Case History

A 74-year-old lady with lung cancer was admitted for shortness of breath and stridor. Her tumour, which was beyond surgical or oncological intervention, had caused main bronchus obstruction. Her symptoms were refractory to conventional palliative treatments including high dose dexamethasone, oxygen therapy and morphine. However, she remained calm and cheerful during her hospital stay though she reported breathlessness every time she was prompted. She was subsequently discharged with long term home oxygen therapy.

A month later she was readmitted with worsening breathlessness. We tried to step up her morphine but the effect was not satisfactory. Although she was in distress, she could still communicate with her family members verbally and appeared peaceful especially in the presence of her family. Our palliative care team and her family members were well aware of the possible further deterioration in dyspnoea.

We discussed the issue of palliative sedation with her family members and they agreed with the care plan of sedation in case patient was in unbearable respiratory distress. We explained that it was not a form of euthanasia. We also came to the consensus that intravenous fluid administration would be avoided if possible to minimize burden to the patient.

A week after the discussion, patient developed severe dyspnoea. She was in obvious distress with cold sweating, grimacing of face and noisy breathing. She was unable to take oral medications although she was still conscious. She was commenced on continuous subcutaneous infusion of midazolam 5mg daily together with her equivalent subcutaneous dose of her usual morphine. A day after starting palliative sedation, patient was sleeping peacefully with shallow breathing but not in sweating. The same dose of midazolam was continued and the patient died two days after the palliative sedation.

Discussion

Palliative care provides symptom relief for patients with advanced life-threatening diseases. Despite advances in technology, there remain circumstances in which patients experience distressing symptoms and unbearable suffering that cannot be adequately relieved. In the face of refractory symptoms, palliative sedation may seem to be valuable as a last resort. However, ethical dilemma and practical challenges remain inevitable. Decision regarding palliative sedation is definitely an area that requires high level of knowledge in symptom management, good communication and counseling skills, and appropriate attitude of respecting the dignity of patients all the time.

Palliative sedation is the use of sedating medications with the primary intention to reduce the consciousness of the patient in order to reduce the experience of unbearable sufferings from symptoms that are refractory to conventional palliative treatments. The intention is not to relieve sufferings by hastening death.

In a survey in the Netherlands over the years after the legalization of euthanasia, a secular trend of increase in palliative sedation and a decline in euthanasia was noted. Although no definite association could be concluded, it was noted that nearly 10% of the cases of palliative sedation was preceded by request for euthanasia that was not granted. Most cases of palliative sedation were initiated without specialist palliative care consultation. In the survey, nearly half of the patients died within one day and nearly all die within one week. Benzodiazepine was used most commonly because of its predictable effect and ease in titration. The commonest indication for palliative sedation was terminal restlessness, which might be difficult to define.

Theoretically palliative sedation is distinct from euthanasia in various ways. However, there are views that palliative sedation may just be a form of ‘slow euthanasia’ or ‘euthanasia in disguise’. 

Palliative Sedation

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It is the different intention that distinguishes the two, palliative sedation is intended to relieve symptoms whereas euthanasia is intended to end life. Ethical arguments supporting the use of palliative sedation include the ‘principle of double effect’, which draws a moral distinction between the intention of an act (to relieve sufferings) and its foreseen but unintended consequence (death).

<table>
<thead>
<tr>
<th>Euthanasia</th>
<th>versus</th>
<th>Palliative sedation</th>
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<tbody>
<tr>
<td>To hasten death</td>
<td>Intend to relieve refractory symptoms</td>
<td></td>
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<tr>
<td>Aim at immediate death</td>
<td>Not to hasten death</td>
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<tr>
<td>Prolonged dying process viewed as complication or failure</td>
<td>As the patient’s disease cause death, duration may be prolonged up to weeks</td>
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We as physicians are often faced with the dilemma of under-treating refractory distressing symptoms of the patients and sacrificing valuable conscious time to spend with family towards the end of life. It has been reported that palliative sedation does not shorten life expectancy as the survival time of palliative care patients after admission with and without palliative sedation was similar.

In reality it may not be easy to convey these messages to patients and their relatives without ambiguity, especially for the difference between palliative sedation and euthanasia. Euphemisms for death in Chinese language also pose challenge in communication. For example, ‘going to sleep’ is sometimes used by layman to indicate ‘dying’.

The discussion itself is already a burden to all the parties involved. The decision-making process is stressful to patients and their relatives. Decision on artificial hydration and nutrition as palliative sedation is initiated is yet another challenge. Finally, like all other treatments, palliative sedation can have complications. Morita reported serious complications including respiratory suppression without cardiac arrest, aspiration, and paradoxical reaction in patients receiving palliative sedation.

While there is room for controversies, palliative sedation is frequently practiced across different countries. A recent systematic review found that the prevalence of palliative sedation is variable, ranging from 3% to 50%. The wide variance in the use of palliative sedation may be due to the variation in definition of palliative sedation, the retrospective nature of many studies, and the lack of consensus on the definition of a refractory symptom (particularly refractory existential suffering) and even the act of palliative sedation itself.

**Summary**

Palliative sedation is generally regarded as ethically acceptable treatment for refractory symptoms at the end of life, with the intention to relieve symptoms. Sedation should be titrated against the clinical effect of symptom relief. However, palliative sedation has its own emotional, ethical and practical challenges. It should be used judiciously and careful communication between family, patients, doctors, and the multidisciplinary team members is of utmost importance. Potential benefit and burdens should be weighted in patient-centered way. Whether to go for palliative sedation or stay with the acceptance of unrelieved sufferings should be tailored with patient’s wish. Palliative sedation is not a one-size-fits-all option to every refractory symptom, and it cannot replace holistic palliative care of each individual patient.

**References**