

סדציה פליאטיבית Palliative Sedation

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“כשאני משתמש
במילה, מובנה הוא
בדיוק המובן שאני
בוחר בשבילה - לא
פחות ולא יותר”

המפטי דמפטי

מרק מושגים

- Physician Assisted Suicide
- Voluntary Euthanasia
- Palliative/Terminal Sedation

מושגים פתוחים לפרשנות

- Terminal
- Imminently dying
- Refractory
- Prolonged
- Possible options
- Severe/extreme/profound
- Adequately controlled

לרוע המזל מי שביכולתו להקל על הסובל הוא גם בעל היכולת לפרש את המושגים, ואולי בשונה מהאדם שחווה את הסבל

מושגים והגדרות לסדציה

Chater et al. (1998)	Terminal sedation	The intention of deliberately inducing and <u>maintaining deep sleep</u> , but not deliberately causing death, for the relief of: 1. one or more intractable* symptoms when all other possible* interventions have failed, or 2. profound* anguish.
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*מושגים סובייקטיביים

מושגים והגדרות לסדציה

Morita et al. (1999)	Sedation	A medical procedure to palliate patients' symptoms refractory* to standard treatment* by intentionally dimming their consciousness.
Quill & Byock (2000)	Terminal sedation	The use of high doses of sedatives to relieve extremes* of physical distress.

Terminal Sedation

(Chater, 1998)

"...[T]he intention of deliberately inducing and maintaining deep sleep, but not deliberately causing death in very specific circumstances. These are:

1. For the relief of one or more intractable symptoms, when all other possible interventions have failed and the patient is perceived to be close to death, or
2. For the relief of profound anguish (possibly spiritual) that is not amenable to spiritual, psychological, or other interventions, and the patient is perceived to be close to death."

Palliative Sedation

(Broeckaert & Nunez, 2002)

"Palliative sedation is the intentional administration of sedative drugs in dosages and in combinations required to reduce the consciousness of a terminal patient as much as necessary to adequately relieve one or more refractory symptoms. (p. 170)."

The Ethics Of Palliative Sedation As A Therapy Of Last Resort

National Ethics Committee, Veterans Health Hosp. 2007
Am. J. Hospice & Pall Med 23(6) 2007

"The administration of non-opioid drugs to sedate a terminally ill patient to unconsciousness as an intervention of last resort to treat severe, refractory pain or other clinical symptoms that have not been relieved by aggressive, symptom-specific palliation"

Refractory symptoms

-Broeckeaert

“Any given symptom can be considered refractory to treatment when it cannot be adequately controlled in spite of every tolerable effort to provide relief within an acceptable time period without compromising consciousness”.

Refractory *ctd*

In deciding that a symptom is refractory, the clinician must perceive that further invasive and noninvasive interventions are either:

- incapable of providing adequate relief
- excessive/intolerable acute or chronic morbidity
- unlikely to provide relief within a tolerable time frame (Cherny & Portenoy, 1994)

סיבות לסדציה

Symptoms	Stone et al. (1997) (n=115)	Morita et al. (1999) (n= 157)	Porta Sales (2001)
דליריום	60%	42%	39%
דיספניאה	20%	41%	38%
כאב	20%	13%	22%
דימום	-	-	9%
בחילה/הקאה	-	2%	6%
תשישות	-	-	20%
נפשי/רוחני	26%	2%	21%

מתי מדובר בסדציה?

בסמוך למוות, כאשר ישנה השפעה סדטיבית לא רצויה שלא ניתן להימנע ממנה בטפול ב:

- כאב
- בחילה
- דיספניאה

האם זו "סדציה פליאטיבית", או שמא מדובר פשוט בטפול אגרסיבי בכאב, בחילה או דיספניאה?

אין מדובר בטיפול מכוון לסדציה; אם היה ניתן להיעזר בטיפול אפקטיבי יותר היוו משתמשים בו.

מתי מדובר בסדציה?

במצב של דליריום בלתי הפיך, עם תוחלת חיים של שעות/ימים, המלווה באגיטציה ואי שקט קיצוני, הטיפול היעיל היחיד הוא סדציה ותמיכה במשפחה.

האם זו "סדציה פליאטיבית" או טיפול בדליריום?

מהם התסמינים שהם "חמורים מספיק" בכדי להצדיק סדציה כפעולה בלתי נמנעת מטיפול יעיל?

האם זה "בסדר" במצב של:

- כאב חמור?
- מצוקה נשימתית... "נחנק למוות"...
- בחילה והקאה... חסימת מעי ממאירה עם הקאה צואתית? הקאה דמית ממושכת?
- סבל קיומי, סבל רוחני, אי שקט נפשי קשה בשעות/ימים אחרונים לחיים?
אם לא, מדוע לא?

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"... permitting ...practitioners to offer palliative sedation when the patient's suffering cannot be defined in reference to clinical criteria could erode public trust in the agency..."

In this statement, the patient's needs have come second to public perception of the institution

Sedation for Anguish

- Does "pain of the soul" not deserve the same aggressive approach as other types of distress in the imminently dying?
- Is it wrong to "numb the brain" in order to address suffering experienced during wakefulness, or should you try to force the person to deal with the demons that plague him/her?
- Is lying on one's death bed, tortured by fear/regrets/guilt/despair less burdensome than severe physical pain caused by tumour?

What Will You Offer Otherwise?

- “Journey with you”
- “Walk your walk with you”
- “Share your path”
- “Be present”

Can you truly fulfill such a commitment?

Will you be there in the dark hours of the night, when solitude and silence magnify fear and despair?

Unless you have lived their lives and are dying their death, how can you presume to “share their journey”?

Sedation for Anguish

Just as in managing severe pain, dyspnea, nausea, agitated delirium when death is near, before accepting that an unconscious state is the only option for comfort, one must...

Sedation for Anguish *ctd*

- Consider reversible causes
- Explore available treatment options
- Consult with expert colleagues (pastoral care, social work)
- Thorough discussion and documentation; pre-emptive discussion about food and fluids
- Ongoing, proactive communication with families
- Consider a measured, titrated approach... “take the edge off” ... not a on/off phenomenon like a light switch

Who Decides?

- Patient: autonomy and related rights
- Family: involved in care planning
- Interdisciplinary team: develops care plan with patient and family
- Advice from external ethics consultation may be helpful
- Advice from external clinicians may be helpful

A Specific Consideration in Palliative Sedation

What is the proximity of expected death from the terminal condition... hours, days, one week, 2 weeks, a month, more?

➤ *How does this compare to the time frame in which sedation itself might result in death?*

Medications used in palliative sedation

- Benzodiazepines (*lorazepam, midazolam*)
- Neuroleptics (*haloperidol*)
- Barbiturates (*phenobarbital*)
- Propofol
- Opioids if concomitant pain/dyspnea

Palliative Sedation vs. Euthanasia

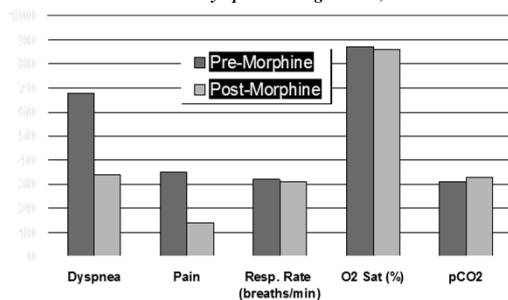
	Palliative Sedation	Euthanasia
Goal	Decrease suffering	Decrease suffering
Intent	<u>To Sedate</u>	<u>To Kill</u>
Process	Administration of sedating drug doses, titrated to effect	Administration of a lethal drug dose
Immediate Outcome	Decreased level of consciousness	Death

Concern About Aggressive Use Of Opioids In The Final Hours

How do you know that the aggressive use of opioids doesn't actually bring about or speed up the patient's death?

SUBCUTANEOUS MORPHINE IN TERMINAL CANCER

Bruera et al. J Pain Symptom Manage. 1990; 5:341-344

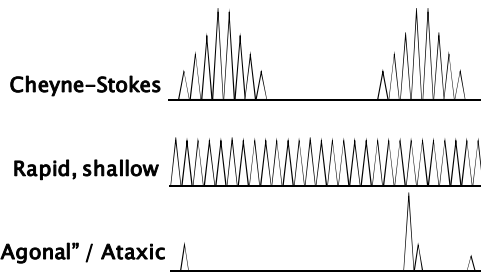


Typically, With Excessive Opioid Dosing One Would See:

- pinpoint pupils
- gradual slowing of the respiratory rate
- breathing is deep (though may be shallow) and *regular*



Common Breathing Patterns In The Final Hours



DOCTRINE OF DOUBLE EFFECT

Where an action, intended to have a good effect, can achieve this effect only at the risk of producing a harmful/bad effect, then this action is ethically permissible providing:

1. The action is good in itself.
2. The intention is solely to produce the good effect (even though the bad effect may be foreseen).
3. The good effect is not achieved through the bad effect.
4. There is sufficient reason to permit the bad effect (the action is undertaken for a proportionately grave reason).

Wilkinson J. *Oxford Textbook of Palliative Medicine* 1993: p 497-8

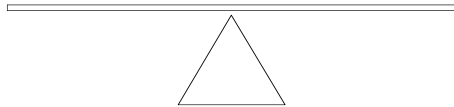
The principle of double effect is not confined to end-of-life circumstances

Good effects

Benefits (Experiential)
Beneficial Effects (Clinical)

Bad effects

Burdens (Experiential)
Side Effects (Clinical)



Mount B., Flanders E.M.; Morphine Drips, Terminal Sedation, and Slow Euthanasia: Definitions and Fact, Not Anecdotes
J Pall Care 12:4 1996; p 31-37

- The doctrine of double effect can reassure health care providers who may otherwise withhold opioids in the dying out of fear that the opioid may hasten the dying process
- A problem with the emphasis on double effect is that there is an implication that this is a common scenario.... in day-to-day palliative care it is extremely rare to need to even consider its implications

Case Presentation

- 55 yo man
- Multiple myeloma
- While covering the ward for the day, asked to talk to him for "just a couple of minutes" about his wish to remain sedated

How would you approach this situation?

Thorough Assessment

- Need to assess “total burden of illness”, Prognosis, expected proximity of death
- Hb 50
- Short of breath, congested, bedridden, severely cachectic
- Estimated prognosis at most 1 week, likely a few days

Why is the medical assessment relevant?

Why Is This Being Requested?

- Treatable depression?
- Fear of dying process – how will it happen?
 - How do people imagine their death will be?
 - Uncontrolled symptoms – pain, choking, confusion
- Burden on family – “Better off without me”
- No meaning/purpose/point in continued existence

Why don't we talk more often about dying with people who are dying?

Consider

- Do you have misgivings about this?
- Would you have misgivings if this were severe pain?
