

## No easy fix

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One night on call, I was asked to assess a 40-year-old woman with diffuse large B-cell lymphoma. She had developed tumour lysis syndrome, with rapidly rising creatinine and potassium levels. As I arrived on the ward, I took in the scene before me: a young, well-groomed, seemingly healthy woman sitting straight up in the hospital bed with her husband standing beside her, gently squeezing her hand. She seemed too well to be sitting here in a green hospital gown. Two nurses fiddled with intravenous poles with nervous energy. The tension in the room was palpable. Acute kidney injury and hyperkalemia tend to do that.

“I’m afraid the lymphoma has caused your kidneys to shut down,” I explained gently to the patient. “Temporarily,” I added, hoping to soften the blow.

“What can we do?” she asked, hope and fear in her voice.

With the hope and confidence of a third-year resident, I looked at her and said, “Don’t worry. We’ll fix it.”

I inserted a central venous dialysis catheter, and we rolled in the machine, which resembled a robot on wheels with flailing arms. Once dialysis started, treating the patient’s potassium level was just a matter of flipping a switch. She needed treatments every two days for the next week until her kidney function recovered, after which I removed her dialysis catheter and walked away with a feeling of accomplishment. Thinking only about her kidneys, I felt I had saved her life! I did not consider what lay ahead for her: more chemotherapy, possible complications, and all the ups and downs that come with cancer treatment.

Ten years later, I still think about that patient. I hope she did well. But now I realize how naive I had been. I had treated that moment as a major victory, but for her it had likely only been a

momentary reprieve in her long battle against lymphoma. Today, as a practising nephrologist with an interest in geriatric and palliative care, I appreciate that we do not have a “magic wand” that can solve all problems. Nowadays, I do not feel like I am fixing much, especially for my older patients receiving dialysis. Living with end-stage kidney disease can be quite burdensome; for older patients, it has the same or worse mortality risk as cancers.<sup>1</sup> Ironically, we used to compare survival on dialysis with stage IV cancers such as lung or colorectal, but now some of those cancers have comparably higher survival with treatment. Chronic dialysis therapy has not changed much; the prognosis is still poor, especially in older patients. There is no artificial kidney yet. In younger patients, dialysis is meant to be a bridge toward kidney transplantation, but for older, more frail patients, who are not always transplant candidates, dialysis is a life sentence.

I watch frail patients undergoing dialysis suffer, trying to live between their dialysis sessions; sometimes their lives seem only to exist to do dialysis. Either way, I consider it my role to make the experience tolerable. When I round on my dialysis patients, I am usually not focusing on fixing their electrolytes or blood pressure. Instead, I try to listen. I listen to them describe their pain, their fatigue, and their pruritus. They talk about their sleep or lack thereof. I listen, but it is not always enough. I get frustrated because there are no switches to flip, no dials to turn, and no catheters to remove.

One day, I received a call from the dialysis charge nurse. “Did you hear about Ms. A?” she asked without preamble. “She wants to stop dialysis.”

I had consulted on Ms. A in my role as a geriatric nephrologist a year prior. She was a 76-year-old woman who lived alone

and did not have any immediate family. She had end-stage kidney disease, but had been unsure about starting dialysis. She and I felt her dialysis experience might be distressing; she had been fiercely independent and had managed her multiple medical comorbidities on her own terms. She appreciated that dialysis in older patients is associated with increased frailty and loss of functional independence. Despite her reservations, she proceeded with treatment to sustain her life. I had not spoken with her since. Now, it seemed she was having some regret, which is not uncommon.<sup>2</sup>

I bolstered myself and went to the dialysis unit to speak with her.

She looked well. She was well dressed, presentable as always. I did my automatic geriatric scan. No walking aid, stable on her feet. No signs of frailty, malnutrition. She appeared to be thriving on dialysis.

“I heard you were having some difficulties with dialysis.”

“Yes,” she said guardedly. “It’s been a trial.”

We sat down to talk. I reminded her that she was in charge, and dialysis was *her* treatment. She decided when to start dialysis and if she wanted to stop. As we talked, she opened up a little. She had no pain or fatigue, and she was tolerating dialysis, but she was not enjoying life. She had lived her life on her own terms, and now she was ready to leave it on her own terms.

After exploring all avenues and ensuring she understood what stopping dialysis meant, we made a plan to admit her to hospital for palliation. She walked away with a smile on her face. As she left the unit, my own smile vanished abruptly. I was glad she was at peace with her decision, but I was sad that we were losing a member of our dialysis family. As dialysis doctors and nurses, we see our patients three times a week. We get to know them

intimately. We share moments of happiness and tragedy, and we get to know their families, some of whom diligently sit by their side every treatment. We worry about them when they become ill.

I felt a trace of doubt creep in. Had the decision been premature? Did I explore all options? Did I really do my due diligence in trying to make her life worth living, worth sustaining? Should I have called psychiatry?

Soon after, I admitted Ms. A. to the nephrology service under my care. We talked before her transfer to the palliative care unit. She was comfortable and felt well.

“Thank you,” she said.

I did not say anything more. I gave a half-hearted smile, squeezed her hand,

and left. I felt sorrow, but realized that what I was doing now was very similar to what I had done as a resident 10 years ago, when I had started dialysis for the young woman with lymphoma; I was simply supporting my patient in a moment of need. We are not always in the business of fixing things. Medicine is about accompanying our patients on their difficult journey, guiding them, listening to them, and helping them live with dignity. Especially in those moments when we cannot fix them.

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## References

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