients with malignancy – ethical problems

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Abstract

The problem of co-occurrence of kidney failure, as well as ESRD and malignancy is relatively often and brings a significant therapeutical and moral challenge. The ethical basis of our consideration are "Evangelium Vitae" by John Paul II and "Declaration Jura et Bona".

The fundamental choice is whether to start and/or continue the kidney replacement treatment. We present 3 algorithms for the most typical situations.

The first ethical postulate in our considerations is that patients with the malignancy of good prognosis should not be denied of any treatment chance and should be dialysed as any other patient.

In the situation of patients with neoplastic disease with bad prognosis and ESRD, the question of 'withholding or withdrawing' dialysis is essentially part of a fundamental question, what should be the ultimate goal of medicine?

There is no doubt that the person most authorized to take a decision in such a situation is the patient provided it is a conscious decision based on full information. Therefore any decision to cease treatment, even submitted at the public notary, should be verified as long as a conscious contact with a patient is possible.

In the situation of continued lack of logical contact with the patient who has not left any clear disposition for such circumstances we must take the decision based on their benefit. It is more than desired that the decision acquires the approval of the patient's family but in the situation when it is not possible the doctor decide. In the doubtful cases we should take decisions "towards life".

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The progress in medicine is one of the most important though not the only reason which makes people's life longer. In the case of kidney replacement treatment it means that in the countries of highly developed medicine it is possible to use the treatment for all patients with kidney malfunctions. However, no one can discuss dialysis without considering the financial implications of such a decision [1].

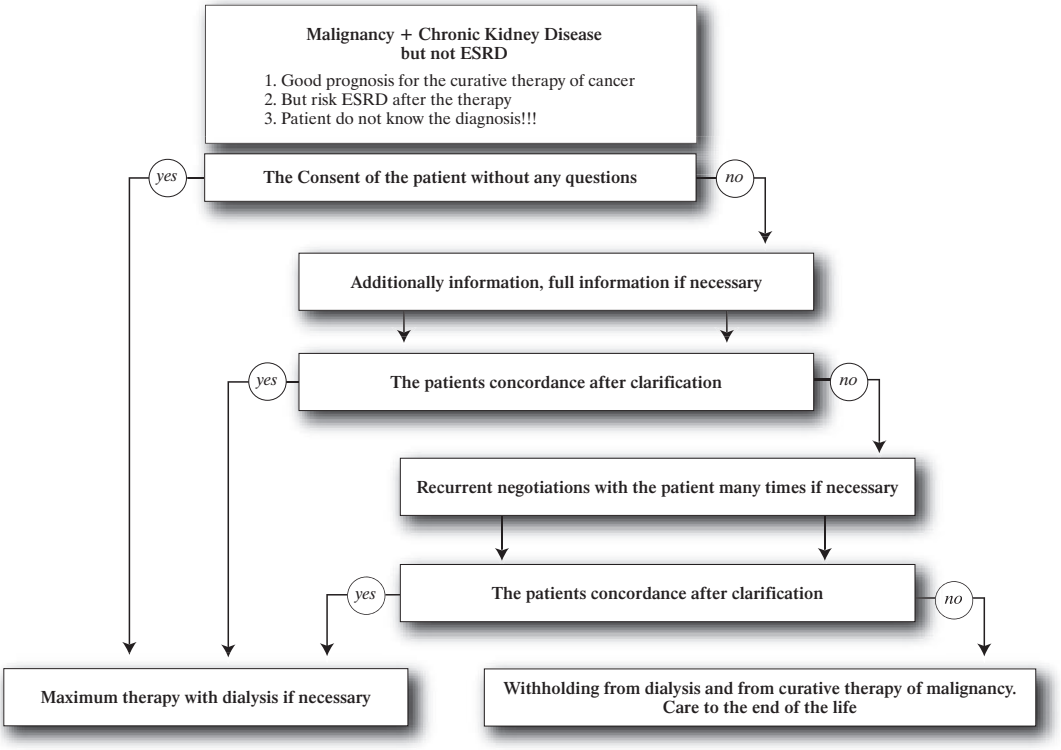
The dialysis treatment ceased to be something unusual or using the bioethical term, it ceased to be an extraordinary means. It does not mean that patients with kidney malfunctions ceased to die (as all other people), however the direct cause of death was not or at least should not be kidney disease.

Patients with End Stage Renal Disease (ESRD) have increased risk of many diseases including cancer. In the year 2002 cancers as the cause of death among German patients with dialysis (9%) occurred more rarely than in general population [2]. The distribution of tumor types resembles the pattern seen after transplantation. The excess risk can largely be ascribed to effects of underlying renal or urinary tract disease, or of loss of renal function, on the kidney and bladder, and to increased susceptibility to viral carcinogenesis. The relative risk, which is especially high in younger patients, gradually diminishes with age [3]. But in the older patients mortality is mostly associated with the presence of cancer ($p=0.053$) [4].

The problem of co-occurrence of kidney failure, as well as ESRD and malignancy is relatively often and brings a significant therapeutical challenge. In the face of dramatically circumstances and a necessity to make difficult moral choices it has its ethical dimension which is the subject of the present analysis.

The fundamental choice is whether to start and/or continue the kidney replacement treatment, most often dialysis in patients with diagnosed tumors or qualified to kidney transplantation in patients of high risk of cancer. Apart from somatomedic aspects one has to take into consideration the psychomedic aspects. The diagnosis

Figure 1. **Ethical considerations in case malignancy and Chronic Kidney Disease but not ESRD**



of cancer, and what should be stressed, regardless of the type, advancement and real prognosis is regarded as a death sentence.

Despite the awareness of doctors as for the existence of many other diseases such as, for example, circulatory insufficiency, which is a worse prognosis, cancer diagnosis similarly to HIV (but not viral hepatitis) causes psychological and social stigmatisation. It is easy, in such situations come to medically groundless resignation from various forms of intensive treatments, in order "not to prolong suffering" which in fact do not appear or at least not in the intensity that would make a real problem.

Therefore the first ethical postulate in our considerations is that patients with the malignancy of good prognosis should not be denied of any treatment chance and should be dialysed as any other patient. The only restriction is the period of awaiting for registering them as candidates for the kidney transplant. The decision is a little more difficult when the prognosis seems relatively positive but the cancer treatment method might cause permanent renal damage and/or worsening of their renal functioning including ESRD. A model example could be the cancer of the only kidney, but a similar case is the situation of a patient in the pre-dialysis situation who is to undergo intensive chemical therapy with nephrotoxic medicine applied. Following the principle of greater benefit for the patient it seems reasonable to propose "maximal therapy", that is cancer treatment and apparent dialysis programme. The decision, of course, is not with the patient.

Additionally, especially in Poland and perhaps in most traditionally Catholic countries, there may be a problem of informing the patient about the nature of their illness, which may in turn violate their "right to unawareness". The best solution seems to be the principle described in article 17 of the Medical Ethics Code: "In the case of unfavourable prognosis, the patient should be informed about it tactfully and with caution. The news about the diagnosis and bad prognosis may not be revealed to the patient only in the case if a doctor is fully convinced that the fact of revealing will cause suffering or other unfavourable consequences for the patient's health; however the doctor is obliged to full information at the clear demand from the patient"[5].

At the same time, we think that in the situation when the patient is not aware of the nature of their disease and a real risk and could make a wrong decision, from the medical point of view (refusal to undergo therapy), they should definitely be informed as to make their decision concerning life and death based on the truth. And again the patient should be informed about it tactfully and with caution [6] (*Fig. 1*).

The really difficult problem to be solved is the situation of patients with neoplastic disease with bad prognosis and ESRD. Those patients can be insured neither cure nor life of high quality and/or without suffering, nor even significant life prolongation. Thus we face the situation described in "Evangelium Vitae" by John Paul II from 1995 [6]: "In such situations when death is imminent and inevitable one may, in accord with one's conscience, resign from procedures which would only cause temporary and painful life prolongation, however the ordinary therapy required in such situations should not be ceased". "Evangelium Vitae" refers to previous declaration

"Jura et Bona" from 1980 [7]: "When death is imminent and cannot be avoided despite using available means, one is free in one's conscience to decide to cease treatment which may result only in uncertain and painful life prolongation". Referring to these documents which are important to Catholics (who are the majority of both patients and doctors in Poland) but also significant to people of other denominations and religions and even for non-believers, we must mention fragments which are significant for our professional responsibility. It means indicating the difference in practice between cessation of persistent therapy which is our responsibility for a dying patient and passive euthanasia which is not an act of true compassion. Knowing the difference between the two is extremely difficult in practice despite relatively precise definitions.

According to "Evangelium Vitae" euthanasia in the strict sense is understood to be an action or omission which of itself and by intention causes death, with the purpose of eliminating all suffering. "Euthanasia's terms of reference, therefore, are to be found in the intention of the will and in the methods used". [6]. However, euthanasia must be distinguished from the decision to forego the so-called too "aggressive medical treatment", in other words, medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family. In such situations, when death is clearly imminent and inevitable, one can in conscience "refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted" [6]. Certainly there is a moral obligation to care for oneself and to allow oneself to be cared for, but this duty must take account of concrete circumstances. It needs to be determined whether the means of treatment available are objectively proportionate to the prospects for improvement. To forego extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death [6].

It is also permitted, with the patient's consent, to interrupt these means, where the results fall short of expectations. But for such a decision to be made, account will have to be taken of the reasonable wishes of the patient and the patient's family, as also of the advice of the doctors who are specially competent in the matter [7].

Doctors who are specially competent in the matter (is that us?) may in particular judge when:

– the investment in instruments and personnel is disproportionate to the results foreseen and

– the techniques applied impose on the patient strain or suffering out of proportion with the benefits which he or she may gain from such techniques [7].

Further consideration will focus on such judgment with reference to patients with ESRD and advanced neoplastic disease. For these patients the question of 'withholding or withdrawing' dialysis is essentially part of a much more important and fundamental question, namely: what should be the ultimate goal of medicine and health care workers [8].

There is no doubt that the person most authorized to take a decision in such a situation is the patient provided it is a conscious decision based on full information. This requirement is not always easy to fulfill, firstly because of the earlier described difficulties connected with giving the patient unfavorable news and a possible negative impact of such news on the last days of their life; secondly because of difficulties faced by any healthy man, also a doctor, to picture oneself realistically in the terminal condition. Therefore any decision to cease treatment, even submitted at the public notary, should be verified as long as a conscious contact with a patient is possible. It is very important because death after withdrawing from dialysis does not most frequently occur immediately.

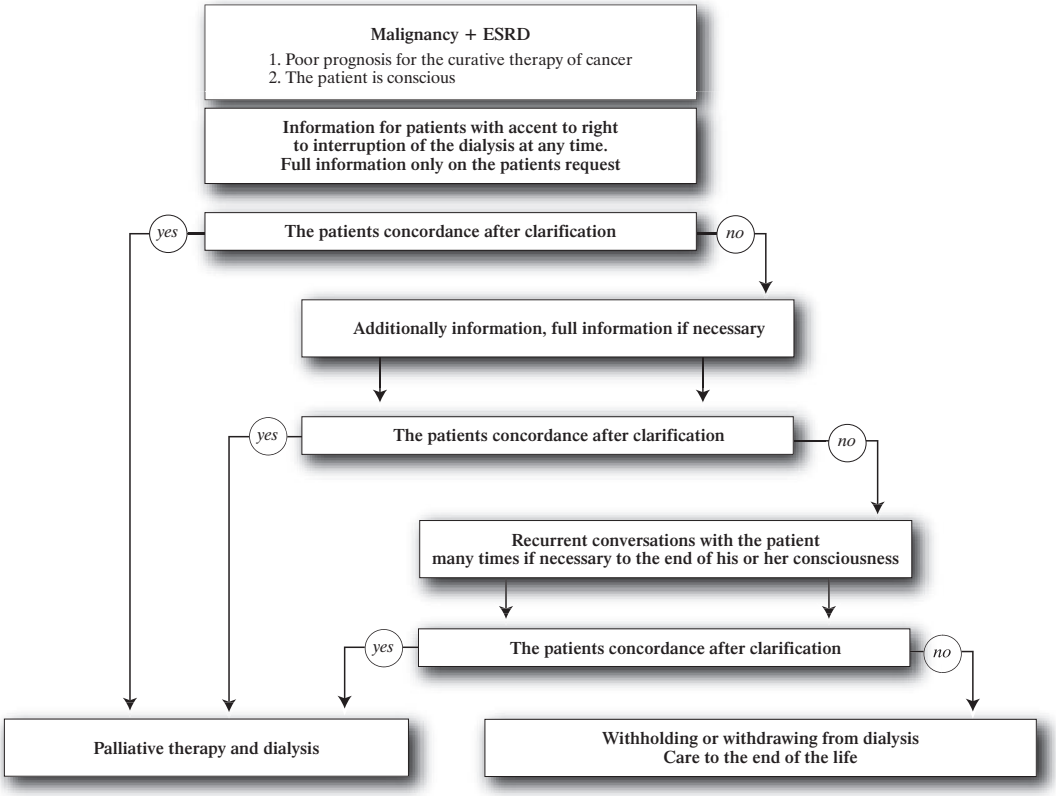
In recent observation from France after the last session of dialysis, the mean survival rate was 8.5 ± 4.8 days (median 7 days, range 4-21 days) [9]. In other opinion if patients died <3 days after withdrawing from dialysis is unlikely that withdrawing from dialysis was the principal cause of death [10].

In fact only 10% [9] to 14% [11] patients decided themselves to stop treatment. Nobody or very few patient's give advance directives [9,12].

The decision to withhold is made mainly by the nephrology team. In the USA in the early 1970s the physician initiated the decision in 66 percent of all patients; in the early 1980s this figure had decreased to 30 percent [13]. In other countries contemporary the situation is similar to USA in 1970s. In recent survey of Jolly and co. the physician initiated the decision in 86% [11]. But the role of family members is growing also in Poland. This may be some support for the treatment team, however, it imposes on the doctor a difficult responsibility to verify the true intentions of the family. Finally in the situation of continued lack of logical contact with the patient who has not left any clear disposition for such circumstances we must take the decision based on their benefit. In this difficult decision we may sometimes be directed by the so-called assumed will of the patient, that is the analysis of their opinions and choices made in their life. It is more than desired that the decision acquires the approval of the patient's family but in the situation when it is not possible the doctor must remember about his responsibility, first of all a moral one for the patient but also legal. One has to remember that our actions undergo legal judgement even after many years as well as ethical judgement. That is why there is a need for legal regulations which will indicate proper court (bioethical committee?) which will solve any possible disagreements between doctors and family of the terminal ill patient. It would certainly require very prompt actions which are unlikely in the present state of organisation of the legal system in Poland. It should be clearly emphasized that our decision cannot be determined by earlier decisions especially the beginning of dialysis therapy. In the ethical sense the distinction, common present in literature, between withholding and withdrawing from dialysis is of little significance. It is very important because doubtful cases we should take decisions "towards life", especially being aware that this solution, if mistaken, is not irrevocable. In practice it is known that doctors refuse to start dialyses more often than to withdraw from them because it is less burdensome for them from the psychological point of view [14] (*Fig. 2*).

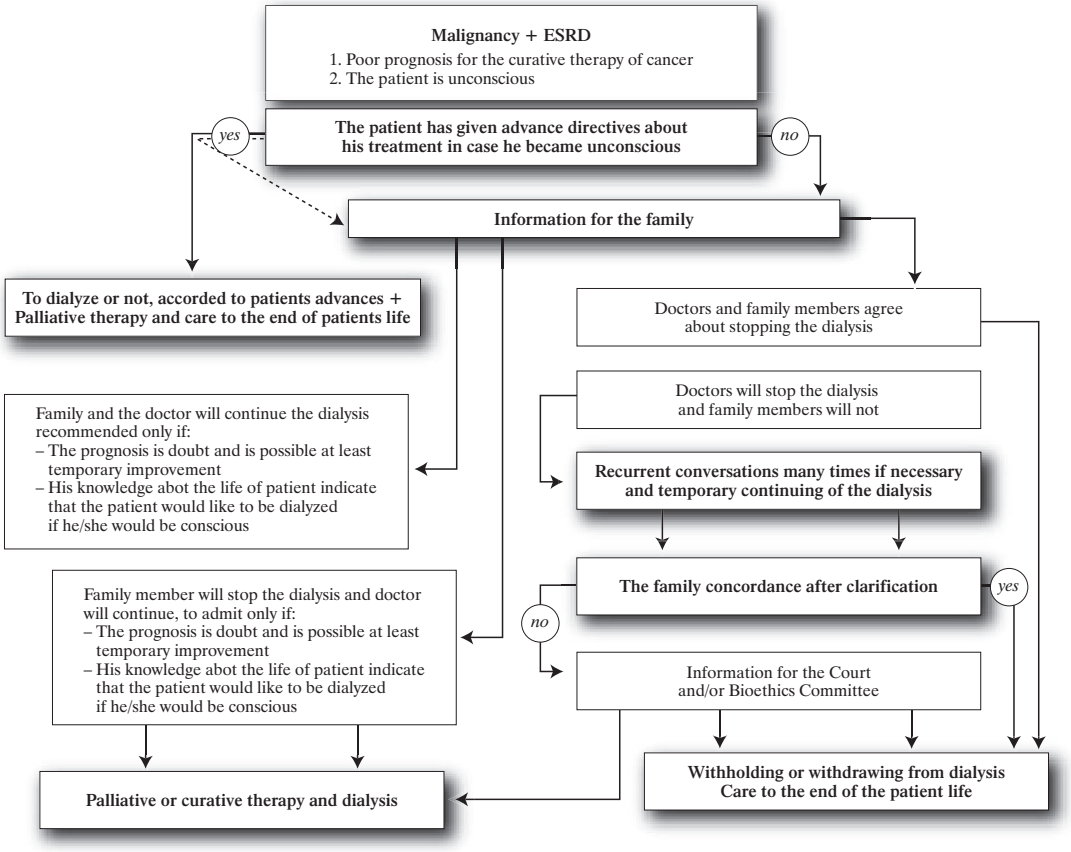
Finally, when the prognosis is definitely bad, contact with the patient is impossible to establish and there are no previous decisions from the patient for that predicament and the patient's life

Figure 2. **Ethical considerations case of malignancy and ESRD if the prognosis is poor and the patient is conscious**



would be continuous suffering we must have courage to withdraw from dialysis and focus on palliative treatment, care and nursing for the days of their life (*Fig. 3*). This most significant decision should be taken by at least two doctors, with at least of them being a specialist in nephrology. The presence of nephrologist favours decisions to carry on dialysis. American experience indicates that family doctors and even internists more easily disqualify patients from kidney replacement treatment without the need to consult the nephrologists [15]. Patients who were predominantly cared for by a general internist were more likely to be referred late to a nephrologist compared with those cared for by a family or primary care practitioner (P=0.002) or another subspecialist (P=0.019) [16]. Delayed referral was highly associated with older age (P<0.001), race other than white or black (P=0.002), and the absence of certain comorbidities: hypertension (P<0.001), coronary artery disease (P<0.001), malignancy (P=0.005) and diabetes (P=0.02). Associations of late referral with male sex (P=0.07) and lower socioeconomic status (P=0.09) were of borderline significance. [16]. Neoplasm's constitute the second in frequency cause of death in general population. The situation was similar among dialysed patients, but recently there was a retrospective report by Birmele et al. The study concerned morbidity in 1436 dialysed patients in France in 2001. In this survey death after withdrawing from dialysis was the most common cause of death (20%) comparable with cardiovascular diseases (18%) and 3 fold greater then cancer (6%) [9]. Cancer was more frequent in the withdrawing group 15% vs continuing patients (7%), but in this small cohort this difference was not significant (p=0.15) [9]. But in the medical record withdrawal from dialysis was equal with cancer 13 vs 12 as the cause of death [9]. But only a further analysis of files showed that in reality the number was not 13 but 40. It should be emphasized that in a patient with a number of disorders as the majority of patients with ESRD and cancer assessing the real cause of death is not easy. Withdrawing from dialysis causes the patient's death after approximately 2 weeks (on average after about 10 days sometimes after a month or longer) [17]. It is frequently assumed that it is impossible that death is a result of withdrawal from dialysis if a patient dies within 3 days in the case of hemodialysis and 7 days of peritoneal dialysis [9,10]. That is why it seems that withdrawal from dialysis is less frequently mentioned as the cause of death than it is the case in reality. In Poland according to few published data the percentage is significantly lower (<1%). According to surveys conducted by our department approximately 1/3 of Polish nephrologists have encountered the problem for the past 5 years but in most cases it concerned withholding rather than withdrawing from treatment [12]. In the recent analysis from USA 26% of patients with ESRD dialysis was stopped before death, but 30% of these patients died <3 days and only in 4% of these patients uremia was indicated as the cause of death. [10]. We were not able to differentiate patients terminating therapy from those continuing treatment on the basis of age or co-morbidity, suggesting that subjective patient perception of their condition is a critical factor in stopping dialysis [18]. It is concluded that beside a patient's individual refusal, late

Figure 3. **Ethical considerations the case of malignancy and ESRD if the prognosis is poor and the patient is unconscious**



referral, social isolation, low functional capacity, and diabetes may have oriented medical decision toward withholding dialysis in a significant proportion of pre-ESRD octogenarians [11], after earlier examination cancer, malnutrition, catabolism, and "dissatisfaction with life" were important associations with the decision to withdraw [19]. But it is not the tumors but a Vascular nephropathy which is the principal disease predicting withdrawal from dialysis; the main precipitating cause is mental incapacity [20]. The physicians with a background in bioethics have a higher rate of withdrawal and/or withholding from dialysis than those who did not have these specific skills [21]. Those doctors probably understand slightly differently their responsibilities and the patient's rights. Perhaps they also understand more deeply the Hippocrates oath where instead of Latin translation of "primum non nocere" – do no harm, they use the original Greek text with the positive expression: ophelein, which in fact means to benefit [8]. Taking into consideration the patient's benefit we present below the proposal of the management scheme in case of ethical doubts in patients with ESRD and cancer.

Final recommendations

1) The decision to withdraw from dialysis as crucial for life or death should be taken by at least two doctors including a nephrologis. It is advisable to discuss the decision at the meeting of the caring team.

2) The patient's will or in case when he/she is unconscious, the previously expressed wish in a written form concerning his/her treatment in such circumstances is the most important factor while taking the decision to continue or withdraw from treatment.

3) Close relatives (or people indicated by the patient and/or people who in our opinion act for the benefit of the patient) should be informed about the doubts and purposefulness of further treatment and together try to come to a common agreement. But the final decision is with the doctors.

4) Before making the decision about continuing or withdrawing from dialysis, consultations with priests, who have bioethical knowledge, lawyers or philosophers.

5) The fact of making such a decision should be described in the patient' file – with due respect to the principles of medical confidentiality. It is advisable to have a uniform model form developed by the Ministry of Health.

6) There is a need for legal regulations concerning the protection of the patient but also the legal protection for those taking part in the decision making process concerning continuing or discontinuing dialysis. The regulations should include the offices and institutions which have the right and obligation to make the decision in the situation of conflict and procedures suitable for hospital reality.

7) In doubtful cases the decisions should be directed towards life also because the contrary actions cannot be corrected.

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