Palliative Sedation

When I use a word...

Marking concepts

- Physician Assisted Suicide
- Voluntary Euthanasia
- Palliative/Terminal Sedation
 MOSHEIM PFIHIM LEFRESHOT

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


terminal sedation
The intention of deliberately inducing and maintaining deep sleep, 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.

MOSHEIM VAGADOT LFSADIZA

| Chater et al. (1998) | Terminal sedation | The intention of deliberately inducing and maintaining deep sleep, 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. |

MOSHEIM VAGADOT LFSADIZA

| 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


“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**

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)

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מתי מдоров בסדציה?
במצבים שונים, כמו סדרת ש流动性 של התערובת של שינה והפגת סטרים אסחילת לא רצוי,
פשעי הול閉ינון מתנה פְּלַגַּן ב: קצב
בחייה
NameValuePair

הוא או "סדציה פליאטיבית", או收費 מдоров פשע
במצבים אחרים, כמו סדרת ש流动性 של התערובת של שינה והפגת סטרים אסחילת לא רצוי.
אין מдоров בסדיכות פְּלַגַּן, אלא זו רצוי מכלול
במצבים אחרים, כמו סדרת ש流动性 של התערובת של שינה והפגת סטרים אסחילת לא רצוי.

מתי מдоров בסדציה?
במצב של דליריום בלתי הפיך, עם תוחלת חיים של שעות/ימים,
המלווה באגיטציה ואי שקט קיצוני, הטיפול היעיל היחיד הוא סדיכה ותמיכה במשפחה.
האם זו "סדיכות פליאטיבית" או טיפול בדליריום?

מהם התסמינים שהם "חמורים מוסיפים" בכדי להצדיק סדיכות כפעולה בלתי נמנעת מטיפול
יעיל?

מהם התסמינים של "חמורים מוסיפים" בכדי להצדיק סדיכות כפעולה בלתי נמנעת מטיפול
יעיל?
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

“... 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; preemptive 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

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<th>Goal</th>
<th>Palliative Sedation</th>
<th>Euthanasia</th>
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<td>Intent</td>
<td>To Sedate</td>
<td>To Kill</td>
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<tr>
<td>Process</td>
<td>Administration of sedating drug doses, titrated to effect</td>
<td>Administration of a lethal drug dose</td>
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<td>Immediate Outcome</td>
<td>Decreased level of consciousness</td>
<td>Death</td>
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### 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
- Cheyne-Stokes
- Rapid, shallow
- “Agonal” / Ataxic

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).

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)

The doctrine of double effect can assure 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 in 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?