Walking the Fine Line Between Palliation and Euthanasia

Michael Hartwick MD, FRCPC
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Rationale

“Passive euthanasia” is now called “appropriate care.” Today, it is universally practiced in Canadian hospitals….

Arthur Schafer The Globe and Mail Aug. 23 2012

Rationale

Teixeira C et al. J Med Ethics, 2013.

Objectives

1. Initiate a discussion about the personal challenges of providing care during WLST.
2. Recognize and apply ethical principals that support this discussion.
3. Indentify some care strategies that create common understanding around WLST.

52 year old woman

- Metastatic Breast Cancer (Bone, Brain, Lung)
- Admitted to the ICU with Pneumonia and Non-healing Wounds
- Decision made for WLST

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PHYSICIAN'S ORDERS
ORDONNANCES MÉDICALES
ICU-USI

Medication Allergies/Reactions	Substances or Food Allergies/Reactions
☐ none known-aucune connue	☐ none known-aucune connue

COMFORT CARE ORDERS FOR THE WITHDRAWAL OF LIFE SUPPORT
ORDONNANCES DE COMFORT POUR LA SUSPENSION DU MAINTIEN DES FONCTIONS VITALES

The intent is to enable a patient who has been deemed to be terminal to achieve a death with dignity and to alleviate or prevent pain and suffering during the withdrawal process. Sedatives and analgesics should be given in sufficient doses and at appropriate intervals to ensure patient comfort. Although respiratory and hemodynamic depression may result from giving sedatives and analgesics, these effects are acceptable if relief of pain and suffering is the primary objective.

1. Complete Life Support Checklist
2. Titrate to comfort
   - morphine - start at present rate or ______ mg/hr, bolus ______ mg prn, adjust infusion prn
   - midazolam - start at present rate or ______ mg/hr, bolus ______ mg prn, adjust infusion prn
   - Hydromorphone - start at present rate or 2 mg/hr, bolus 1 mg prn, adjust infusion prn

   NO DOSAGE LIMIT
   - increase infusion rate if any signs of distress:
   - grimacing, clutching, gasping, restlessness, diaphoresis
   - respiratory rate >24/min, nasal flaring, accessory muscle use
   - heart rate increase >20 %, SBP increase > 20%
3. Assess family's perception of patient's comfort level q 1h + prn, and their coping
4. Liberalize visitation, transfer to a private room if available
5. Minimal intravenous fluids
6. Enteral feedings may continue if requested by the family
7. Begin oral nutrition if requested by patient or family
8. Stop all investigations, drugs except sedatives, etc. AND wean vasopressors by 50% q5mins until discontinued
9. Remove all devices not necessary for comfort when possible and at discretion of RN/MD/family (eg catheters, NG tubes, vascular cannulas, monitors, restraints, SCDs, etc)
10. Wean down FiO_2 to 0.21, PEEP to 10 cm H_2O, PS 10 cm H_2O. Rate to CPAP from existing mode of ventilation. Make changes q5-10 mins, and observe patient for any signs of distress
    - grimacing, clutching, gasping, restlessness, diaphoresis
    - respiratory rate >24/min, nasal flaring, accessory muscle use
    - heart rate increase >20 %, SBP increase > 20 %

    If distress apparent
    - increase sedatives,
    - increase ventilation until sedative are effective
    - Scopolamine 0.3-0.6 mg IM SC, q6h PRN for secretions

    If distress is not apparent
    - do not increase sedatives, proceed to 5/5 trial; try 5/5 trial for 10 mins
    - if satisfactory, extubate +/- oral airway prn, unless family or caregivers believe patient would be less comfortable (use T piece instead of extubation)
    - if unsatisfactory, increase sedation and try again
11. Disconnect from electronic monitor and discontinue vital sign measurements when off the ventilator
12. No chest compressions or other resuscitation
13. Clinical rather than electrical definition of death (apnea, no pulse, etc)

Date: Time: 2045 Physician-Médecin (signature): Signature:

Date (notes-notée): Time-Heure: Processed by-Traités par: Signature (Nurse-Infirmière):

SPO 82 (11/2004) 1-CHART-DOSSIER 2-PHARMACY-PHARMACIE © The Ottawa Hospital-L'Hôpital d'Ottawa

Relevant Ethical Principles

- Beneficence
  - The obligation of health care providers to “do good”
    - What constitutes a doing of “good” for a patient at the end of life?
    - How do we define what a “good” is?
    - Who defines the “good”, the patient, the provider, both?

Relevant Ethical Principles

- Nonmaleficence
  - The obligation of health care providers to “do no harm”
    - What constitutes a doing of “harm” for a patient at the end of life?
    - How do we define what a “harm” is?
    - Who defines “harm”, the patient, the provider, both?

Relevant Ethical Principles

- Autonomy
  - Does a capable patient have a “right” to request euthanasia?
  - Does such a request create an obligation on the part of the provider to act?

Relevant Ethical Principles

- Respect for Human Life and Dignity
  - Is euthanasia “disrespectful of human life?
  - How do we understand human dignity at the end of life?
  - Can dying be dignified or is it inherently an undignified process?

Ethical Issues in the Palliative Care vs. Euthanasia Discussion

- When doing “good” causes “harm” how do we proceed?
- The question of intention.
- Should decisions to initiate palliative care be patient\family driven, care team driven or a collaborative venture?

Ethical Issues in the Palliative Care vs. Euthanasia Discussion

- Can\should the application of personal values and beliefs be legislated.

- Vulnerable Populations.

Clinical Challenges

- 52 year old with metastatic breast cancer
- 72 hrs since WLST
- Extubated
- 20mg/hr
  - Midazolam
  - Hydromorphone

Consistency and Objectivity

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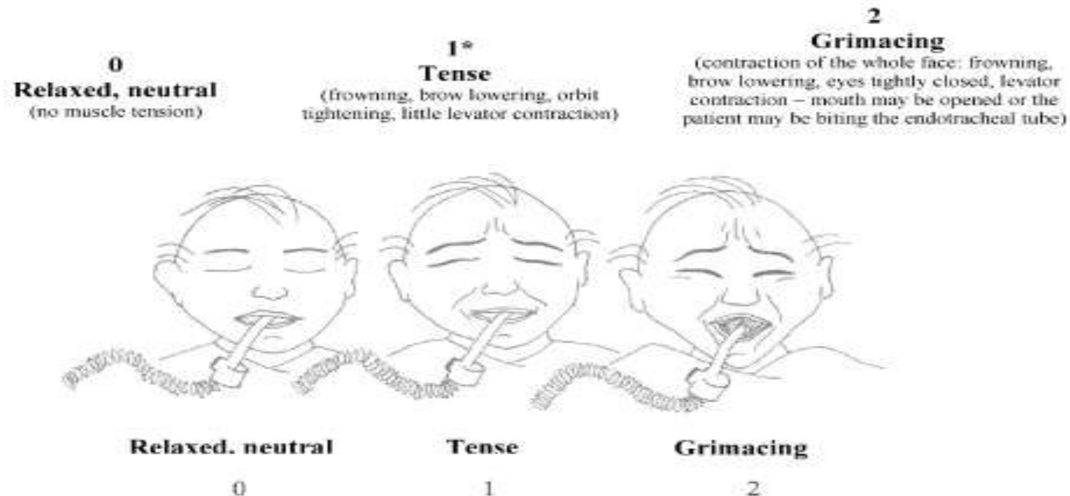
Assessing and Managing Symptoms

Critical Care Pain Observation Tool (CPOT)

Facial expressions



Drawings by Caroline Arbour, RN, B.Sc., PhD(student), McGill University

* A score of 1 may be attributed when a change in the patient's facial expression is observed compared with rest assessment (e.g. open eyes, weeping eyes).

The drawings were inspired from : Prkachin, K. M. (1992). The consistency of facial expressions of pain : a comparison across modalities. *Pain, 51*, 297-306.

Gelinas C et al, Am J Crit Care, 2006.

Assessing and Managing Symptoms

Richmond Agitation Sedation Scale (RASS) *

Score	Term	Description	
+4	Combative	Overtly combative, violent, immediate danger to staff	
+3	Very agitated	Pulls or removes tube(s) or catheter(s); aggressive	
+2	Agitated	Frequent non-purposeful movement, fights ventilator	
+1	Restless	Anxious but movements not aggressive vigorous	
0	Alert and calm		
-1	Drowsy	Not fully alert, but has sustained awakening (eye-opening/eye contact) to *voice* **(≥10 seconds)**	Verbal Stimulation
-2	Light sedation	Briefly awakens with eye contact to *voice* **(<10 seconds)**	Verbal Stimulation
-3	Moderate sedation	Movement or eye opening to *voice* **(but no eye contact)**	Verbal Stimulation
-4	Deep sedation	No response to voice, but movement or eye opening to *physical* stimulation	Physical Stimulation
-5	Unarousable	No response to *voice or physical* stimulation	Physical Stimulation

Procedure for RASS Assessment

1. Observe patient
   a. Patient is alert, restless, or agitated. **(score 0 to +4)**
2. If not alert, state patient's name and *say* to open eyes and look at speaker.
   b. Patient awakens with sustained eye opening and eye contact. **(score –1)**
   c. Patient awakens with eye opening and eye contact, but not sustained. **(score –2)**
   d. Patient has any movement in response to voice but no eye contact. **(score –3)**
3. When no response to verbal stimulation, physically stimulate patient by shaking shoulder and/or rubbing sternum.
   e. Patient has any movement to physical stimulation. **(score –4)**
   f. Patient has no response to any stimulation. **(score –5)**

* Sessler CN, Gosnell M, Grap MJ, Brophy GT, O'Neal PV, Keane KA et al. The Richmond Agitation-Sedation Scale: validity and reliability in adult intensive care patients. Am J Respir Crit Care Med 2002; 166:1338-1344.

* Ely EW, Truman B, Shintani A, Thomason JWW, Wheeler AP, Gordon S et al. Monitoring sedation status over time in ICU patients: the reliability and validity of the Richmond Agitation Sedation Scale (RASS). JAMA 2003; 289:2983-2991.

Ely W et al, JAMA, 2003.

Being with Dying / Moral Distress

- Moral distress is not inherently good or bad
- Being with dying is both an intensely selfless and self-centred experience

Discussion/Questions