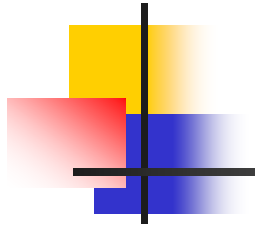


"When I use a word, it means just what I choose it to mean - neither more nor less"



Palliative Sedation

Presentation to Manitoba Palliative Care Nursing
Certification Study Group, Jan. 12, 2005

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With liberal use of slides kindly shared with permission by:

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Terms Open to Various Interpretations

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

Unfortunately, those with the power to treat the suffering are also empowered with interpreting these terms, rather than the person experiencing the suffering



Terms and Definitions for “Sedation”

Subjective Terminology Highlighted In **Red**

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.
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Terms and Definitions *ctd*

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 <u>physical</u> distress. (<i>my emphasis</i>)



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).”



Broeckaert -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)



Reasons for Sedation

Symptoms	Stone et al. (1997) (n=115)	Morita et al. (1999) (n= 157)	Porta Sales (2001)
Delirium	60%	42%	39%
Dyspnea	20%	41%	38%
Pain	20%	13%	22%
Bleeding	-	-	9%
N/V	-	2%	6%
Fatigue	-	-	20%
Psych	26%	2%	21%



When is it “Sedation”?

In an imminently dying person, if there are unintended yet unavoidable sedating effects of medication intended to relieve

- Pain
- Nausea
- Dyspnea

Is this “palliative sedation”, or is it simply treating pain, nausea, or dyspnea?

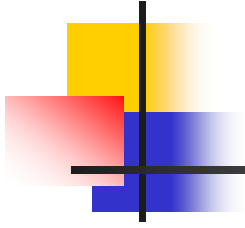
There is no intent or desire to sedate; if alternative effective means could be used, they would be.



When is it “Sedation”? *ctd*

In an irreversible delirium with hours or days to live and an agitated, restless state, effective options to relieve distress are limited to sedating the patient and supporting the family.

Is this “palliative sedation”, or treating a delirium?



What symptoms are “Bad
Enough” to allow sedation as an
inescapable outcome of
effective treatment?



Is it “OK” for...

- Severe pain?
- Shortness of breath... choking to death
- Nausea and vomiting... as in a bowel obstruction near death where someone is vomiting up feces, or ongoing vomiting of blood?
- Anguish... severe emotional distress in someone who is hours to days from dying? *If not... why not?*



Sedation for Anguish

- Does “pain of the soul” 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”



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



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 when sedation itself might result in death?*



Medications used in palliative sedation

- Benzodiazepines (*lorazepam, midazolam*)
- Neuroleptics (*haloperidol, methotrimeprazine [Nozinan®]*)
- Barbiturates (*phenobarbital*)
- Opioids if concomitant pain/dyspnea



Palliative Sedation vs. Euthanasia

	Palliative Sedation	Euthanasia
Goal	Decrease suffering	Decrease suffering
Intent	To Sedate	To Kill
Process	Administration of sedatives, titrated to effect	Administration of a lethal drug
Immediate Outcome	Decreased level of consciousness	Death

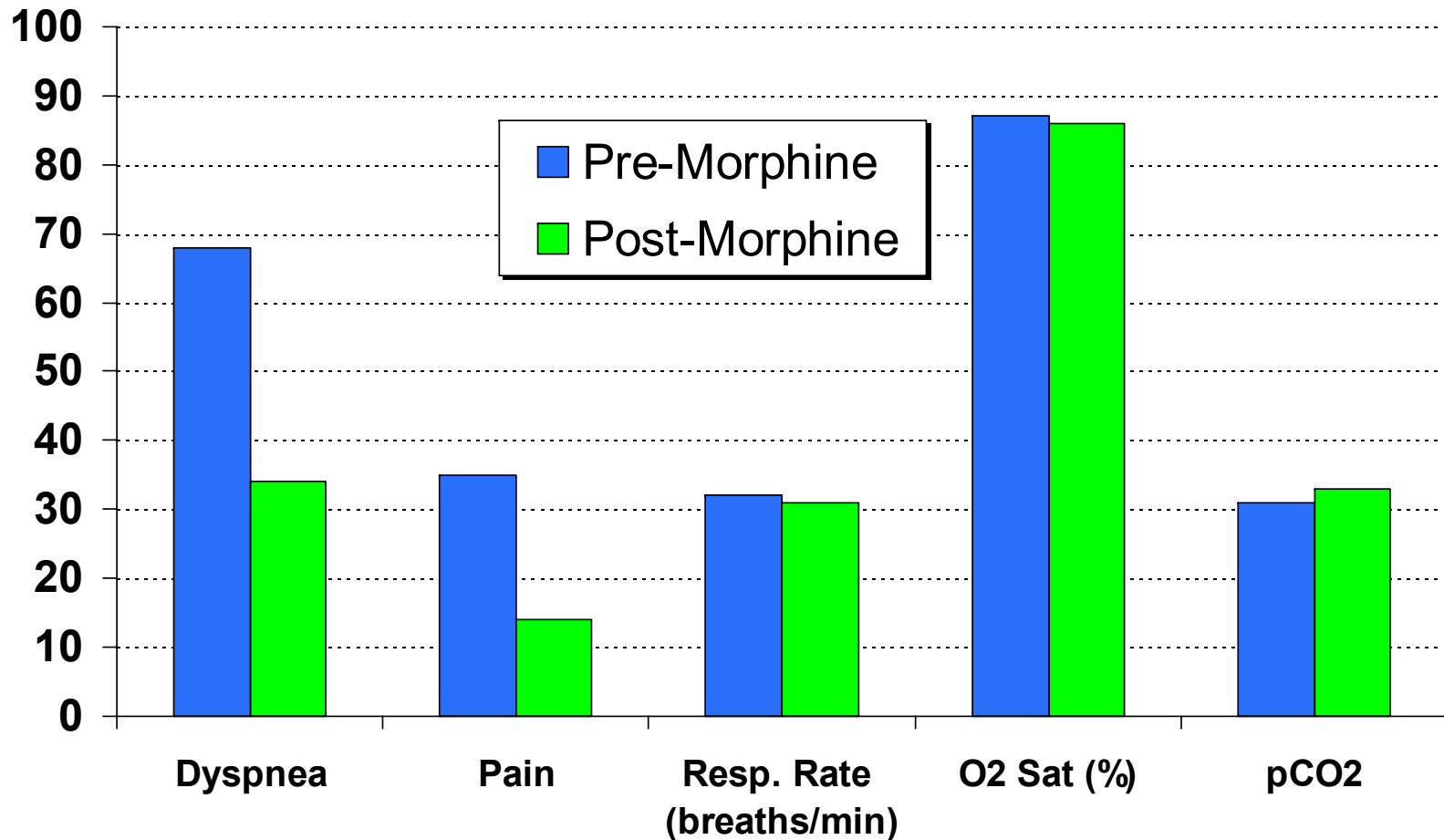


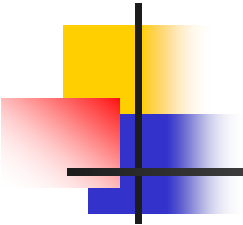
A COMMON CONCERN ABOUT AGGRESSIVE USE OF OPIOIDS IN THE FINAL HOURS

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*

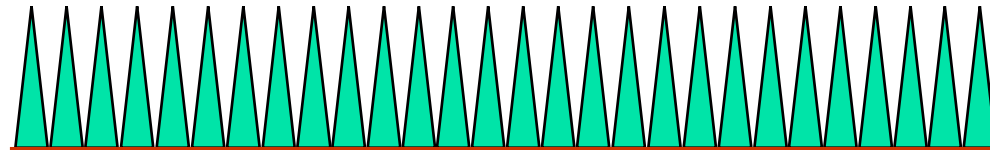


COMMON BREATHING PATTERNS IN THE FINAL HOURS

Cheyne-Stokes



Rapid, shallow



“Agonal” / Ataxic



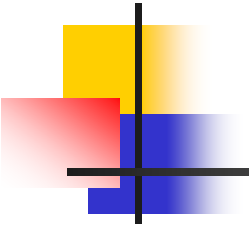


DOCTRINE OF DOUBLE EFFECT

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

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).



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

Good effects

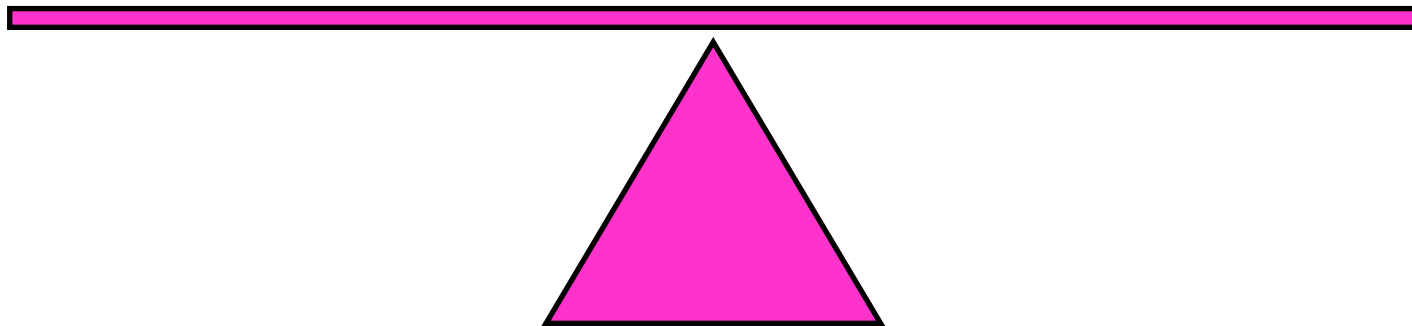
Benefits

Beneficial Effects

Bad effects

Burdens

Side Effects



- The difference in aggressive opioid use in end-of-life circumstances is that the “bad effect” = Death
- The doctrine of double effect exists to support those 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 be sedated

How would you approach this situation?



Thorough Assessment

- 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 Asked For?

- 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?

What is the ripple effect?

- Family
- Health Care Team





Consider

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

Curve Ball...



“Don’t tell my wife...”