Palliative Sedation: The basics, the ethical considerations, and the controversy

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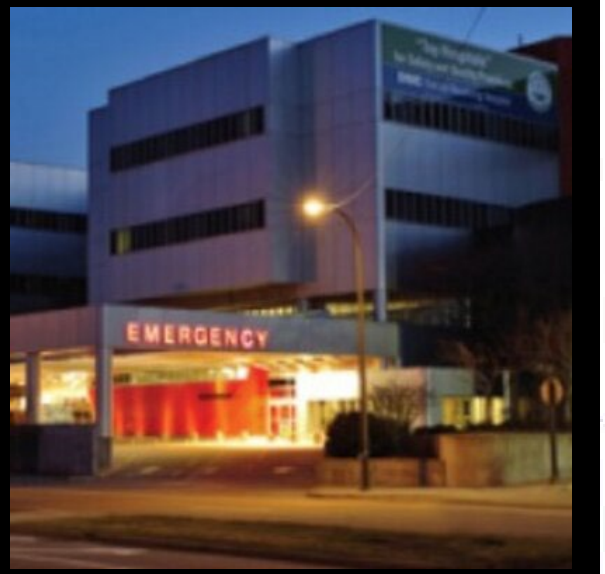
EMERGENCY


Palliative Ward
"He's our new Palliative Specialist!"


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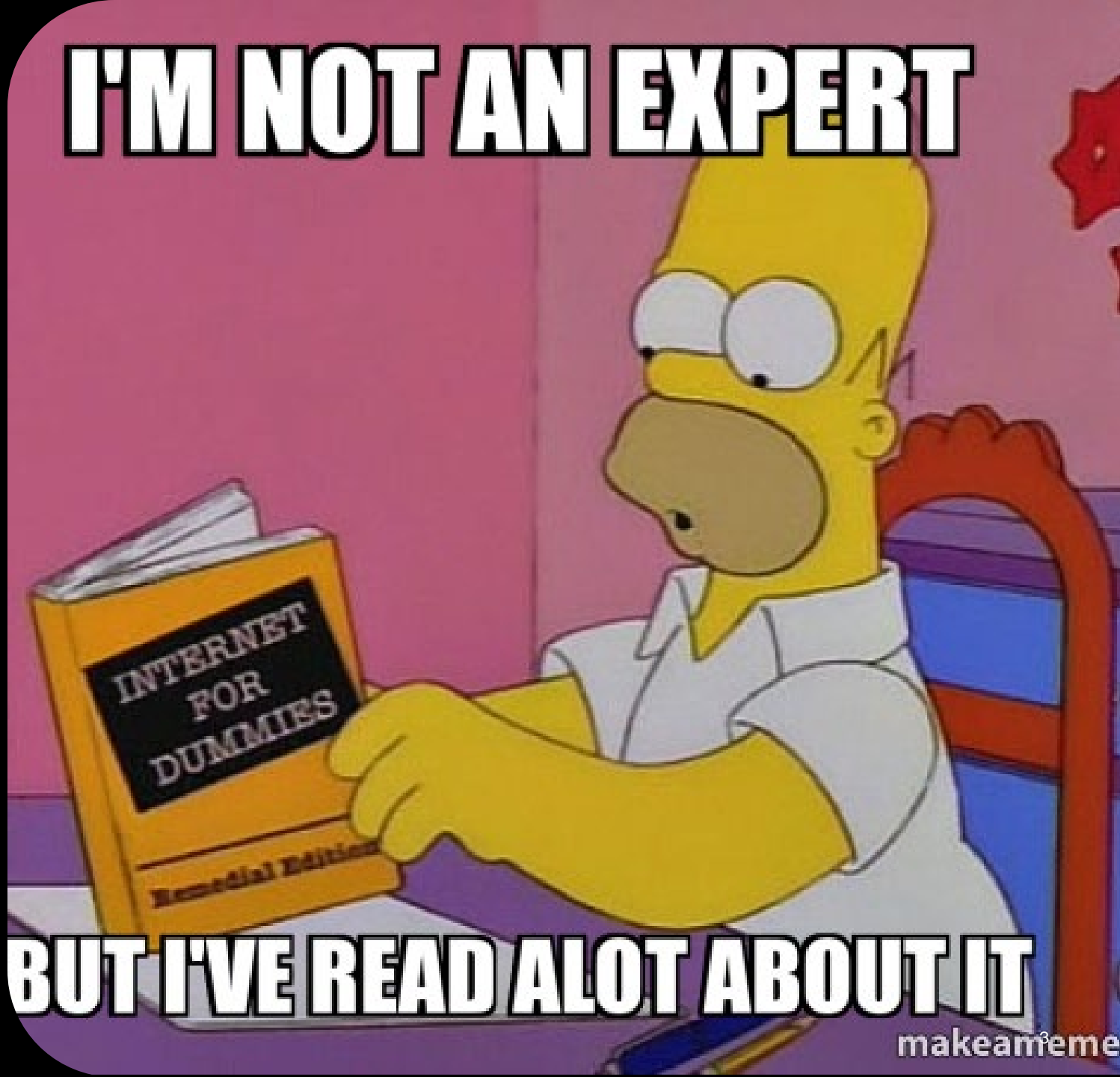
Disclosures

- None



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Objectives

1. Define Palliative Sedation and other related practices
2. Discuss indications
3. Discuss ethical considerations
4. In Practice
5. Medications
6. Reflection

Case

- 34 y Male admitted on Home Hospice.
- History of ESRD, substance use disorder, and an unspecified psychiatric disorder
- Mother at home and Home Hospice team was having troubling managing his agitation as he neared end of life
- Oral medications were no longer working, so a subcutaneous line was placed at home, and he required escalating doses of Benzos and opioids

Case continued...

- Home hospice nurse called the Inpatient Hospice Unit, stating:

"We cannot keep doing this, we are killing him. And I am not credentialled for Euthanasia."

Objective 1: Define Palliative Sedation and other related topics

Euthanasia

- ”Deliberate medical ending” of a patient’s life, with **clinician administered medication**
- Motivation to end suffering in the face of a terminal illness
- Refers to a voluntary patient, ie with Decision making capacity
- Voluntary Euthanasia is legal in Australia, Spain, Canada, Netherlands, Belgium, Luxembourg, New Zealand, Portugal Columbia.
- In the United states, ethical consensus appears to be that Euthanasia is unethical

“Physician” Aide in Dying

- Clinician enables a terminally ill patient to end their life with **self administered fatally dosed medication, at the patient’s request to relieve suffering**
- Decriminalized in a number of states in the USA
- Other terminology used include ”Physician assisted suicide” and “Death with dignity”
- No obvious ethical consensus among clinicians
- Surveys suggest that nearly 75% of the US public support it (far increased from 37% in 1947)

Assisted Dying

EUTHANASIA

- Goal = Relief of suffering, with intent of medical ending of life
- Methods = Medical Killing.
- Agent = Physician.

“PHYSICIAN” AID IN DYING

- Goal = Relief of suffering, with intent of medical ending of life
- Methods = Medical Killing
- Agent = Patient.

Canada

- Medical Aid in Dying
  - + Includes both physician aid in dying and Voluntary Euthanasia
  - + Concern for slippery slope emerging

Palliative Sedation

- “The lowering of patient consciousness using medications for the express purpose of limiting patient awareness of suffering that is intractable and intolerable”
- ”Proportional use of medications” used to relieve refractory suffering in patients with life-limiting disease
- Multiple terms exist for this same topic: Terminal Sedation, Continuous deep sedation, Total sedation, Palliative Sedation Therapy, Controlled Sedation, end of life sedation, Palliative Sedation to consciousness

EUTHANASIA

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“PHYSICIAN” AID IN DYING

- Goal = Relief of suffering, with intent of medical ending of life
- Methods = Medical Killing
- Agent = Patient.

PALLIATIVE/PROPORTIONATE SEDATION

- Goal = Relief of suffering, not with the intent of ending life
- Methods = Pharmacologic medication, proportionate to extent of suffering
- Agent = clinician

Objective 2:

Indications for Palliative Sedation

Indications

+ Severe symptoms that are refractory to other forms of treatment
+ Relief of suffering in a patient with terminal illness
+ Intention for intervention is symptom relief
+ Interdisciplinary team is “on board”

Symptoms

- Agitated delirium
- Dyspnea
- Refractory pain
- Nausea/Vomiting
- Convulsions/Seizures

What is a refractory symptom?

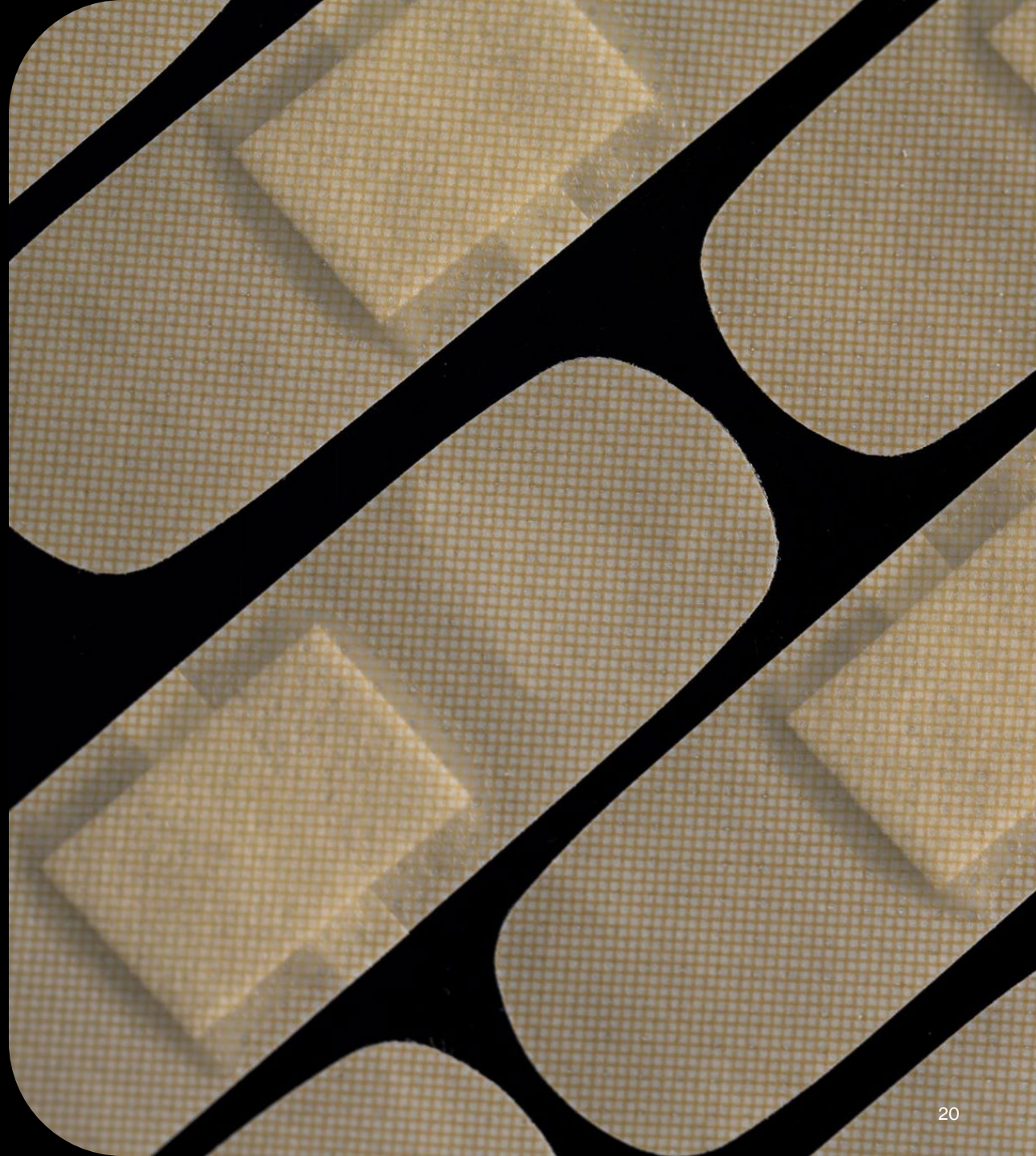
- Symptom or cluster of symptoms* that do not respond to “usual” treatments
- Worry that more “usual” treatments either would take too long to work, or side effects of usual treatments are not acceptable

*the symptom certainly does not have to be a physical one.

What is suffering?

Special indications

- Respite
- Intermittent
- Existential distress
- Emergency cases



Indications

- Patients with terminal illness
- Experiencing symptoms that are refractory to traditional methods
- Family and IDT aware and amenable

Objective 3: Ethical considerations

Principle of Double Effect

- One act can have “two effects”:
  + Intended good effect
  + Unintended bad effect
- Morality of the fundamental action is governed by the intended effect (ie. The goal)
- Ethically permissible if:
  + Act is good or morally neutral
  + ONLY the good effect is intended
  + Good effect outweighs the bad effect (aka Proportionate)
  + Good effect is not achieved by way of the bad effect

Example of Double effect

- Anna struggles with insomnia
- Doctor prescribes a sleep aid to help her fall asleep
- Side effect of drowsiness during the day is foreseeable, but not a primary intent
- Treatment is ethically permissible

Apply Principle of Double effect

- Morphine for pain in Palliative Care Clinic
  + Goal of better pain control, maximizing quality of life, better functionality etc
  + Side effect of sedation, constipation etc. is foreseen
  + Morphine deemed ethically permissible
- Palliative Sedation
  + Goal of refractory symptom control
  + Sedation/unconsciousness is acceptable and a foreseen side effec
  + Treatment is ethically acceptable if symptoms are appropriately deemed refractory and uncontrolled

Palliative Sedation → Proportionate Sedation

- Given that goal is symptom relief, medications should be titrated to the minimum level of consciousness reduction necessary to render symptoms tolerable.
- Goal is **NOT** to make patient unconscious

	Minimal Sedation (Anxiolysis)	Moderate Sedation/Analgesia (Conscious Sedation)	Deep Sedation/Analgesia	General Anaesthesia
Responsiveness	Normal response to verbal stimulation	Purposeful* response to verbal or tactile stimulation	Purposeful* response after repeated or painful stimulation	Unarousable, even with painful stimulus
Airway	Unaffected	No intervention required	Intervention may be required	Intervention often required
Spontaneous ventilation	Unaffected	Adequate	May be inadequate	Frequently inadequate
Cardiovascular function	Unaffected	Usually maintained	Usually maintained	May be impaired

Sedation Spectrum

What is the spectrum we expect?

- Match the distress of the symptom
- Goal continues to be symptom relief
- Sedating medications (often Benzodiazepines) progressively increasing to match symptom burden
- Sedation is often an unintended side effect of the medications

Palliative sedation = Proportionate Sedation

1. Ordinary Sedation/Symptom management (pain control or general symptom control)
2. Proportionate Sedation
    1. Increasing Levels of sedation
    2. Up to unconsciousness

Some common ethical quandries

- Is this Euthanasia?
- Am I hastening death?
- Can we do this?
- What about nutrition and hydration?


BREATHE
DEEPLY

Data supports the current practice

- Palliative sedation isn’t as common as we might think
  + 15% of patients admitted to an Academic Palliative Care Unit
  + 2% of patients in a large hospice program
  + 5-10% of “comfort care” deaths in the US and Europe
- Multiple studies suggest it does not hasten death

Legally supported

- Vacco v. Quill 1997 US Supreme Court supported PS

  + Justice O’Connor: “A patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication from qualified physicians, even to the point of causing unconsciousness and hastening death”.

Objective 5: Palliative Sedation in Practice

Palliative Sedation in Practice per European Guidelines

1. Pre-Emptive discussion of potential role of sedation in Advanced Care planning
2. Describe indications in which Palliative Sedation would be considered
3. Describe the medical evaluation
4. Specify consent requirements
5. Discuss need with decision-making process with family
6. Present direction for selection of sedation method
7. Present direction for dose titration, patient monitoring
8. Guidance for consideration of decisions regarding hydration
9. Care for the Family
10. Care for the medical professionals

Palliative Sedation in Practice really comes down to...

- Discuss with interdisciplinary team
  + Confirm it’s a last resort
- Discuss with family and caregivers
  + Consent and Anticipatory guidance is key
- Evaluate medications and orders
  + Would discontinue all non-comfort medications
  + consider discontinuing IVF and artificial nutrition

Opioids

- Opioids
  - Not recommended for sedation medications
  - If on prior to decision to pursue PS, would continue unless adverse effects observed
  - Potential for opioid withdrawal syndrome if discontinued
  - Consider opioid rotation if hyperalgesia

Medications

- Benzos
  - Midazolam (SQ, IV): 5 mg bolus, 1 mg/hr drip
  - Lorazepam (SQ, IV): 2-5 mg bolus, 0.5-1.0 mg/hr drip
- Phenobarbital -200 mg IV/SQ bolus, or 30 mg/hr drip
- Propofol

Medication	Pharmacology	Dosing
Midazolam	Benzodiazepine	Bolus: 1-5 mg IV/2.5-10 SQ Continuous: 0.5-1 mg/hr IV/SQ titrated up
Lorazepam	Benzodiazepine	Bolus: 1-5 mg IV/SQ Continuous: 0.01-0.1 mg/kg/hr IV/SQ titrate up
Phenobarbital	Barbiturate	Bolus: 200 mg IV/IM Continuous: 30 mg/hr IV/SQ titrate up by 30 mg/hr
Propofol	Rapid Anesthetic	Continuous: 1mg/kg/hr titrate up by 0.5 mg/kg/hr

Other medications to consider

- Etomidate
- Dexmedetomidine
- Ketamine
- AntiPsychotics

Back to the case...

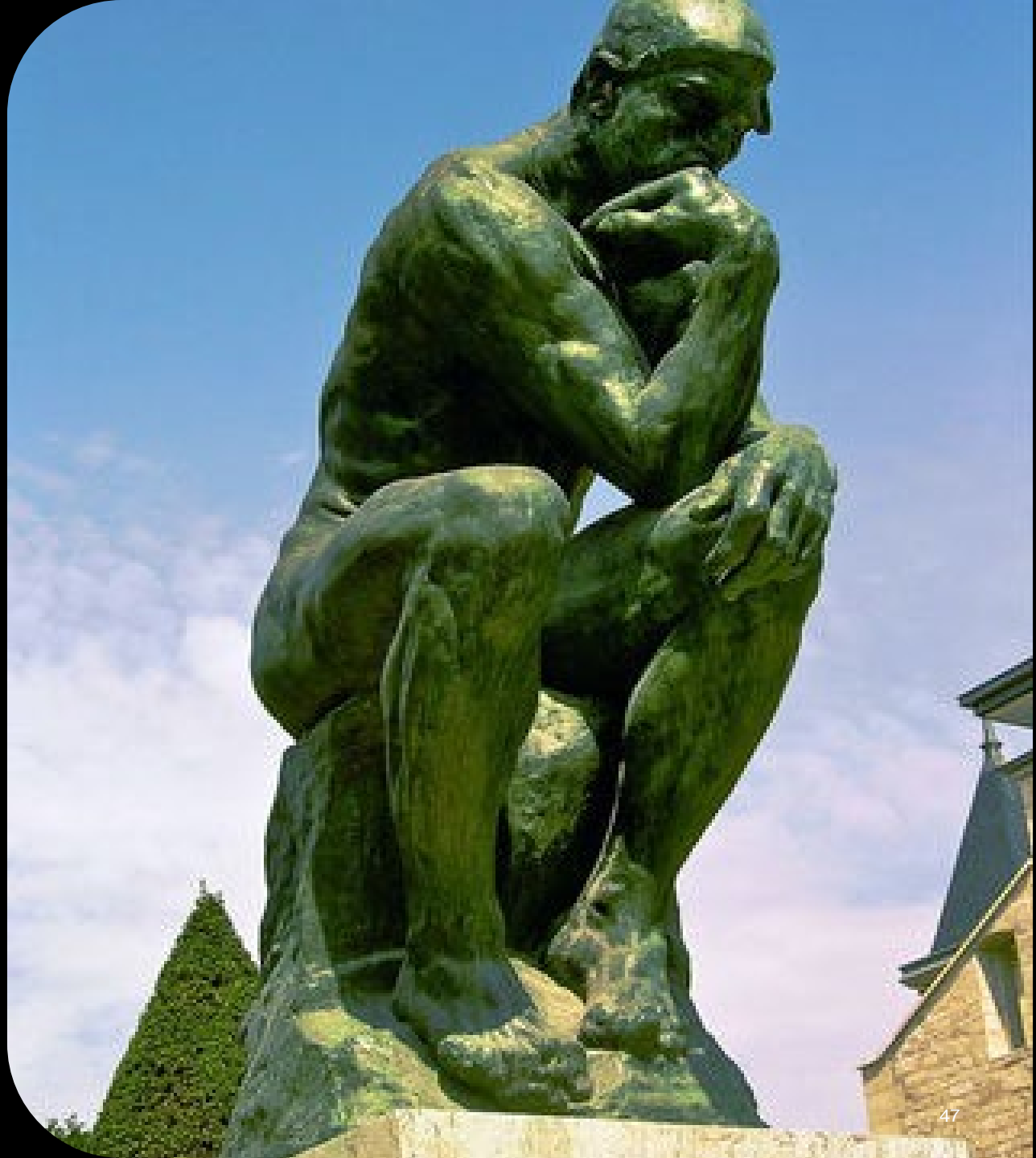
- 34 y Male hx of ESRD and unspecific psychiatric disorder admitted on Home Hospice, who was having worsening agitated delirium
- Oral medications not working, so escalating doses of Benzos were being called for
- Came into the Inpatient Hospice Unit
- Continue his Opioid regimen along with PRN Anti-Psychotics
- Started on Midazolam drip
- Started Phenobarb drip
- Considered Ketamine

Objective 6: Reflections

Reflections

- Palliative Sedation = Proportionate Sedation
- Part of good Palliative Care
- Would benefit from National and **Institutional** guidelines

What do you think?



Questions?

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- My wife

Thank you

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