

Irish Association for Palliative Care

PALLIATIVE SEDATION

Discussion Paper

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Why Are Sedative Medications Used in Palliative Care?

Sedative drugs are commonly used in palliative care to control symptoms of delirium, agitation, anxiety and dyspnoea. In most cases these drugs are given with the sole intention of relieving the symptom without causing sedation.¹ When sedative drugs are prescribed it is important that their effect is assessed and the dose adjusted until the symptom is controlled.

What is Palliative Sedation?

Sedation is defined as “the process of calming.”²

“Palliative sedation is the monitored use of medications intended to induce a state of decreased or absent awareness (unconsciousness) in order to relieve the burden of otherwise intractable suffering in a manner that is ethically acceptable to the patient, family and healthcare providers.”³

“In palliative sedation, the physician intends only to relieve severe refractory suffering using sedation as a last resort. There is no intention to end the patient’s life as in euthanasia and physician-assisted suicide.”⁴

The IAPC considers sedation to be an important and necessary therapy in the care of selected palliative care patients with otherwise refractory distress.

Refractory Symptoms

Occasionally in the palliative care setting symptoms persist despite intensive efforts to control them. Such symptoms are known as refractory symptoms and have been defined as “symptoms that are uncontrolled despite aggressive efforts to identify a tolerable therapy that does not compromise consciousness.”⁵

There are significant implications if a symptom is designated as refractory as it suggests that it will not be relieved by routine measures. In deciding if a symptom is refractory “the clinician in charge must perceive that further invasive or non invasive interventions are either incapable of providing adequate relief, or that the therapy is associated with excessive and intolerable acute or chronic morbidity and is unlikely to provide relief within a tolerable time frame.”⁶

The most common physical symptoms include agitated delirium, dyspnoea, pain and convulsions. Emergency situations may include massive haemorrhage, severe terminal dyspnoea and overwhelming pain crisis.⁷

Occasionally palliative sedation is considered for severe non-physical refractory symptoms of existential, spiritual, emotional or psychological distress, when the prognosis is estimated in terms of hours or days. These symptoms may be especially difficult to control in the last few days of life as the patient get weaker and is no longer able to benefit from psychological support.

When sedation is used as part of symptom management without the intention of inducing deep sleep or unconsciousness other interventions may lead the symptom to improve or subside. Therefore it may be possible to reduce or stop sedation, a concept sometimes referred to as respite sedation or temporary sedation. Regular review and reassessment of the patient ensures that a proactive approach is taken so that as the patient’s condition improves or deteriorates, treatment is adjusted accordingly.

Who makes the decision?

Every adult patient is presumed to have the capacity to make decisions about his/her own healthcare. Healthcare professionals have a duty to help patients make decisions for themselves by giving them information in a clear and comprehensible manner.

In assessing a patient’s capacity to make a decision, the doctor must assess the patient’s level of understanding and retention of the information he/she has been given, as well as his/her ability to apply the information to his/her own personal circumstances and come to a decision.⁸

Where an adult patient is deemed to lack capacity to make a decision, it should be determined whether the patient wrote an advance healthcare plan and if the plan covers the situation that has arisen. The plan should be adhered to, provided several criteria are met, in keeping with the Irish Medical Council’s guidelines.⁹ Where a patient lacks capacity to make a decision, and no advance care plan exists, responsibility for decision-making ultimately lies with the patient’s doctor.

In order to make an informed decision regarding palliative sedation, it is advisable for the doctor to discuss the situation with other members of the multi-disciplinary team, as well as considering the wishes and concerns of the patient’s family.

The Decision-Making Process

In the first instance the patient should be assessed by a clinician with sufficient experience and expertise in palliative care. Wherever possible this

The Irish Association for Palliative Care (IAPC) is the all-island multidisciplinary representative body for professionals and others engaged in, or having an interest in, the delivery of palliative care in Ireland.

Palliative care is a person-centred discipline that seeks to achieve the best possible quality of life for each individual patient facing a terminal illness.

This paper is aimed at healthcare professionals. It highlights for discussion some of the ethical issues arising in the use of palliative sedation.

The paper is intended also to serve as a focus point when issues of sedation are being considered.

evaluation should be multi-disciplinary and should include reference to the following:

- the patient's general condition, including the cause of the intolerable distress, treatments that have been attempted, limitations of other options of care
- the rationale for the decision that palliative sedation is the only method available for achieving symptom relief within an acceptable time frame (i.e., the symptoms are truly refractory)
- the aims of sedation
- the method of sedation
- the anticipated effects of sedation, including degree of reduction in consciousness levels, communication and oral intake
- the potential uncommon risks such as paradoxical agitation, delayed or inadequate relief
- medical treatments and nursing care to be maintained during sedation: treatments and care to maximize the patient's comfort are continued
- the expected outcomes if palliative sedation is not performed, including other treatment options, degree of suffering likely to persist with each option and expected survival with each option
- commitment to the patient's well being and provision of best possible care

Guidance for decisions regarding hydration and nutrition and concomitant medications

The decision about artificial hydration and nutrition during palliative sedation is independent of the decision about sedation itself. Each decision regarding artificial hydration or nutrition should be made following consideration of benefits and burdens of each treatment as relative to each individual patient.

Medications used before palliative sedation was commenced should be continued unless they are no longer effective or have distressing side effects. Medications which are irrelevant to the goal of patient comfort should be discontinued.

Ethical Principles Involved

Beneficence is the requirement to do good.¹⁰ It refers to all actions done for the benefit of others. The principle of beneficence asserts an obligation to help others further their important and legitimate interests.

When dealing with sedation, beneficence is met by careful attention to the patient's condition and ensuring the best possible symptom control. This includes the management of non-physical causes of distress, to reduce the need to treat problems by sedation. The aim of palliative sedation must be to treat intractable problems.

Non Maleficence means that it is imperative that your intentions are not to do harm.

The risk of sedation must be carefully weighed against the benefits of relieving a patient's distress.

Autonomy must be respected. Patients who are autonomous (competent) should be involved in decision making about their treatments, including sedation. However, autonomy is not absolute. A patient may want sedation where the risk outweighs the benefit.

The **Principle of Double Effect** states that where an action, intended to have a good effect, can achieve this effect only at the risk of producing a harmful effect, then the action is ethically permissible provided that:

1. The action is good in itself.
2. The intention is solely to produce the good effect.
3. The good effect is not achieved through the harmful effect.
4. There is sufficient reason to permit the harmful effect.¹¹

In the context of refractory symptoms, the intention of palliative sedation is to relieve a patient's distress. There should be no intention to cause harm. The risk of harm is carefully assessed and the benefit to the patient must outweigh the risk of harm.

It is essential that all symptoms are carefully assessed and treatment options explored. When sedation is used, the decision has to be carefully thought out with an understanding of the ethical principles underpinning treatment.

IAPC Position and Discussion Papers are developed and written by the IAPC Ethics Working Group following wide consultation with the Association's membership.

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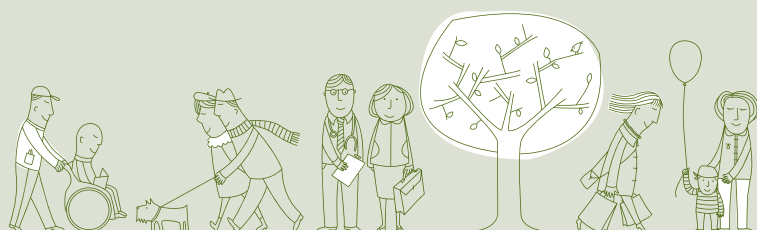
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Established in 1993, The **Irish Association for Palliative Care (IAPC)** is an all island body that exists to promote palliative care nationally and internationally through opportunities for networking, education, publications, and representation on national bodies.

As the sole membership organisation for those involved in the provision of palliative care, the IAPC is the primary collective and expert voice for palliative care in Ireland. Its mission is to drive national policy for patient-centred, equitable, accessible and accountable palliative care for all who need it.

A multi-disciplinary organisation, the membership reflects the multi-disciplinary team which delivers palliative care, and includes also those with an interest in the provision of palliative care.

Led by a Chairperson and Board of Directors elected by the Association's members, the IAPC is organized around a number of specialist fora and working groups. These groups provide individual disciplines with the opportunity to consider specific issues relevant to their own area of interest and expertise. The working groups are designed to create a forum for shared best practice and learning opportunities, and for members to further their professional development, education and research.

Current IAPC working groups include the Education and Research Forum, the Palliative Nursing Forum, the Ethics Working Group, the Children's Palliative Care Special Interest Group, the Palliative Care Pharmacists Group and the Palliative Care Social Work Group.

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