PALLIATIVE CARE NETWORK OF WISCONSIN

FAST FACTS AND CONCEPTS #106
CONTROLLED SEDATION FOR REFRACTORY SUFFERING – PART I

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Introduction Controlled Sedation for Refractory Suffering (also known as '*total,' 'palliative,' or 'terminal' sedation*) can be defined as *sedation for intractable distress in the dying*. The use of sedation has been reported to be anywhere from 2-50% of hospice patients. Muller-Busch reported the indications for sedation included: anxiety/psychological distress (40%), dyspnea (35%) and delirium/agitation (14%). This *Fast Fact* reviews the medical decision-making surrounding these practices; *Fast Fact* #107 reviews techniques.

Existential Suffering While there exist objective criteria for quantifying and treating physical distress, evaluating psychological distress (e.g. 'existential suffering') is more difficult. There are no simple and clinically oriented tools to evaluate spiritual and psychosocial components of mental suffering. Many clinicians find the idea of sedation for existential suffering to be ethically more challenging than similar treatment for physical suffering. In either case, the decision to begin a trial of sedation is always difficult for clinicians, requiring thorough patient assessment and discussions with the patient, family and other team members.

Ethical/Legal Basis In the United States, Supreme Court rulings (Vacco v. Quill, 1997 and Washington v. Glucksberg, 1997) supported the concept of sedation when used to relieve intractable suffering. However, controversy still surrounds the use of sedation due to confusion with euthanasia. From an ethical and legal standpoint, the key difference is *intent*. In euthanasia the *intent* is to produce a hastened death. In sedation, the *intent* is to relieve intractable suffering, not hasten death. Of note, some studies have found no difference in survival between hospice patients who required sedation for intractable symptom control during their last days and those who did not.

What is a refractory/intractable symptom? Cherney and Portenoy clarified the distinction between a difficult vs. a refractory symptom. A refractory symptom, one for which total sedation may be appropriate, should have the following three attributes:

- Aggressive efforts short of sedation fail to provide relief.
- Additional invasive/non-invasive treatments are incapable of providing relief.
- Additional therapies are associated with excessive/unacceptable morbidity, or are unlikely to provide relief with a reasonable time frame.

Guidelines Several similar sedation guidelines have been published; listed below are Rousseau's guidelines for sedation in patients with existential suffering. These guidelines would also be appropriate for decisions concerning physical symptoms.

- The patient must have a terminal illness.
- All palliative treatments must be exhausted, including treatment for depression, delirium, anxiety, etc.
- Psychological assessment by a skilled clinician.
- Spiritual assessment by a skilled clinician or clergy.
- A do-not-resuscitate order must be in effect and informed consent obtained and documented.
- Nutrition/hydration issues need to be addressed prior to sedation.

Respite Sedation One additional consideration proposed by Rousseau and others is the concept of *Respite Sedation* – a time limited trial (usually 24-48 hours) in an attempt to break a cycle of psychological suffering.

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