Letter to the Editor | Palliative Medicine and Palliative Care for Serious or Advanced Diseases

It simply makes sense

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I am a third-year geriatrics resident, and when I was on my nephrology rotation, I received an interconsultation to define the continuity of hemodialysis in an 87-year-old man. I read about his current hospitalization, a case of aspiration pneumonia. He had multiple pathologies and medications and had been under outpatient nephrology follow-up for seven years for end-stage chronic kidney disease with renal replacement therapy type hemodialysis, with poor adherence as evidenced by some missed sessions in the last year due to a lack of interest and a desire to travel with his family. I went to the room where he was assigned in the system, but the patient was not there. I went back to the nephrology unit, entered the hemodialysis room, and found that the patient was connected to the hemodialysis machine, receiving the session of the day. I saw that he was somnolent, had hypotension, and had poor interaction. During the following days, he persisted with respiratory difficulty, altered consciousness, and increased oxygen requirements in relation to his pulmonary compromise.

I spoke to the patient's wife in relation to the different geriatric dimensions, and she told me that in the last year he had had a progressive functional decline that had led to a dependence on his self-care activities, had been losing weight and muscle mass, at times presenting altered consciousness, with little interest in performing his daily activities, and made emphasis on the difficulty she had to transfer the patient to his dialysis sessions because of his clinical deterioration. I expressed to the nephrologist in charge my concern about the continuity of hemodialysis due to his clinical condition, the progression of his disease, poor adherence to hemodialysis sessions, and functional decline, to which she replied, "*All my colleague nephrologists know him, and at this point we can let him go to his hemodialysis sessions whenever he wants, because at 87 years old he can do whatever he wants regardless of whether it is good or bad for his clinical condition to continue or not with hemodialysis*". I told her that we could consider other alternatives since I did not believe that he was a candidate to continue the hemodialysis therapy, and I suggested conservative renal treatment as an option to improve his quality of life and manage his symptoms, to which she replied, "*I am the attending; I am the one who makes the decisions, and you are a resident, you listen*", so at that moment I had to write in the clinical history that hemodialysis would be continued.

The socially constructed nature of medical knowledge and education has been repeatedly recognized throughout the years, and comprehending this relationship is not an easy task. In the field of palliative care and in general, it is difficult to reach a common ground on what makes sense from one specialty to another, and from my training and the evidence in the literature, it made sense to me that the patient should not continue with hemodialysis and offer him an alternative palliative approach; however, from my position as a resident, it was not a decision that I could make. The understanding of the interplay between person, situation, and behavior is improved by elucidating the intricate interplay among autonomy, decision-making, and patient care (1). Was the autonomy of the patient considered? Well, unfortunately, in the early stages of his disease, nephrologists never talked to him about poor outcomes, and when he had to decide, he was not able to do so.

The core idea of palliative care could be understood as a tangible action performed towards another, starting with an understanding of the vulnerability and frailty of the

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human condition (2). There is something in this core idea that simply makes sense; palliative care is a great option in the whole dimension of the disease, and it has been widely described in the literature, which makes me wonder about the barriers to its early implementation or when it is clear that it is necessary to adapt the objectives of an intervention.

Finally, the patient's health continued to deteriorate, and when it became clear that he could not handle more hemodialysis sessions, the nephrology team decided to start giving him comfort care. Subsequently he died.

The late introduction of a palliative approach in this case resulted in the loss of what should be the least wasted at the end of an elderly person's life: time.

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