

The Integration of Palliative Care in the Critical Care Management of Patients with Advanced Renal Diseases: A Necessity in Patient-centered Outcome

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RJCCN 2026; 2: 70-1
www.rjccn.org

DOI: [10.66224/rjccn.2.2.40](https://doi.org/10.66224/rjccn.2.2.40)

End-stage kidney disease patients are frequently admitted to the ICU for critical and fatal conditions. These patients experience a high mortality rate, symptom burden, and difficult decisions about life-sustaining treatments such as renal replacement therapy. Previous studies have established that the current disease management approach in caring for ICU patients does not address the holistic needs of these patients.

Nephrology and critical care overlap to create a very intense field of practice and outcome. Most patients with end-stage renal disease have an increased incidence of requiring ICU care due to associated complications such as infections, cardiovascular complications, and metabolic derangements. Once in the ICU, the mortality rate for those patients requiring either invasive mechanical ventilation or inotropic/sympathomimetic therapy is greater than 50%. Not only do these patients face a high mortality rate, but they also face a high symptom burden due to associated pain, shortness of breath, fatigue, confusion, and itching. The use of technology in the ICU (such as dialysis) has often resulted in loss of focus on patient-centered goals and has been termed the 'Technological Imperative'. Ultimately, palliative care is a type of medical service for the purposes of helping improve the quality of life for an individual suffering from a serious or potentially life-threatening condition, and this is not the same as end-of-life care but is instead intended to occur at the same time as curative or life-prolonging treatment.

The World Health Organization has estimated that there are 40 million individuals annually who need palliative care, and 78% of these individuals live in low and middle-income areas.

Still, only a small percentage, less than 10%, of those people in low and middle-income areas are able to receive palliative care. Additionally, it has also been estimated that with the rate at which the population is increasing, the need for palliative care will only continue to grow in the coming years. For example, in the U.S., there are upwards of 90 million people suffering from different types of illnesses, with 80% of those people being in need of palliative care, yet only 50% of those hospitalized and in need of palliative care are able to receive it. The five basic principles on which palliative care is based are as follows, regardless of the differences among palliative care patients: the needs of the patient are the focus, the continuity of palliative care is important in the course of medical treatment, use palliative care at the time of diagnosis, use inter-professional teams, and the public should be able to access palliative care services in each community. These principles have been in place for a number of years in many countries. However, it appears there is no well-structured palliative care program in place for Iran. Instead, palliative care is viewed as a challenge to the Iranian health care system due to the lack of attention given to palliative care patients.

CHALLENGES FOUND IN THE NEPHROLOGY ICU

RRT Decision Making for Critically Patients

The concept of using, extending, or withholding dialysis from a patient who is critically ill can be difficult both ethically and practically in all



Please cite this article as: Rahimzadeh Kalaleh A. The Integration of Palliative Care in the Critical Care Management of Patients with Advanced Renal Diseases: A Necessity in Patient-Centered Outcome. RJCCN. 2026;2(2):70-1.

situations. “Time-limited trials of RRTs are a highly useful but largely underdeveloped tool.”

The High Burden of Symptoms

The symptoms are often not recognized or treated adequately. The uremic symptoms also pose an additional burden to the already present critical illness, as well as the burden of dialysis itself, which may include leg cramping and fatigue.

Prognostic Uncertainty

It is common for both the healthcare providers and the families to have unrealistic expectations regarding the chances for survival as well as the chances for the restoration of function after the illness caused by ESRD for these patients.

Communication Breakdowns

The breakdown occurs regarding the discussion of prognosis, goals of care, long-term functional impairments.

Caregiver Distress

The families of these patients are already engaged with the duration of chronic dialysis treatments for the patients. When the family decides to consider the ICU admission for the patients, the caregiver expresses a high level of distress

Models for Integrating Palliative Care

Integration can be achieved through the primary or specialist models:

Primary Palliative Care. Palliative Care must have the ICU Team and Nephrologists with primary knowledge of assessing patient symptoms; both teams will require communication skills; at minimum should understand ethical issues. Develop core triggers that will enable the two teams to proactively start to work on developing an intervention with the service.

Trigger Criteria. Automatic referral to consult patients with ESRD after ICU admissions: ≥ 2 admissions within 30 days, metastatic cancer, end-stage dementia, prolonged mechanical ventilation (> 7 days), or significant pre-admission decline

Specialized Palliative Care Service. If the patient comes with severe symptoms that are complicated, there is a direct conflict between the family or

patient, and there is a high degree of existential distress, then referral to a multidisciplinary palliative care service is likely. This type of referral is required for high psychosocial issues, complicated family sessions, or severe symptom management.

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Received February 2026