FROM THE EDITOR

Choosing Dialysis Modality—Patient Choice or Physician Bias?

While numbers of patients on peritoneal dialysis (PD) are increasing in several countries that have developing health-care economies, rates are declining in the more economically developed countries (1), with the exception of the USA following recent changes to dialysis funding (2). This is despite evidence that most developed countries can provide PD at a lesser expense to the healthcare system than hemodialysis (HD) (3). The impact of an increasingly dependent and aging population with their associated burden of multiple long-term conditions presents a well-documented challenge for healthcare providers. Meanwhile, there is a growing body of evidence to support the value of treatment pathways that are community based and that empower people to take a greater role in their own healthcare (4).

In the UK, technology appraisals have evaluated the merits of home HD and PD (5). A 2002 report concluded that expanding home and satellite HD services may provide a method of coping with increased numbers of people requiring dialysis (6), with fewer additional resources than would be needed to expand hospital HD units. A 2011 guideline on the role of PD suggested that it should be offered as the first choice for children 2 years old or younger, people with residual renal function, and adults without significant associated comorbidities (5). Despite these reports, the trend for PD continues to decline in the UK, with a recent modest increase in the use of home HD. This situation is markedly different in Australia and New Zealand, where there is clear support from nephrologists for home therapies (7). The prevalence of home dialysis is 30% in Australia and 49% in New Zealand (8), compared with 17% in the UK with a wide variation between centers (9).

Fundamental to dialysis modality selection is information sharing—a concept that becomes more complicated the closer it is examined. What constitutes genuine modality choice for patients facing dialysis? How is this impacted by mode of presentation, social circumstances, level of dependency, and geographic considerations? Factors that can mitigate against the choice of a home therapy include an assumption that care is safer in the hospital, a lack of confidence to take on care, and the competing complexities of the modern lifestyle—work, family, home circumstances. In any health system, a range of factors external to the patient influence decision-making—including availability of services, cost to the patient or provider, policies (e.g. PD or home first policies) and cultural issues relating to concepts of self-efficacy.

In the UK, renal center-specific factors and physician practice patterns impact on the use of home dialysis, including physician aspiration, using PD for unplanned start, and home visits to provide patient information or troubleshooting advice for existing home patients. When videos or DVDs were included in patient education, this was associated with a lower likelihood of home therapy use and correlated with lack of physician enthusiasm (10). The specialty of providing patient information has developed rapidly over the last decade, with the recognition that material for patients and carers has not been appropriately designed to convey all the necessary information and to minimize bias (11). The use of patient narratives to present information may be particularly prone to this problem due to uncertainty in the way such narratives might be balanced to present an appropriate range of patient experience (12).

This issue of *PDI* includes an evaluation of a dialysis decision aid (DA) (Hilary Bekker and colleagues). In the accompanying commentary, Rachael Morton discusses the factors that she and the team she works with at the University of Sydney found to be important to patients when it comes to modality selection. These include confronting mortality, lack of choice, gaining knowledge of options, and weighing alternatives (13). Through systematic review utilizing a mixed methods approach, they found that patients and family carers value treatment that enhances survival and can be performed at home, including dialysis-free days, respite, and the ability to travel (14). Australian dialysis and transplant patients preferred renal replacement therapy that enhanced freedom and autonomy and where convenience, safety, and simplicity were central, minimizing confinement and risk (15).

Ultimately, the proof of the pudding is in the eating—did patients get the modality that they selected? Liebman and Ziolkowski, in this issue of *PDI*, explore that question through a qualitative analysis of interviews with 24 patients who started in-center HD despite initially choosing a home modality. The reasons for not getting their chosen modality broadly fell into 3 themes—lack of confidence, home issues such as lack of space, and a feeling of insufficient education. The authors highlight problems with nephrologists or other patients putting individuals off their initial choice and suggest that, in addition to improving education pathways, mentoring of nephrologists is also required so that their confidence is increased to recommend a home therapy. Peer support programs have the potential to increase patient confidence in home therapy selection. This not the first research program that has indicated that the extent of information that the patient receives is heavily subject to the quality of the local education program (16).

Multiple factors affect the likelihood of patients selecting a home therapy, and the challenge to healthcare teams is to provide the right set of circumstances to give individuals the confidence to dialyze in the community, without feeling pressured into doing so. A recent systematic review, again from Sydney, reported that patient and carer attitudes to home HD included benefits with respect to thriving, freedom, flexibility, wellbeing, and relationships. However, some voiced anxiety and fear about starting home HD due to the “confronting nature of the treatment and isolation from medical and social support” (17). It is therefore imperative that community patients feel adequately supported, and indeed, supporting individuals to rehabilitate within their communities is the subject of a recent report by the Health Foundation (4). This report poses the question, *How do we re-engineer our health and care services systems to realize the value of people and communities at the heart of health?* Potential solutions include providing peer support, self-management education, health coaching, and group activities. However, this will not be achieved until clinical teams that look after patients get the message that rehabilitation in the community is in the interests of patients and healthcare systems.

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