
PALLIATIVE CARE
DOCTOR
Is in energy saving mode.
Please wait
until recharged.

PALLIATIVE SEDATION, COMPASSIONATE EXTUBATION & VOLUNTARILY STOPPING EATING AND DRINKING (VSED)

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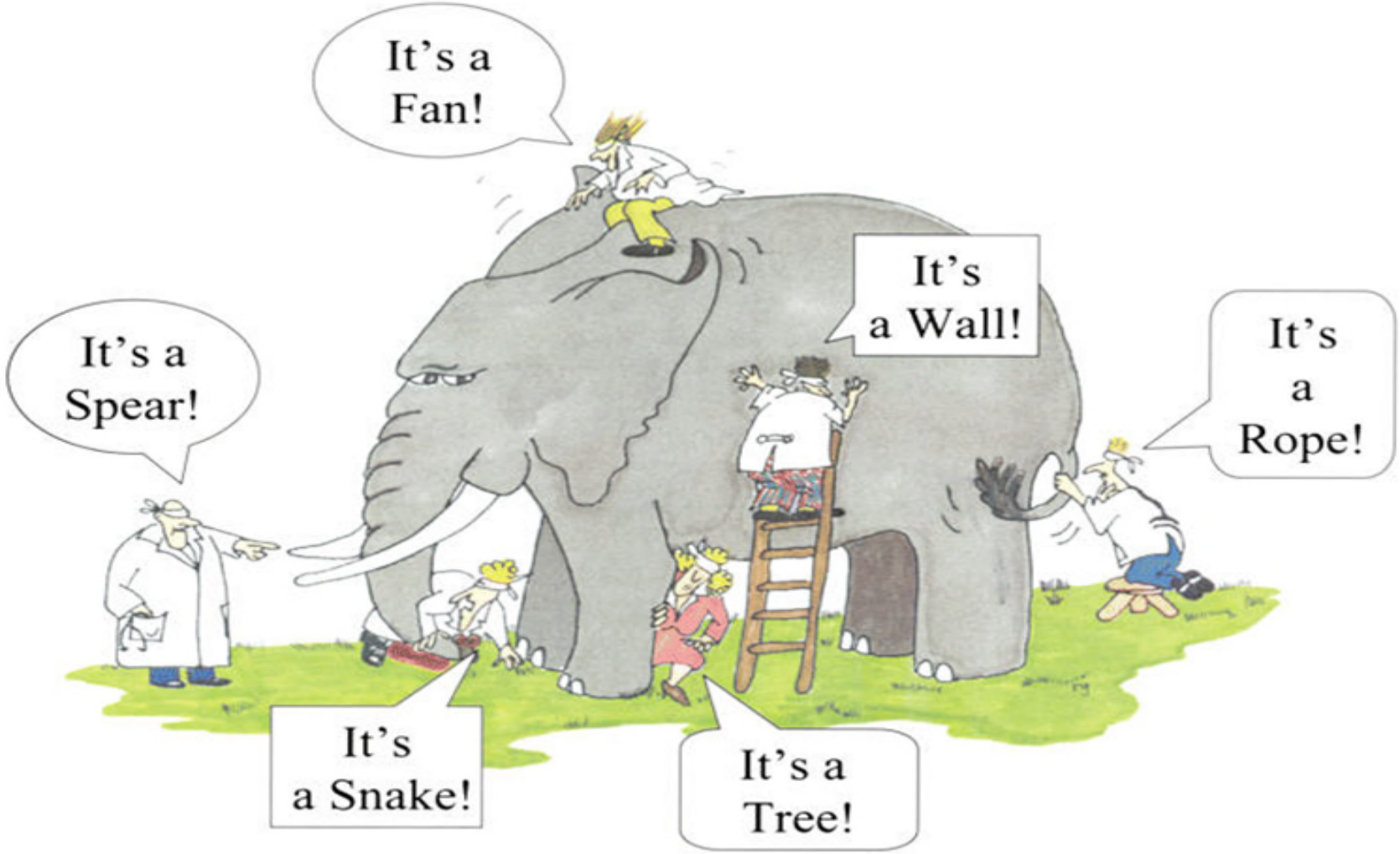
Disclosures

- I have nothing to disclose

“Elephant in the Room”



Patient Asking “Will You Help Me Die?”

- Do not ignore
- Address the request explicitly: “ I don’t want to live this way” or “I want to die”
- Explore reasons behind the request: uncontrolled symptoms, psychiatric issues, spiritual suffering, caregiver fatigue etc.
- Discuss the natural progression of the disease
- Offer support to address symptoms, consults (SW, mental health, palliative care, chaplaincy)
- Referral to hospice
- Discuss withdrawal of treatment, food, hydration. Ethically accepted
- Discuss palliative sedation
- Discuss MAID (Medical Aid in Dying)

Voluntarily Stopping Eating and Drinking (VSED)

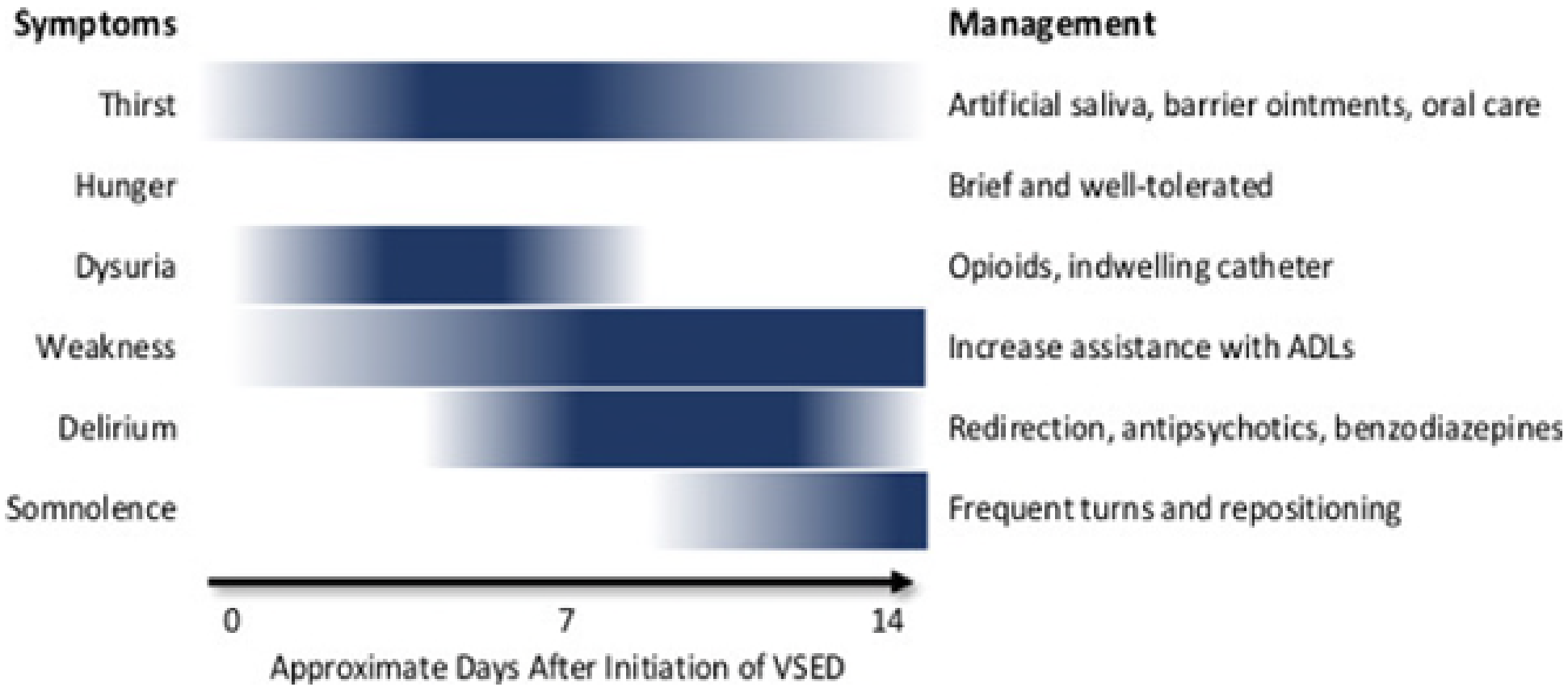
- Deliberate, self-initiated attempt to hasten death in the setting of suffering refractory to optimal palliative interventions or prolonged dying that a person finds intolerable

- Patients considering VSED:
  - age 80 and older
  - significant burden of disease
  - poor quality of life and depending on others for daily care
  - have a short life expectancy
  - life perceived as being “pointless”
  - desire to die at home
  - wish to control the circumstances of death
  - place a high value on independence

Wax JW, An AW, Kosier N, Quill TE. Voluntary Stopping Eating and Drinking. J Am Geriatr Soc. 2018 Mar;66(3):441-445. doi: 10.1111/jgs.15200. PMID: 29532465.

VSED - Symptoms

- After starting VSED: thirst, hunger, dysuria, disability, somnolence, delirium



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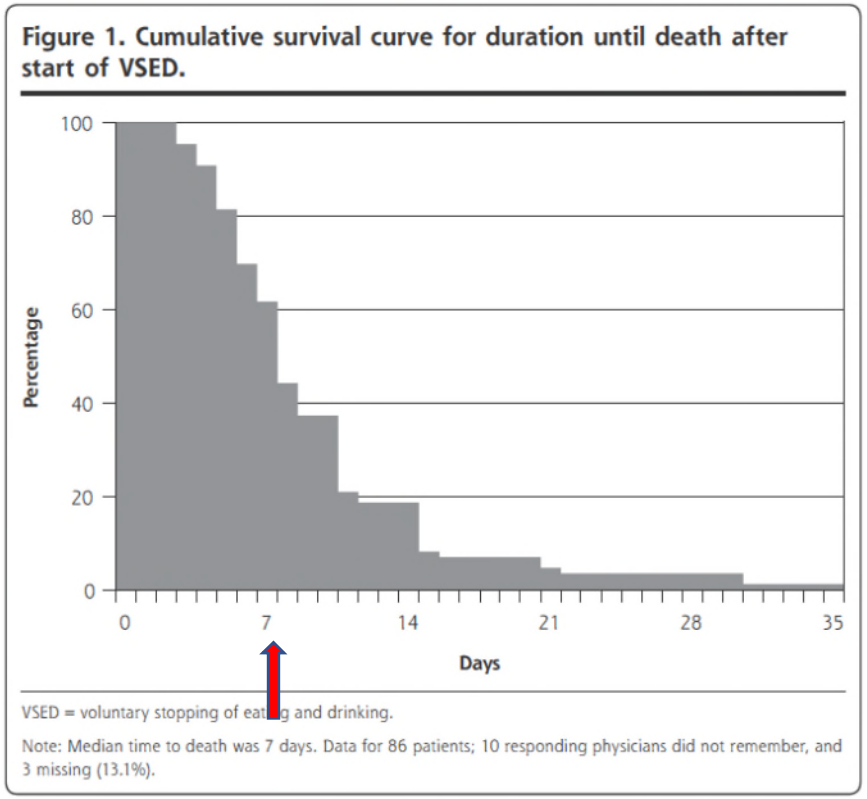
VSED - Outcome

- Once oral intake stops ➔ lose consciousness in 3 – 8 days
- Once in a coma ➔ death in 5 – 8 days
- VSED patient will not die of starvation but of dehydration
- Death certificate: ○ dehydration secondary to the principal illness that caused the individual's intractable suffering
  ○ use of the word “suicide” on death certificates discouraged



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https://endoflifechoicesca.org/end-of-life-choices/vsed-voluntarily-stopping-eating-and-drinking/
Bolt EE, Hagens M, Willems D, Onwuteaka-Philipsen BD. Primary care patients hastening death by voluntarily stopping eating and drinking. Ann Fam Med. 2015 Sep;13(5):421-8. doi: 10.1370/afm.1814. PMID: 26371262; PMCID: PMC4569449.

VSED – Controversies

- Considered a form of suicide
- Is like other types of self-harm that clinicians are ethically required to prevent
- Counseling / assisting patients during VSED may represent complicity in suicide

- What if the patient changes his / her mind or a delirious patient is asking for water after forgetting the decision that was made?
- Should honor the request knowing this will prolong the dying process and is likely to cause additional discomfort? Should refuse the basic right of access to water?

Chargot J, Rosielle DA, Marks A. Voluntary Stopping of Eating and Drinking in the Terminally Ill #379. J Palliat Med. 2019 Oct;22(10):1281-1282. doi: 10.1089/jpm.2019.0337. PMID: 31584334

Lanken PN, Terry PB, Delisser HM, Fahy BF, Hansen-Flaschen J, Heffner JE, Levy M, Mularski RA, Osborne ML, Prendergast TJ, Rocker G, Sibbald WJ, Wilfond B, Yankaskas JR; ATS End-of-Life Care Task Force. An official American Thoracic Society clinical policy statement: palliative care for patients with respiratory diseases and critical illnesses. Am J Respir Crit Care Med. 2008 Apr 15;177(8):912-27. doi: 10.1164/rccm.200605-587ST. PMID: 18390964.

Jox RJ, Black I, Borasio GD, Anneser J. Voluntary stopping of eating and drinking: is medical support ethically justified? BMC Med. 2017 Oct 20;15(1):186. doi: 10.1186/s12916-017-0950-1. PMID: 29052518; PMCID: PMC5649087.

VSED – Controversies

- Patients are terminally ill and not psychiatrically ill ➔ no “underlying mental illness” to be treated
- Not characterized by an invasive or aggressive act resulting in a relatively rapid death
- Will lead to death after at least several days ➔ reversed by resuming eating and drinking
- Dying phase in VSED resembles that of the natural dying process
- ANA, IAHPC, AAHPM: VSED a legal option for terminally ill patients to hasten their deaths
- Has not been a definitive higher court ruling but VSED is considered legal in the United States

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VSED – Physician's Role

- Assess terminal or serious debilitating illness with intolerable suffering
- Assess full decision-making capacity
- Determine VSED is voluntary and free from coercion
- Determine VSED is not influenced by mental illness or cognitive impairment
- Request for VSED is consistent with well-established patient values
- Ensure DNR in place
- Inform of risks/benefits and possible alternatives
- Ensure support from main caregivers
- Support patient and caregivers during the process
- Involve Hospice
- Transfer patient to a colleague if personal moral codes prevent involvement in VSED

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Withholding / Withdrawing Treatments – AAHPM Statement

- Withholding / withdrawing nonbeneficial medical interventions:
  - acceptable throughout the course of progressive, life-limiting illness, although patients with whom these discussions are held are often close to death
  - appropriate when consistent with the patient's goals of care
- Examples: ventilatory support, hemodialysis, implanted cardiac defibrillators (ICDs), cardiopulmonary resuscitation (CPR), vasopressors, artificial (assisted) nutrition / hydration, antibiotics

Statement on Withholding and Withdrawing Nonbeneficial Medical Interventions - Approved by the AAHPM Board of Directors in November 2011

Withholding / Withdrawing Treatments – Physician's Role

- Assess decision-making capacity of the patient
- Identify overall goals of treatment and care for the patient
- Identify intended goals, burdens, benefits of the intervention under consideration
- Assess burdens / benefits of starting / withholding or continuing / withdrawing an intervention
- Make recommendation concerning continuing / starting or withdrawing / withholding a nonbeneficial intervention based on the patient's values, goals, and likelihood of success
- Explain what treatments will be continued and what additional treatments will be added
- Emphasize the types of support that can be provided to either the patient or family
- Engage an ethics committee or other institutional committee in cases of disagreement

Statement on Withholding and Withdrawing Nonbeneficial Medical Interventions - Approved by the AAHPM Board of Directors in November 2011

Withholding / Withdrawing Treatments – Physician's Role

- Physician preferences for treatment withdrawal: blood products
  hemodialysis
  vasopressors
  mechanical ventilation
  total parenteral nutrition
  antibiotics
  intravenous fluids
  tube feedings

- Earlier withdrawal of treatments perceived as more artificial, scarce, or expensive

- Specialists prefer to withdraw therapy they are most familiar with: e.g., pulmonologists withdraw mechanical ventilation, nephrologists withdraw dialysis etc.

Truog RD, Campbell ML, Curtis JR, Haas CE, Luce JM, Rubenfeld GD, Rushton CH, Kaufman DC; American Academy of Critical Care Medicine. Recommendations for end-of-life care in the intensive care unit: a consensus statement by the American College [corrected] of Critical Care Medicine. Crit Care Med. 2008 Mar;36(3):953-63. doi: 10.1097/CCM.0B013E3181659096. Erratum in: Crit Care Med. 2008, May;36(5):1699. PMID: 18431285.

Compassionate Extubation (CE)

- Withdrawal of mechanical ventilation when the absolute priority in care delivery is to afford comfort and dignity at the end of life and allow for natural death to occur

- When all attempts at weaning from ventilation have failed and maintenance of ventilatory support becomes futile

OR

- When the patient's quality of life is unacceptable and without any hope of improvement

OR

- When it becomes clear that support is causing unnecessary suffering

Coradazzi AL, Inhaia CLS, Santana MTEA, Sala AD, Ricardo CP, Suadicani CO, Santos DC, Faleiros DM, Damiati FR, Ribeiro LS, Araújo MM, Araújo NP, Carneiro PM, Kumbis SM, Marcari TB, Ito TN, Santo VE, Guimarães ST, Caponero R. Palliative withdrawal ventilation: why, when and how to do it? Hospice & Palliative Medicine International Journal, Vol 3 Issue 1 – 2019. 10.15406/hpmij.2019.03.00141 DOI: 10.15406/hpmij.2019.03.00141

CE - Methods

- Terminal weaning = gradual decrease of the FiO_2 and / or the mandatory ventilator rate to the minimum over 10 to 60 minutes and then discontinue ventilatory support

- Terminal (immediate) extubation = discontinuation of mechanical ventilation without any previous decrease in the ventilator settings

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Terminal Weaning

- ***Pluses*** - less signs of upper airway obstruction ➔ less distress from stridor or oral secretions
  - less symptoms of acute air hunger
  - practitioners feel it allows for better symptom control b/o titration of pain, dyspnea & agitation meds with each reduction in ventilator support
  - less anxiety in family / caregivers
  - less moral burden of family / caregivers (perceived as less "active" than terminal extubation)

- ***Minuses*** - many institutions do not allow patients with ET to transfer out from ICU
  - presence of ET may prolong the dying process if no lung pathology

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Terminal Extubation

- ***Pluses*** - does not prolong the dying process
  - allow the patient to be free from the “unnatural” endotracheal tube (ET)
  - process cannot be confused with a therapeutic wean

- ***Minuses*** - associated with higher incidence of airway obstruction, respiratory distress, pain

Truog RD, Campbell ML, Curtis JR, Haas CE, Luce JM, Rubenfeld GD, Rushton CH, Kaufman DC; American Academy of Critical Care Medicine. Recommendations for end-of-life care in the intensive care unit: a consensus statement by the American College [corrected] of Critical Care Medicine. Crit Care Med. 2008 Mar;36(3):953-63. doi: 10.1097/CCM.0B013E3181659096. Erratum in: Crit Care Med. 2008, May;36(5):1699. PMID: 18431285.

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CE - Survey

1992 survey:

- Critical Care MDs: - 33% preferred terminal weaning
  - 13% preferred immediate extubation
  - 54% used both
- Surgeons & anesthesiologists: more likely to use terminal weaning
- Internists & pediatricians: more likely to use immediate extubation

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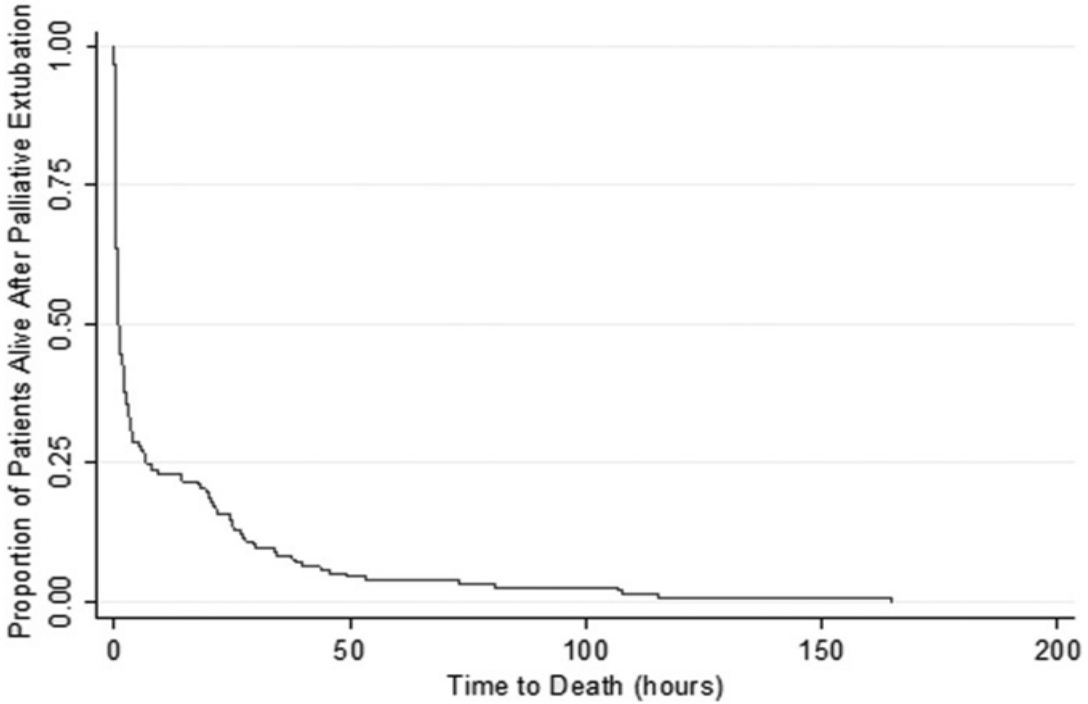
CE - Outcome

- Median time from compassionate extubation to death:
  - 54 minutes (U. C. study)
  - 35 minutes (U. W. study)
  - 0.9 hours
  - 8.9 hours



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Pan CX, Platis D, Maw MM, Morris J, Pollack S, Kawai F. How Long Does (S)He Have? Retrospective Analysis of Outcomes After Palliative Extubation in Elderly, Chronically Critically Ill Patients. Crit Care Med. 2016 Jun;44(6):1138-44. doi: 10.1097/CCM.0000000000001642. PMID: 26958748.

Huynh TN, Walling AM, Le TX, Kleerup EC, Liu H, Wenger NS. Factors associated with palliative withdrawal of mechanical ventilation and time to death after withdrawal. J Palliat Med. 2013 Nov;16(11):1368-74. doi: 10.1089/jpm.2013.0142. Epub 2013 Oct 1. PMID: 24083651; PMCID: PMC3822388.

CE - Outcome

- Survival shorter than 60 minutes after palliative extubation:
  - pH 7.32 or lower
  - respiratory rate ≤ 10 breaths per minute
  - systolic arterial pressure < 84 mmHg
  - positive end-expiratory pressure (PEEP) > 10cm H2O
  - peak inspiratory pressure (PIP) > 35cm H2 O
  - fraction of inspired oxygen (FiO2) > 70%
  - use of vasopressors
  - no analgesia

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CE – Physician's Role

- Organize family meeting to discuss prognosis, procedure
- Turn off monitors unless families prefers the monitors to be left on
- Ensure NPO
- Discontinue neuromuscular blockade at least 2 hours before the procedure
- Remove as much volume as possible before extubation for patients under dialysis
- Discontinue futile routine measures (sample collection for tests, checking vital signs, etc.)
- Reinforce in the medical records that life-prolonging measures should not be started
- Discontinue artificial hydration and nutrition 24-48 hours before extubation
- Start medication to reduce pulmonary secretions 12 to 48 hours before extubation
- Prepare equipment to drain secretions and nebulization
- Preemptive administration of medications for pain, anxiety and dyspnea
- *Delay CE while the patient's organs are evaluated for suitability and the logistics of donation are arranged*

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Palliative Sedation (PS) - Definition

- Many definitions, same ideas:
  1) the use of (a) pharmacological agent(s) to reduce consciousness
  2) reserved for treatment of intolerable and refractory symptoms
  3) only considered for a patient with an advanced progressive illness
  4) use of ongoing sedation continued until the patient's death

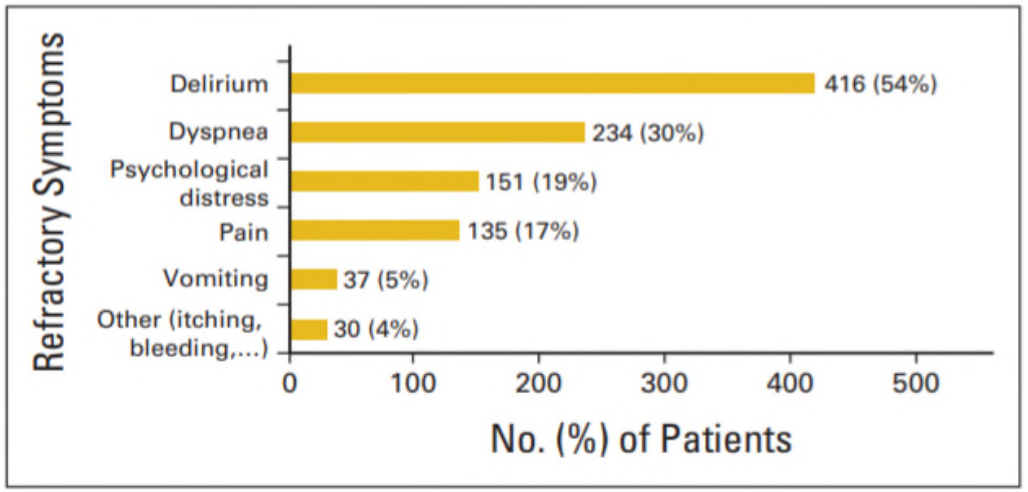
- "Continuous Palliative Sedation Therapy (CPST) is a specialized medical intervention leading to the intentional induction and continuous maintenance of a reduced level of consciousness to relieve refractory symptom(s) that have not responded to other treatments during the last hours to days of life for patients whose goal of care is comfort."

Olsen ML, Swetz KM, Mueller PS. Ethical decision making with end-of-life care: palliative sedation and withholding or withdrawing life-sustaining treatments. *Mayo Clin Proc*. 2010;85(10):949-954. doi:10.4065/mcp.2010.0201
Continuous Palliative Sedation Therapy (CPST) Guidelines Developed by the Division of Palliative Care, Dept. of Family Medicine, McMaster University. 31March 2020 - https://fhs.mcmaster.ca/palliativecare/documents/McMasterPalliativeSedationGuidelines202031March2020.pdf

Refractory Symptom - Definition

- **Refractory symptom** = symptom for which the clinician perceives that further invasive or non-invasive interventions are:
  - ► incapable of providing adequate relief
  - ► unlikely to provide relief within a tolerable time frame
  - ► associated with excessive and intolerable acute or chronic morbidity

- Most patients requiring PS have more than one refractory symptom



Cherny NI; ESMO Guidelines Working Group. ESMO Clinical Practice Guidelines for the management of refractory symptoms at the end of life and the use of palliative sedation. Ann Oncol. 2014 Sep;25 Suppl 3:iii143-52. doi: 10.1093/annonc/mdu238. PMID: 25210083.

Maltoni M, Scarpi E, Rosati M, Derni S, Fabbri L, Martini F, Amadori D, Nanni O. Palliative sedation in end-of-life care and survival: a systematic review. J Clin Oncol. 2012 Apr 20;30(12):1378-83. doi: 10.1200/JCO.2011.37.3795. Epub 2012 Mar 12. Erratum in: J Clin Oncol. 2012 Sep 20;30(27):3429. PMID: 22412129.

AAHPM Statement on PS

- Must satisfy the criteria of having a specific clinical indication, a target outcome, and a benefit/risk ratio acceptable to both the clinician and patient
- PS is an intervention reserved for extreme situations
- PS should only be considered after all available expertise to manage the target symptom has been accessed
- The level of sedation should be proportionate to the patient's level of distress
- As with all treatments, patients, when able, should participate in the decision to use PS
- Treatment of other symptoms should be continued alongside PS because sedation may decrease the patient's ability to communicate or display discomfort

Statement on Palliative Sedation - Approved by the AAHPM Board of Directors on December 5, 2014

Criteria for PS

- Each of the following criteria needs to be met prior to initiating PS:

  - Informed consent for No Cardio-Pulmonary Resuscitation or Allow Natural Death comfort focused care has been obtained
  - The patient's life expectancy is hours to about 2 weeks
  - The patient is experiencing one or more refractory symptom(s)
  - Informed consent for PS has been obtained from the patient or substitute decision maker(s) if the patient lacks capacity
  - Input has been obtained from a palliative care clinician or team

Continuous Palliative Sedation Therapy (CPST) Guidelines Developed by the Division of Palliative Care, Dept. of Family Medicine, McMaster University. 31March 2020 -https://fhs.mcmaster.ca/palliativecare/documents/McMasterPalliativeSedationGuidelines202031March2020.pdf

Criteria for PS

- Patient / family understands condition and prognosis & risks and benefits
- Institutional guidelines: Ethics consult ?
- interdisciplinary conference prior to procedure
- Discontinue life prolonging therapies, artificial nutrition / hydration
- Monitor patient: goal of care = ensure comfort until death
- Support family: listen to concerns, address grief and physical/psychological burdens and guilt
- Support nurses

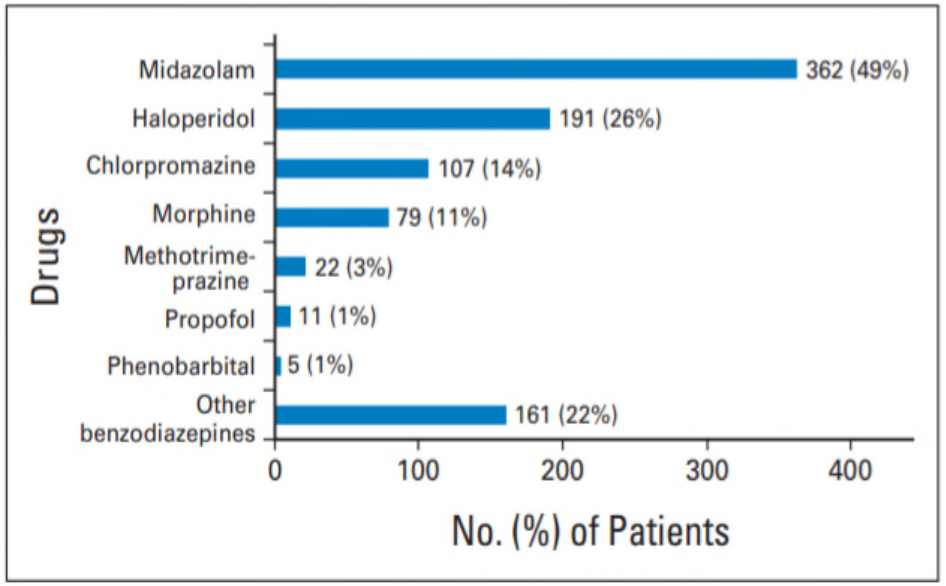
Bobb B. A Review of Palliative Sedation. Nurs Clin North Am. 2016 Sep;51(3):449-57. doi: 10.1016/j.cnur.2016.05.008. PMID: 27497018.
Eisenchlas JH. Palliative sedation. Curr Opin Support Palliat Care. 2007 Oct;1(3):207-12. doi: 10.1097/SPC.0b013e3282f19f87. PMID: 18685365.
Gurschick L, Mayer DK, Hanson LC. Palliative Sedation: An Analysis of International Guidelines and Position Statements. Am J Hosp Palliat Care. 2015 Sep;32(6):660-71. doi: 10.1177/1049909114533002. Epub 2014 May 7. PMID: 24807825.

AAHPM Statement on PS - Medication

- There is no clear consensus or scientific evidence regarding the most appropriate medication(s) to effect palliative sedation

- The agent should be selected based on safety, efficacy and availability

- Medications used: benzodiazepines, antipsychotics, barbiturates, sedatives



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PS - Medications

Drug	Suggested Dose
Midazolam	0.5–5 mg bolus IV/SC, then CII/CSI at 0.5–1 mg/h; usual maintenance dose 20–120 mg/day
Lorazepam	0.5–2 mg PO, SL, SC every 1–2 hours **OR** 1–5 mg bolus IV/SC, then CII/CSI at 0.5–1 mg/h; usual maintenance dose 4–40 mg/d
Chlorpromazine	10–25 mg PO, IV, **OR** PR every 2–4 hours
Haloperidol	0.5–5 mg PO or SC every 2–4 hours **OR** 1–5 mg bolus IV/SC, then CII/CSI at 5 mg/d; usual maintenance dose 5–15 mg/d
Pentobarbital	60–200 mg PR every 2–4 hours **OR** 2–3 mg/kg bolus IV, then CII at 1 mg/h; titrate upward to maintain sedation
Phenobarbital	200 mg IV, SC bolus, then CII/CSI at 600 mg/d; usual maintenance dose 600–1,600 mg/d
Thiopental	5–7 mg/kg bolus IV, then CII at 20 mg/h; usual maintenance dose, 70–180 mg/h
Propofol	10 mg/h as CII; may titrate by 10 mg/h every 15–20 minutes; bolus of 20–50 mg may be used for emergency sedation

PO = oral; PR = per rectum; SL = sublingual; IV = intravenous; SC = subcutaneous; CII = continuous intravenous infusion; CSI = continuous subcutaneous infusion

Stanford School of Medicine / Palliative Care / Medications of Choice
P. Rousseau – Palliative sedation in the management of refractory symptoms – The Journal of Supportive Oncology, 2004, Mar-Apr;2(2):181-6. PMID:15328821
J. Bodnar (2017) A Review of Agents for Palliative Sedation/Continuous Deep Sedation: Pharmacology and Practical Applications, Journal of Pain & Palliative Care Pharmacotherapy, 31:1, 16-37, DOI: 10.1080/15360288.2017.1279502

PS - Controversies

- Efficacy rates for PS ranging from 71% to 92% and defined as the patient, family, or physician's perceived relief of refractory physical symptoms
- "Once unconscious, patients typically die of dehydration, starvation, or a complication of the treatment, with death usually occurring within several days"
- "Once the patient is unconscious, generally no attempt is made to restore the patient to consciousness, and medical nutrition and hydration are terminated. Some have argued that terminal sedation is merely a covert form of euthanasia."
- Controversial medical act

Olsen ML, Swetz KM, Mueller PS. Ethical decision making with end-of-life care: palliative sedation and withholding or withdrawing life-sustaining treatments. *Mayo Clin Proc*. 2010;85(10):949-954. doi:10.4065/mcp.2010.0201

Truog RD, Campbell ML, Curtis JR, Haas CE, Luce JM, Rubenfeld GD, Rushton CH, Kaufman DC; American Academy of Critical Care Medicine. Recommendations for end-of-life care in the intensive care unit: a consensus statement by the American College [corrected] of Critical Care Medicine. Crit Care Med. 2008 Mar;36(3):953-63. doi: 10.1097/CCM.0B013E3181659096. Erratum in: Crit Care Med. 2008 May;36(5):1699. PMID: 18431285.

PS vs. Euthanasia vs. MAID (PAS)

Action Item	Palliative Sedation	Euthanasia	Medical Aid in Dying
INTENTION	**RELIEVE intolerable suffering at EoL**	**ENDING patient's LIFE**	**ENDING patient's LIFE**
PROCEDURE	**USE a sedating drug for symptom control**	**MD PRESCRIBES *AND* ADMINISTERS lethal drug**	**MD PRESCRIBES *BUT NOT* ADMINISTERS lethal drug**
OUTCOME	**ALLEVIATION of distress**	**immediate DEATH**	**immediate DEATH**

PS vs. Euthanasia vs. MAID (PAS)

- Euthanasia – illegal in the United States

- Medical aid in dying – legal in OR, WA, MT, VT, CA, CO, HI, D.C., NJ, ME, NM

- Palliative sedation - legal throughout US
  - rule of double effect:
    - grounded in the ethical principle of proportionality
    - originated from Thomas Aquinas in the 13th century
    - an action in the pursuit of a good outcome is acceptable, even if it achieved through means with an unintended but foreseeable negative outcome, if that negative outcome is *outweighed* by the good outcome
  - in 1997 Supreme Court confirmed that palliative sedation is permitted under current law

Olsen ML, Swetz KM, Mueller PS. Ethical decision making with end-of-life care: palliative sedation and withholding or withdrawing life-sustaining treatments. *Mayo Clin Proc.* 2010;85(10):949-954. doi:10.4065/mcp.2010.0201

AAHPM Statement on PS - Ethics

- Is ethically defensible when used:

  1) after careful interdisciplinary evaluation and treatment of the patient

  2) when palliative treatments not intended to affect consciousness have failed or, in the judgment of the clinician, are very likely to fail

  3) where its use is not expected to shorten the patient's time to death

  4) only for the actual or expected duration of symptoms

Statement on Palliative Sedation - Approved by the AAHPM Board of Directors on December 5, 2014

PS Problems - Injudicious use

- Instances of inadequate patient assessment in which potentially reversible causes of distress are overlooked
- Situations in which before resorting to sedation, there is a failure to engage with clinicians who are experts in the relief of symptoms despite their availability
- The case of an overwhelmed physician resorting to sedation because he is fatigued and frustrated by the care of a complex symptomatic patient
- Situations in which the demand for sedation is generated by the patient's family and not the patient him / herself

Cherny NI, Radbruch L; Board of the European Association for Palliative Care. European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care. Palliat Med. 2009 Oct;23(7):581-93. doi: 10.1177/0269216309107024. PMID: 19858355.

PS Problems - Injudicious withholding

- Clinicians defer the use of sedation excessively whilst persisting with other therapeutic options that do not provide adequate relief

Cherny NI, Radbruch L; Board of the European Association for Palliative Care. European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care. Palliat Med. 2009 Oct;23(7):581-93. doi: 10.1177/0269216309107024. PMID: 19858355.

PS Problems - Substandard Clinical Practice

- Inadequate consultation with the patient, family, or staff members
- Inadequate monitoring of symptom distress or adequacy of relief
- Inadequate assessment of psychological, spiritual or social factors that may be contributing to the patient's distress
- Inadequate monitoring of physiological parameters that may indicate risk of drug overdose
- Hasty dose escalation of sedative medications without titration to effect
- Use of inappropriate medications to achieve sedation (i.e., opioids)
- Inadequate care of the patient's family
- Inadequate attention to the emotional and spiritual well being of distressed staff members

Cherny NI, Radbruch L; Board of the European Association for Palliative Care. European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care. Palliat Med. 2009 Oct;23(7):581-93. doi: 10.1177/0269216309107024. PMID: 19858355.

PS Problems - Abuse

- Slow Euthanasia = clinicians sedate patients approaching the end of life with the primary goal of hastening the patient's death

Cherny NI, Radbruch L; Board of the European Association for Palliative Care. European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care. Palliat Med. 2009 Oct;23(7):581-93. doi: 10.1177/0269216309107024. PMID: 19858355.

THANK YOU

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The End


WHEN I DIE,
I WANT TO DIE LIKE
MY GRANDMOTHER,
WHO DIED PEACEFULLY
IN HER SLEEP. NOT
SCREAMING LIKE ALL THE
PASSENGERS IN HER CAR.