



The Psychological and Ethical Specificities of Dialysis Treatment of the Elderly



¹ Marta Klarić

² Jagoda Nikić

³ Dragan Klarić

¹ General Hospital, Zadar, Croatia

² Nursing school Mlinarska, Zagreb, Croatia

³ Department of Nephrology and Dialysis, Zadar General Hospital, Zadar, Croatia

treatment; however, in some cases, family members urge cessation of treatment among these patients. The aim of this paper is to provide an analytical clinical case discussion of psychological and ethical specificities in dialysis care in advanced age, rather than an empirical investigation.

Summary



Nephrologists often deal with dialysis treatment of the elderly, considering that life expectancy has been increased. Somatic treatment has been shown to be quite complicated, which requires expertise, as well as empathy. Nephrologists should understand the basics of psychological functioning in this particular group of patients in order to enhance competence and decision-making. Defence mechanisms play an important role and may shape how patients cope with distressing aspects of illness. Treatment is ideal when a patient is cooperative. However, psychiatric advice and/or treatment may be necessary if, for any reason, the patient becomes non-adherent or refuses treatment. Moreover, physicians are often confronted with ethical dilemmas when somatic, psychological and/or psychiatric treatment methods have been exhausted. It is a physician's duty to provide appropriate care to all patients, including patients with dementia and those at the end of life. Most of the time, family members demand maximal

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Corresponding author:

Jagoda Nikić

A: Tuškanac 56, 10000 Zagreb

T: +385 99 401 68 11

E-mail: jagodanikic@yahoo.com

Introduction

The population of the elderly among dialysis patients is constantly rising, as a result of increased life expectancy and improvements in treatment methods. Because of normal physiological changes in the elderly, such as poor eyesight, hearing problems, limited mobility, and similar conditions, they tend to depend on their surroundings and caregivers for help. When these are accompanied by chronic illness, the situation becomes ever more difficult, and the need for assistance becomes more pronounced, e.g. in feeding, hygiene, control of medication, transport to health institutions, among others. Old age is associated with Alzheimer's disease as a specific chronic illness in this population. This illness interferes greatly with treatment, creating additional ethical dilemmas. Therefore, the importance of an individual approach to treatment methods is significant (1, 2).

It is known that among the elderly, one in three individuals shows signs of dementia, while one in five shows symptoms of depression. Many of them have trouble coping with chronic pain. Furthermore, more than a third of these patients with ESRD suffer from four or more chronic diseases, and as such are not taken into account as transplant candidates. Confronting the patient and their family with news of illness and its prognosis represents a great deal of stress for both the patient and their family, as well as for the person delivering the news.

If these elderly patients fully understood the seriousness of their illness, many of them would decline treatment, given that it would only prolong their suffering. Many say that they are too old and tired to continue fighting the disease (it is well known that chronic disease is exhausting both physically and mentally, and may sometimes cause psychiatric comorbidities). In these cases, a psychiatric assessment is required to evaluate whether the patient shows signs of mental illness, such as depression, or simply lacks the will to continue treatment.

Quality of life is a very important factor for all individuals, and it can be compared to the number and severity of diseases one might have. Studies have shown that nephrological patients who have undergone transplantation have a better quality of life. However, they too are often greatly disturbed by the fear of losing their graft (3).

The aim of this paper is to provide a clinical case discussion of psychological defence mechanisms and ethical decision-making in the context of hemodialysis in advanced age. It is not an empirical study, but a structured reflection based on a representative clinical example.

Case report

An 89-year-old man with arterial hypertension, hyperlipidemia, diabetes, prostate adenoma and urinary retention was admitted to the hospital due to deterioration of renal function. Laboratory findings indicated (pre)terminal renal insufficiency and that he needed the creation of an arteriovenous (AV) fistula, but the attempt failed. His blood vessels were calcified, and in agreement with the vascular surgeon, further attempts to create one were abandoned. Given the deterioration of laboratory findings (urea 44.2 mmol/L, creatinine 816 mmol/L, potassium 5.9 mmol/L), a central venous catheter (CVC) was placed in the right subclavian vein, and he started hemodialysis treatment. Due to urinary retention, a urologist placed a permanent urinary catheter.

After three months, the patient was readmitted for the placement of a permanent CVC for hemodialysis. Nine months after the first presentation, he was hospitalised due to high inflammatory parameters. He had pre-existing dry gangrene of his left foot, and now also of the right foot. Surgeons indicated bilateral above-the-knee amputation, which he refused.

In a state of full awareness of his condition, well-oriented in all directions, he refused hemodialysis. According to heteroanamnestic data, he was taking high doses of opioid analgesics due to foot pain, which made him sleepy, and he reduced his oral intake. He had not been drinking much in the preceding days.

The letter

“To whom it may concern:

My grandfather means the world to me, since my father passed away when I was a child. Now he is very old and he undergoes dialysis. I love him very much. For the past few days, he has been begging me not to let him go to dialysis because he is aware

that the end is near. Against his wishes, I kept taking him to dialysis, afraid that he wouldn't come back. I have now decided not to take him to dialysis any longer. What do you think - am I doing the right thing?" The following week, we received another letter: "My grandfather has passed away. Thank you for everything."

What is written in the letter is brief, but it reveals one of the most difficult aspects of the case. It shows how psychological coping and family responsibility can collide when prognosis is limited and distress and symptom burden increase. In this context, treatment refusal requires two steps: understanding the patient's psychological state and decision-making capacity, and then responding in a way that primarily respects autonomy.

Discussion

Upon being informed of a serious illness and a negative outcome, patients tend to use psychological defence mechanisms. One of the most common reactions to illness is regression. This occurs due to the fear of illness and is an unconscious reaction. Illness is a significant stress factor, and as such, triggers the mechanism of regression. Patients may show more dependent, childlike behaviour and seek reassurance that provides a sense of safety, similar to earlier life when others provided care. This is especially pronounced among dialysis patients, since dialysis requires the aid of trained personnel.

Besides regression, denial is a common defence mechanism that patients use to take their mind off the disease, negative outcomes, and death. Under the influence of denial, patients deny the fact that they suffer from a serious illness. Instead, they may believe the condition is minor or easily treatable and does not require sustained attention. Patients tend to act according to their standpoint. As a result, they may become less engaged in treatment and may take medication inconsistently or not at all. Sometimes, patients unwittingly become ill-tempered or even show aggressive behaviour towards the medical team. However, the physician, as a trained and experienced professional, is an excellent role model for the elderly, who may experience social vulnerability. This means that the majority of patients follow

their physician's recommendations and prioritise them highly. Hence, the physician helps patients confront their illness and accept the process of therapy, in spite of the defence mechanisms and anger they might have.

Nephrologists do not have formal training in the field of psychology, even though they come across situations that require psychological aid, such as confronting and caring for patients who are chronically ill. It is important to respect the patient's right to choose what they think is best for their health, i.e. accepting or refusing therapy. Difficulties arise in patients with dementia, whose reality testing and decision-making capacity may be impaired and who may be fully dependent on their caregiver.

The ethical issues raised by this case can be considered within the four principles of biomedical ethics: respect for autonomy, beneficence, non-maleficence, and justice (4). Autonomy is central when a competent patient refuses dialysis; beneficence and non-maleficence require balancing potential benefits against suffering and treatment burdens; and justice supports fair, proportionate care and responsible use of healthcare resources in the context of limited prognosis and multiple comorbidities.

It is evident from this example that because of their disabilities and comorbidities, everything care becomes more complex for elderly patients and requires careful decision-making. As was mentioned earlier, the decision regarding treatment in elderly patients should be their own, taking into account their physical and mental status and prognosis. Patients with dementia pose particular clinical and ethical challenges, and their situation resembles that of children, where parents make decisions on behalf of the child. In these situations, the patient with dementia must have a surrogate decision-maker who will make decisions in the patient's best interests, as the patient would if able (5).

Many times, we come across similar situations in clinical practice. For instance, a patient who is very old, critically ill, and has no chance of survival is kept on the ward and treated since a moral dilemma unfolds - to continue or cease therapy? In this scenario, the term *dysthanasia* comes to mind. Should we proceed with treatment, even though there will be no improvement, and that death is the only outcome? Physicians are not obligated to make these decisions. They carry on with treatment even though the patient's state does not improve because they were taught to never give up on a patient.

In such cases, it may be ethically appropriate to explicitly consider the patient's preferences (or surrogate preferences when decision-making capacity is impaired) and to re-evaluate whether ongoing interventions remain proportionate to the expected benefits and burdens. Along with ethical issues among the elderly, we often come across financial instability and psychiatric comorbidities such as depression, anxiety, and even psychosis. Since symptoms of depression and uraemia intertwine, the expertise of a psychiatrist is sometimes needed to distinguish the diagnosis. It is possible to improve a patient's compliance with treatment with the help of a psychiatrist. Psychiatric consultation is necessary when a patient refuses treatment and dementia is not evident. In these situations, a psychiatrist evaluates whether the patient has a psychiatric illness that could disrupt decision-making capacity.

In clinical practice, we come across different scenarios. For instance, a patient who is psychologically and cognitively stable and refuses to initiate or continue treatment is acceptable. However, if a patient refuses to be treated but has psychological or cognitive problems, treatment should still be considered, in order to protect the patient's best interests when decision-making capacity is impaired. The patient's comorbidities should be treated as well. It is possible that the patient becomes compliant and comes to the realisation that life remains meaningful to him and that he wants to live, in spite of his agony.

Psychiatric evaluation is the only relevant factor we can use to guide treatment. It is important to mention that not all patients react alike, even though they might have the same diagnosis, sex, occupation, age, etc. Personality features shape how an individual reacts to illness. Patients who have learned to rely heavily on others and show a fragile ego structure and anxiety may respond differently than those who cope more effectively and show a more mature ego structure and psychological stability.

Another ethical issue is religion and spirituality. This aspect of life can be fulfilling for the individual and have a positive effect on one's outcome. We do not know how to behave in certain situations regarding religious views, as there are no legal regulations. Clinicians may reflect on how we would react in the same situation. Although discussing death is difficult, communicating preferences in advance can reduce the burden on family members who may later need to make important decisions.

Conclusion

Many times, clinicians often face the task of delivering bad news to elderly patients, such as the diagnosis of a disease or its prognosis, which can be rather stressful for both patients and clinicians. It is even more difficult to make decisions that differ from the ethical perspective traditionally held by physicians: to help every patient until the very end. The elderly receiving dialysis often experience complex and evolving health conditions, sometimes shaped by psychological defence mechanisms and ethically difficult choices. This case suggests that treatment refusal should be approached by carefully assessing decision-making capacity and by maintaining clear communication with family members and the medical team.

Clinicians should respect autonomy while still weighing likely benefits against burden and providing care that is fair and responsible. In practice, combining a structured psychiatric assessment with explicit ethical framing can facilitate shared decision-making and reduce distress for patients, families, and clinicians.

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PSIHOLOŠKE I ETIČKE SPECIFIČNOSTI DIJALIZNOG LIJEČENJA BOLESNIKA STARIJE ŽIVOTNE DOBI

Sažetak

Nefrolozi se sve češće susreću s dijaliznim liječenjem bolesnika starije životne dobi, s obzirom na produljenje očekivanog trajanja života. Liječenje kronične bubrežne bolesti u ovoj populaciji često je složeno i zahtjevno te iziskuje visoku razinu stručnosti, ali i razvijene komunikacijske i empatijske vještine. Poželjno je da nefrolozi poznaju osnovne značajke psihološkog funkcioniranja starijih bolesnika kako bi unaprijedili kliničko odlučivanje i kvalitetu skrbi. Obrambeni mehanizmi imaju važnu ulogu te mogu znatno utjecati na način suočavanja bolesnika s opterećenjem kronične bolesti i dijaliznog liječenja.

Optimalan ishod liječenja postiže se uz dobru suradljivost bolesnika. Međutim, u slučajevima nesuradljivosti ili odbijanja liječenja potrebno je razmotriti psihijatrijsko savjetovanje i/ili liječenje. Nadalje, u kliničkoj praksi često se javljaju etičke dvojbe kada su iscrpljene mogućnosti somatskog, psihološkog i/ili psihijatrijskog liječenja. Obveza je liječnika osigurati primjerenu skrb svim bolesnicima, uključujući bolesnike s demencijom te bolesnike u završnom stadiju bolesti.

Članovi obitelji najčešće zahtijevaju maksimalno liječenje, no u pojedinim slučajevima zagovaraju i prekid dijaliznog liječenja. Cilj ovog rada jest pružiti analitički prikaz kliničkog slučaja s naglaskom na psihološke i etičke specifičnosti dijaliznog liječenja u starijoj životnoj dobi, a ne empirijsko istraživanje.

Ključne riječi: bolesnik starije životne dobi, dijalizno liječenje, etičke dvojbe
