Palliative Care Nurses Interest Group - Position Statement on Palliative Sedation.

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Background

Palliative sedation is becoming increasingly common in practice. One study demonstrated this stating in 1995 palliative sedation was used in 7% cases whereas in 2002 it was used in 19% of cases (Muller-Busch, 2003). As we approach the end of 2010 there is still a dearth of good evidence about palliative sedation and easily transferable guidelines.
In Canada there is no obvious position statement from a provincial or professional association explicitly on palliative sedation. To fill this gap the Palliative Care Nurses Interest Group (PCNIG) of Ontario provides the following position statement on palliative sedation.

Definition

Palliative sedation is the monitored use of medications intended to induce varying degrees of unconsciousness, but not death, for relief of refractory and unendurable symptoms in terminally ill patients. This is not specific to an age group and should be assessed on a case by case basis.
The varying degrees of palliative sedation, from temporary light sedation to complete unconsciousness is determined relative to the degree of sedation necessary to provide relief from the refractory symptom coupled with how much the patient wishes to be aware of their symptoms.

Sedation is proportionate to the level of distress, the goals of the patient, what they [patient] consider tolerable and wish to experience. The least amount of sedation to achieve this should be employed.

To assess if goals of care are being achieved and if sedation level needs to be altered, e.g. reduced as a comfort level is now acceptable, ongoing, at minimal daily and as required evaluation of depth and level of sedation along with symptoms should occur.

When and How?

In any setting it is vital that all options of treatment have been explored and considered by an interprofessional team, with palliative expertise, to manage distress and achieve the goals of care before using palliative sedation. For example, it would not be a good reason to employ palliative sedation for intractable pain simply because one does not have access to intrathecal analgesia and this course of treatment would resolve the pain. The goal here would be to find a centre that could perform the intrathecal procedure if this was the best method of pain relief for that person. With good symptom management the use of palliative sedation in the clinical setting should actually be quite rare.
There is no evidence to suggest specific settings are superior to deliver palliative sedation. What is clear from the literature is that the teams in whichever setting should have specialized, ongoing training and education in palliative sedation and symptom management and be readily accessible (24 hours, 7 days a week) for the ongoing monitoring and assessment.

Using an interprofessional approach fosters discussion, allowing a thorough informed consent process naturally involving the patient. The use of distress scales and patient/family meetings can be helpful to standardize the process, understand the decision making as well as gain informed consent to the procedure.
The length of sedation required is based upon achieving the goals of care. Ongoing evaluation will determine the length of this intervention along with patient/family input. It is important that the patient is aware they can have this intervention stopped at any time.
The undesirable side effects of palliative sedation can also be discussed at this time, as this intervention is not without its own burden.

Pitfalls and Burdens of Palliative Sedation

The burdens of palliative sedation are often not discussed or considered. The literature states that this is an important and significant component of discussion with the patient that often doesn't occur. At what cost is the sedation used, how acceptable is it to the patient to not be able to communicate with their family? Patients do not often realize the impact of the psycho-social effects of sedation until they are sedated, up to that point it is an abstract concept.

Another key point is the pharmacology used to instigate sedation has a significant side effect profile, and the discerning eye needs to recognize the toxic limitations rather than interpreting these signs as an agitated patient requiring more sedation and simply increasing doses.

Another major consideration which should be explicitly understood by the interprofessional team and the patient and family is that although the intent is not to hasten death this could occur as an unintended consequence. It is important to make it clear, that the **intention** of sedation is to **provide relief** from the refractory symptom.

Beneficence vs. maleficience, promotion of dignity and alleviation of suffering and the rule of the double effect are all core components of the ethical debate and discussion with the interprofessional team and patient/family.

Conclusion

Palliative sedation is a valid option for the interprofessional team to relieve suffering. More work needs to be done to develop evidence based international guidelines and protocols.

Symptom management for anyone with a terminal disease should be aggressive, utilising all options to ensure optimal management and achieve the goals of care in all domains.

Therefore palliative sedation should be used with careful consideration, by experts who have experience in this area and by patients who fully understand the benefits, risks, side effects and the burden of using such an intervention.

References

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