

Ethical Issues Surrounding Palliative Sedation at the End of Life

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Palliative Care Definition: WHO

“An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.”

World Health Organization. WHO definition of Palliative Care [Available from: <http://www.who.int/cancer/palliative/definition/en/>].

Comfort

Connection

Contentment

Control

Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer

Jennifer S. Temel, M.D., Joseph A. Greer, Ph.D., Alona Muzikansky, M.A., Emily R. Gallagher, R.N., Sonal Admane, M.B., B.S., M.P.H., Vicki A. Jackson, M.D., M.P.H., Constance M. Dahlin, A.P.N., Craig D. Blinderman, M.D., Juliet Jacobsen, M.D., William F. Piv, M.D., M.P.H., J. Andrew Billings, M.D., and Thomas J. Lynch, M.D.

In patients with metastatic non-small cell lung cancer, as compared with usual care, those randomized to early palliative care led to significant improvements in both quality of life and mood with less aggressive care at the end of life, and also longer survival.

Temel J, Freer, J, et al NEJM 2010;363:733-742

Objectives

- Define the terms palliative sedation, proportional sedation, respite sedation, and continuous sedation
- List the symptoms for which palliative sedation is most commonly used
- Summarize the conditions that should be met before palliative sedation is used
- Highlight potential ethical concerns in the application of palliative sedation

Case

- A 46-year-old woman with recurrent rectal cancer metastatic to lungs and multiple bones
- Admitted to the inpatient hospice unit with severe “dull, achy” pelvic pain—8/10 at rest and 10/10 with movement
- Karnofsky performance status was 30
- Diagnosed with rectal cancer three years before and had undergone low anterior resection
- Multiple cycles of irinotecan and oxaliplatin-based chemotherapy with no response.
- Best supportive care for three months
- Computed tomography (CT) revealed multiple metastatic bone lesions in her pelvic bones

adapted from Song HN, et al / *Pall Med* Volume 18, Number 9, 2015

Case

- Attempted Treatments:
 - High doses of multiple opioids (oxycodone, hydromorphone, morphine), pushed to 900 mg/day of morphine equivalent daily dose
 - Radiotherapy
 - Epidural nerve blocks
 - Simultaneous administration (pain still remains > 5/10):
 - intravenous ketamine (300 mg/day)
 - haloperidol (5 mg/day)
 - antidepressants
 - diclofenac
 - Zolpidem (Ambien) of no help for insomnia
- Psychologist provided periodic consultation to assess psychoexistential suffering.
 - Antidepressants and anxiolytics given for adjustment disorder and mood disorder, but no effect on pain

adapted from Song HN, et al / *Pall Med* Volume 18, Number 9, 2015

Historical Perspective

The concept of “terminal sedation” was first introduced in the palliative care literature by Enck in 1991 to describe the practice of drug-induced sedation for symptoms that are difficult to control.

Enck RE Drug-induced terminal sedation for symptom control. *Am J Hosp Pall Care* 1991 8: 3-5

Palliative Sedation Definition American Academy of Hospice and Palliative Medicine (AAHPM)

“The intentional lowering of awareness towards, and including, unconsciousness for patients with severe and refractory symptoms.”

AAHPM December 2014

AAHPM Position Statement: Perspective

- Palliative sedation is a medical procedure
 - Indication(s)
 - Target outcome
 - Benefit/risk acceptable to both patient and clinician
- Reserved for extreme situations
- Used only after “all available expertise to manage target symptom has been accessed”
- Sedation is proportionate to patient’s distress
- Intent is to palliate symptoms, not shorten survival
- Pt should participate in decision-making re: its use, when possible

AAHPM December 2014

PS Definition: Veterans Health Administration

“The administration of nonopioid 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.”

National Ethics Committee-Veterans Health Administration 2007

Respite Sedation

- **RESPIRE:** A pause; a period of temporary delay
- Transient use of sedation to relieve severe symptoms (eg, malaise, pain, agitation, nausea) that are not necessarily refractory; provides adequate relief before continuing with further trial of nonsedating palliative approaches (radiation, surgery)
- After such respite, some patients will be sufficiently rested to consider further trials of symptomatic therapy
- Goal is to bring patient back to pretreatment level of consciousness
- Medication: lowest effective dose that will relieve symptoms
- Routine physiologic parameters are monitored to optimize safety

--adapted from Cherry N Palliative Sedation, *UpToDate*, Sept 2017

Continuous Sedation: Preconditions

- Presence of one or more **refractory symptoms** leading to unbearable suffering for the patient
 - **Refractory symptom:** none of the conventional treatments are effective (within a reasonable time frame) and/or these treatments are accompanied by unacceptable side effects
- Death must be expected within one to two weeks
- Assumptions
 - Artificial hydration, as a medical intervention will not contribute to the relief of suffering and may, in fact, have disadvantages
 - The need for a subcutaneous or intravenous needle access for administration
 - Possible increase of some symptoms and signs (e.g., pain, edema, bronchial secretion, and urinary incontinence)
- General recommendation is to avoid fluid administration
 - *Respect individual values and preferences*

Verkerk M, et al. A national guideline for palliative sedation in the Netherlands. *J Pain Symp Man* December 2007 Vol. 34 No. 6

Symptoms

Refractory symptoms commonly managed with palliative sedation

- Delirium
- Dyspnea
- Pain
- Vomiting
- Nonphysical symptoms (psychological distress and existential suffering)

Bobb B *Nurs Clin N Am* 51 (2016) 449–457

Intent

- Palliative sedation is intended to relieve suffering through sedation, not through death.
 - Minimize the suffering; support the sufferer
- Voluntary active euthanasia: a lethal dose of medication is administered at the request of a competent patient; the intent is to relieve suffering through death of the patient.
 - Eliminate the suffering; end the patient's life

AAHPM Position Statement

Palliative sedation is ethically defensible when used

- 1) after careful interdisciplinary evaluation and treatment of the patient, and
- 2) when palliative treatments that are not intended to affect consciousness have failed or, in the judgment of the clinician, are very likely to fail, and
- 3) where its use is not expected to shorten the patient's time to death, and
- 4) only for the actual or expected duration of symptoms.

AAHPM December 2014

AAHPM Position Statement

Palliative sedation should not be considered irreversible in all circumstances. It may be appropriate, in some clinical situations when symptoms are deemed temporary, to decrease sedation after a predetermined time to assess efficacy, continued symptoms, and need for ongoing sedation.

AAHPM December 2014

Cochrane Database Syst Rev. 2015 Jan 2;1:CD010206. doi: 10.1002/14651858.CD010206.pub2.

Palliative pharmacological sedation for terminally ill adults.
 Beller EM¹, van Driel ML, McGregor L, Truong S, Mitchell G.

- 14 studies reviewed, none randomized
 - All consecutive case series
 - 4167 adults, 1137 received PS
 - 95% of pts had cancer
- Delirium and dyspnea appeared to be continuing troubling symptoms in sedated patients
- Control of other symptoms appeared same in sedated and non-sedated patients
- Survival from admission/referral → death measured in 13 of 14 studies
 - No statistically significant difference in survival between sedated and non-sedated patients

How is Palliative Sedation Understood among Hospice and Palliative Medicine Clinicians?

Palliative Sedation Survey HPM Clinicians

What is your primary work environment?

Hospice	39.5 (336)
Long-term care facility	1.9 (16)
Inpatient community hospital	21.2 (180)
Academic care center	32.9 (280)
Palliative care outpatient clinic	4.6 (38)

Maiser S, et al *J Pall Med* Vol 20 (9), 2017

Recent Experience with PS HPM Clinicians

When is the last time you prescribed PS?

Within the last week	7.3 (57)
Within the last month	17.8 (140)
Within the last six months	25.1 (197)
Within the last year	15.9 (125)
Within the last five years	19.1 (150)
Never	14.9 (117)

Maiser S, et al *J Pall Med* Vol 20 (9), 2017

Frequency of Use with PS HPM Clinicians

How many times within the last 12 months do you recall implementing palliative sedation? (n = 334), n (%)

0	93 (28%)
1-5	199 (60%)
5-10	20 (6%)
10-20	15 (4%)
>20	7 (2%)

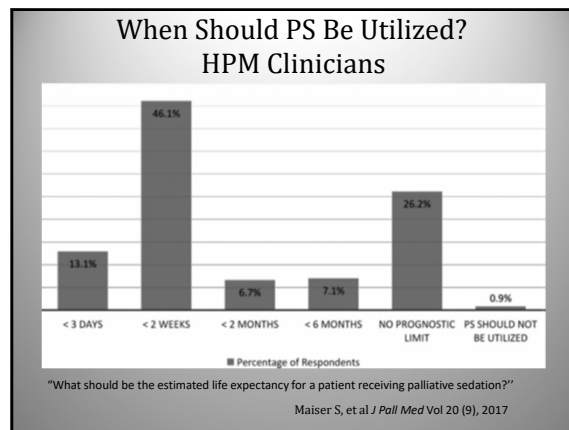
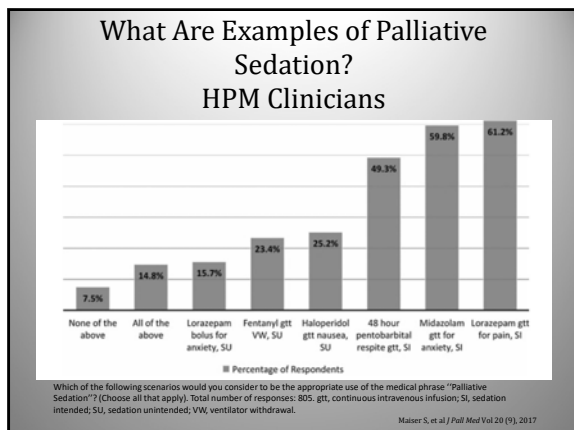
Lux M, et al *A Jour Hosp Pall Med* 2017, Vol. 34(3) 217-222

Role of Ethics Advisory Committee HPM Clinicians

How often do you consult an ethics advisory committee before instituting palliative sedation? (n = 326), n (%)

Never	157 (48%)
Sometimes	107 (33%)
Frequently	27 (8%)
Always	35 (11%)

Lux M, et al *A Jour Hosp Pall Med* 2017, Vol. 34(3) 217-222



Preferred Agent for PS HPM Clinicians

Benzodiazepines	63.1 (476)
Barbiturates	18.9 (143)
Opioids	9.4 (71)
Propofol	4.9 (37)
Antipsychotics	2.7 (20)
Dexmedetomidine	1.1 (8)

Maiser S, et al *J Pall Med* Vol 20 (9), 2017

- ### Unpacking Existential Distress
- Loss of personal meaning
 - Loss of sense of life purpose
 - Fear of dying and death
 - Despair
 - Helplessness
 - Hopelessness
 - Being a burden to others
 - Loss of dignity and independence
 - Feeling betrayed by life
- Henry B, *Curr Opin Support Pall Care* 2016, Vol 10

AAHPM Position Statement: Palliative Sedation and Existential Suffering

The Academy recognizes that existential distress may cause patients to experience suffering of significant magnitude, there is **no consensus around the ability to define, assess, and gauge existential suffering, to measure the efficacy of treatments for existential distress, and whether it is in the realm of medicine to palliate such suffering when it occurs absent of physical symptoms.** Patients with existential suffering should be thoroughly assessed and treated through vigorous multidisciplinary efforts which may include involving professionals who are not usual members of the palliative care team (e.g., experts in psychological, family therapy, or specific spiritual services). **If palliative sedation is used for truly refractory existential suffering, as for its use for physical symptoms, it should not shorten survival.**

AAHPM December 2014

UNCERTAINTY BEGS POLICY

Key Elements of Palliative Sedation Protocols and Guidelines

- Patient condition meets criteria for PS
 - Interdisciplinary assessment completed
 - Pt is close to death
 - DNR order in place/resuscitation status clarified
 - Severe intolerable symptoms refractory to treatment
 - Expert consultation from other specialties cannot add any other alternatives
 - Completion of a psychological assessment
 - Completion of a spiritual assessment

adapted from Nelson P J Hosp Pall Nursing Volume 19 (5) Oct 2017

Key Elements of Palliative Sedation Protocols and Guidelines

- Clinician/team member competence, involvement, and care
 - Consultation and collaboration
 - Patient and family are assessed by the palliative interdisciplinary team
 - Collaboration with primary team members, hospice (as appropriate), and palliative care team members with pt, family, and direct care providers (nurses)
 - Team education and support
 - All clinicians and team members understand process and ethics of PS
 - Conscientious objection of member(s) respected; transfer of care process in place
 - Debriefing

adapted from Nelson P J Hosp Pall Nursing Volume 19 (5) Oct 2017

Key Elements of Palliative Sedation Protocols and Guidelines

- Informed consent and decision-making with the patient and family
 - Comprehensive education and discussion re: PS, including risks and anticipated outcome
 - Discussion of impending death
 - Planning for death experience, including cultural & religious aspects; and personal preferences
 - Clarifying discontinuation of artificial nutrition and hydration (AN&H)
- Care of the family
 - Compassionate and truthful communication
 - Assurance of non-abandonment

adapted from Nelson P J Hosp Pall Nursing Volume 19 (5) Oct 2017

Family Perception

- Knowledge of PS among public is limited
- Families generally perceive that their loved one had a good death when witnessing appropriate PS
- Families continue to identify anxieties about whether continuous sedation shortened the patient's life or whether an alternative approach would have been better

Henry B, Curr Opin Support Pall Care 2016, Vol 10

Key Elements of Palliative Sedation Protocols and Guidelines

- Selection of medication for PS
 - Analgesics are not appropriate as primary sedative; continue to use for analgesia
 - Commonly used medications
 - Pentobarbital
 - Midazolam
 - Propofol
 - Dexmedetomidine (Precedex)
- Care of the patient
 - Maintain hygiene; respect dignity
 - Comfortable environment for patient and family
 - Bereavement plan to support family after death

adapted from Nelson P J Hosp Pall Nursing Volume 19 (5) Oct 2017

Potential Complications

- Partial or complete impairment of communication with family and friends
- Possible paradoxical agitation in patient
- Distress among family and friends
- Distress among caregivers
- Potential increased risk of aspiration
 - Airway not actively protected

adapted from Ten Have H, et al J Pain and Symp Man Jan 2014 (47):1

Potential Complications

- Is there motivation to forego expensive and time-consuming expertise in favor of less costly EOL care?
- PS also eases caregiver burden of family who may not feel the need to remain at bedside of patient or to visit patient

Ten Have H, et al *J Pain and Symp Man* Jan 2014 (47):1

“Simply using a common term does not guarantee the use of a common concept.”

Rietjens JAC, et al Palliative sedation: The end of heated debate? *Pall Med* 1-2 2018

Brief report

Labelling of end-of-life decisions by physicians

Jef Deyaert,¹ Kenneth Chambaere,¹ Joachim Cohen,¹ Marc Roelands,¹ Luc Deliens^{1,2}

- A stratified random sample of Flemish death certificates June 1-Nov 30, 2007 (N=6927)
- Certifying physicians contacted:
 - 58.4% response rate from physicians questioned on these deaths
 - 1st questionnaire: Intent of actions in last practice
 - 2nd questionnaire: Categorization of practice
- Physicians given options to categorize their last practice:
 - Decision to forgo further treatment
 - Symptom treatment
 - Palliative or terminal sedation
 - Compassionate life-ending
 - Euthanasia
 - Physician-assisted suicide
 - 'Other'

J Med Ethics 2014; 40:505-507

Brief report

Labelling of end-of-life decisions by physicians

Jef Deyaert,¹ Kenneth Chambaere,¹ Joachim Cohen,¹ Marc Roelands,¹ Luc Deliens^{1,2}

1.26 % of physicians labelled last practice as euthanasia or assisted suicide

In 97.5% of cases physicians had an explicit life-shortening intention by means of drug administration
In 95.1% of these cases, patients explicitly requested the initiation of this EOL decision

9.6% of physicians labelled last practice as palliative sedation

21.6% of these PS cases, physicians indicated they had administered drugs with the explicit intention, and in 20.9% with the co-intention, of shortening the patient's life.

J Med Ethics 2014; 40:505-507

Vol. 47 No. 1 January 2014

Journal of Pain and Symptom Management

Special Article

Palliative Sedation Versus Euthanasia: An Ethical Assessment

Henk ten Have, MD, PhD, and Jos V.M. Welie, MA, MMedS, JD, PhD
Center for Healthcare Ethics (H.A.H.), Duquesne University, Pittsburgh, Pennsylvania; and Center for Health Policy and Ethics (J.V.M.W.), Creighton University, Omaha, Nebraska, USA

“When heterogeneous sedative practices are all labeled as palliative sedation, there is the risk that palliative sedation is expanded to include practices that are actually intended to bring about the patients' death.”

Physician Prognostication

Summary of studies comparing physicians' estimated survival to patients' actual survival

Investigator	Median estimated survival, weeks	Median actual survival, weeks	Estimated survival/ actual survival
Parkes 1972	4.5*	2*	1.8
Evans 1985	NR	NR	3.2*
Hayse-Moore 1987	8	2	4
Forster 1988	7 [§]	3.5	2
Maltors 1994	6	5	1.2
Maltors 1995	6	4.6	1.3
Oxenham 1998	3	2.1	1.4
Maltors 1999	6	4.7	1.3
Christakis 2000	NR	3.4	5.3*

NR: not reported.

* Values estimated from graph in paper.

§ Ratio of mean estimated survival/mean survival.

Δ 7 weeks calculated through statement in paper that survival was overestimated by 3.4 weeks on average.

UpToDate

Copyrights apply

Lee S, Smith A Survival estimates in advanced terminal cancer. *UpToDate* March 6, 2017

Separation of PS from other End-of-Life Decisions

- Decision to use PS is not an automatic decision to forego life-sustaining treatments
- DNR is usually in place but should not be automatically required
 - Matter for discussion in policy development for each institution
- Artificial nutrition and hydration (AN&H) should be openly clarified
 - usually not done because of concerns it will increase complications (aspiration of enteral formula; TPN requires lab monitoring & central line w/ ↑ sepsis risks, etc.)

Ten Have H, et al *J Pain and Symp Man* Jan 2014 (47):1

Principle of Double Effect: Formal Requirements

An action with 2 possible effects, one good and one bad, is ethically acceptable if the action

- 1) Is not itself unethical
- 2) Only intends the good effect, even though the possible bad effect may be foreseen
- 3) Does not achieve the good effect by means of the bad effect
- 4) Is done for a proportionately serious reason

Sulmasy DP, Pellegrino ED. *Arch Intern Med* 1999;159:545-550

Ethical Principles: Bedside Clinician

- Autonomy
 - Focuses on shared decision-making
 - With patient when possible
 - Informed consent
- Fidelity
 - Keep our commitment to the welfare of pt
 - Non-abandonment
- Beneficence
 - Treat the distress of patient the best we can
- Non-maleficence
 - Do no intentional harm through commission or omission
 - Inadequate treatment of pain and suffering at end-of-life, when we have means to treat, is maleficence

Nelson P *J Hosp Pall Nursing* Volume 19 (5) Oct 2017

Caution for Palliative Care: Focus

- Therapy rather than care
- Physical dimension rather than the whole person
- Primacy of intervention over receptiveness and presence

Ten Have H, et al *J Pain and Symp Man* Jan 2014 (47):1

Case

The treating team proposed to the patient and caregivers sedation limited to nighttime only. Intravenous midazolam was given every night (9 p.m. to around 6 a.m.) to induce unconsciousness. The dose was 2.5 mg for induction of sedation, and then 0.1 mg/kg/h as a continuous infusion.

After sedation was held in the morning, the malignant bone pain was significantly reduced in severity, rated as 3/10 on the NRS during the daytime. Intermittent sedation was continued each night and the pain level remained constant. The patient died peacefully four months afterwards

adapted from Song HN, et al *J Pall Med* Volume 18, Number 9, 2015

Summary

- Palliative sedation, when appropriately applied, can effectively relieve extreme suffering as patients approach EOL
- Wide variation exists in the understanding of what actions define palliative sedation
- Development of policies and protocols are essential for any institution or other entity anticipating the practice of appropriate palliative sedation