Middle Articles

CONTEMPORARY THEMES

Selection of Patients for Haemodialysis

In the past few months there has been much debate on the ethical difficulties in selecting patients for haemodialysis—including a Ciba Symposium¹ and statements by the Sheffield Regional Hospital Board² and by the Minister of Health.³ To discuss various aspects of this problem we have invited contributions from four doctors in different fields—a general physician, a consultant in clinical renal physiology, a professor of urology, and a family doctor.

Who Best to Make the Choice?

From Dr. J. D. N. Nabarro, Physician, Middlesex Hospital, London

Doctors, from the day they start practising medicine, have to make decisions, and if they come to the wrong decision the consequences for the patient may well be disastrous. In fact, however, patients seldom die as the result of doctors' mistakes, and few doctors spend sleepless nights or develop anxiety states as the result of worrying about their patients. The physician who runs a chronic haemodialysis unit has a much more difficult task. Faced with ten candidates for a single place in a dialysis programme, he can give one person a chance of survival and is condemning the remaining nine to die. Stated thus it is a frightening decision to have to make, and it is not surprising that some doctors finding themselves in this position have sought to share the responsibility.

The situation, however, is not really quite so bad as it may seem. There are medical considerations which make it possible to place the ten candidates in some sort of order of priority. Thus the age of the patient, the cause of the renal failure, the cardiovascular status, and other factors will make it clear that some patients have a better chance than others of prolonged benefit from this form of treatment. Assessment of the patient's personality is clearly essential, though not necessarily made by a psychiatrist, and must be taken into account when selecting suitable patients. Due weight must inevitably be given to social conditions. A man who would be able to continue regular work in suitable employment, or a married woman with young children, is likely to be given a place in preference to an unemployed labourer with no fixed abode. It is really only the doctor who has been in touch with the patient for a considerable period who can assess fully the medical aspects and the patient's personality.

There can be little doubt that a doctor running a chronic dialysis unit, if he had been able to follow the patient over a period of some months, would be the best person to make the selection. In many cases patients are followed in other hospitals and then referred to a dialysis unit, where the doctor in charge has to make a decision on the basis of reports and one or two interviews. This point is considered further below. Emotional pressure may well be brought to bear on a doctor known to be personally responsible for selection. One may visualize telephone calls at his home, appeals to his wife, and hysterical relations on the doorstep. I think that the assessment of the candidates should be made by a senior doctor on the unit, but I am sure that it would be helpful to him—both in sharing responsibility and avoiding personal pressure—if a small unnamed group of people officially made the final decision. I visualize the doctor bringing the data to the group, explaining the points in relation to each case, and obtaining their approval of his order of priority.

Thus far I have written as an observer on the sidelines, working as I do in a hospital with neither a chronic dialysis nor a renal transplantation programme. I think that probably a great

deal of the selection, and possibly many difficult decisions, have to be taken by physicians in this situation. We have the advantage that we often know the patient for some time before the need for chronic dialysis or similar treatment arises. We have to decide when a young patient is obviously going into chronic renal failure, whether to try to get him into a chronic dialysis programme, whether to try to get him taken on by a home dialysis unit, whether he would be suitable for reference to a centre interested in transplantation, or whether for medical, psychological, or social reasons it would be wiser to use only dietary measures in his management. In the last instance there may be pressure from relations who wish to donate kidneys, or who feel that the patient should be treated by dialysis.

If it is thought that active treatment is indicated it is essential to start to make arrangements early, though this may mean alerting the patients to the gravity of the situation before they have realized it. Renal transplantation remains a hazardous procedure, and I am still a little hesitant about recommending it. Chronic haemodialysis seems at the present time to be the most encouraging approach, but clearly it can be used only if the patient lives within reasonable distance of a suitable centre. The dialysis may be performed either in the patient's home or in a hospital. The former is more expensive in terms of initial capital outlay, and the apparatus must be simple and include built-in safety devices. The patient's home conditions must be satisfactory, and there must be a husband, wife, or other relation who is capable of supervising the procedure. Hospital dialysis would be practicable for a larger number of patients, and, though the cost of a single machine would cover the initial capital outlay for three patients, maintenance cost and use of hospital beds would be greater. There also seems to be a risk of virus hepatitis affecting both patients and staff working in such a unit. The number of places available for chronic haemodialysis is hopelessly inadequate, and the physician caring for a young patient with renal failure has a worrying task trying to get his patient included in a dialysis programme. In North-west London there has recently been a new development. Suitable patients for whom the necessary money can be found (£4,000 initial outlay and £1,000 per annum maintenance) may be taken on for home dialysis by the National Kidney Centre. This raises some difficult problems. What advice should be given to a patient who fails to get a place, or who is unlikely to get a place in a National Health Service treatment programme? Should he be referred to this centre where his life may be preserved but at great financial cost to his family? To those of us who believed that the N.H.S. would provide essential medical care this is an unhappy development. It is to be hoped that if N.H.S. facilities cannot be provided for a particular patient the Ministry will cover the cost of treatment at the National Kidney Centre or better still that a way will be found to bring the highly skilled staff of the centre back into the National Health Service.

J. D. N. NABARRO.

¹ *Ethics in Medical Progress*, edited by G. E. W. Wolstenholme and Maeve O'Connor, 1966. London.

² See *Brit. med. J.*, 1967, 1, 121. ³ See *ibid.*, 1967, 1, 439