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Palliative Sedation: Responding to Severe Suffering in a Metastatic Breast Cancer Patient

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The goal of palliative care is to provide comfort and relief from suffering, especially for patients in the end-of-life stage. Holistic care with a team-based approach seems to be the most promising solution.¹ While physicians can address physical suffering in different stages, social, emotional, and spiritual suffering often requires specialized expertise. What would be the next step if the symptoms become intolerable and barely manageable?

Palliative sedation is the intentional reduction of a dying patient's level of consciousness through titration of one or more sedating medicines to alleviate intolerable suffering associated with refractory symptoms.² Palliative sedation is easy to discuss, but it faces numerous ethical, operational, and social challenges in practice.

Mrs. J. was a 36-year-old woman with metastatic breast cancer in her lungs who arrived at the emergency department with severe dyspnea. Initial investigations revealed widespread lung metastases but no pleural or pericardial effusion and no signs of infection. Her family was aware of the prognosis, and their only request was for comfort.

She was subsequently transferred to the palliative medicine unit, where morphine was promptly initiated. Since she had not previously received opioid medications, the morphine injection was initiated at low doses, starting at 2.5 to 5 mg every 4 hours. Over the course of 6 days, the morphine dosage gradually increased to 20 mg every 4 hours. Midazolam was later added to the morphine regimen as she was experiencing sensations of suffocation, irritability,

and difficulty sleeping. Despite the administration of five milligrams of midazolam every 4 hours, her dyspnea, irritability, and confusion persisted.

As the patient lacked the capacity to actively participate in medical decision-making due to her mental confusion, the option of palliative sedation was presented to her family members, who, in the absence of clear guidance for determining the surrogate decision-maker, are generally recognized as the substitute decision-makers in our center. Midazolam was replaced with chlorpromazine, with doses gradually increasing up to 50 mg every 6 hours. Since both midazolam and chlorpromazine were not readily available, phenobarbital was administered subcutaneously, initially at 50 mg every 12 hours, and eventually increased to 300 mg every 8 hours. Despite these interventions, she continued to struggle for each breath, and her family inquired about the possibility of medical assistance in dying.

Life expectancy is limited after lung metastasis, with a median survival of only 22 months post-treatment.³ Approximately 60–70% of mortality of metastatic breast cancer is due to lung metastases.⁴

Literally, whenever an end-stage patient's symptoms are refractory and intolerable despite appropriate evaluation and management, the intentional administration of sedative drugs by a palliative care expert should be considered. This means reducing the consciousness of a terminal patient as much as necessary to relieve one or more refractory symptoms adequately.¹

Based on medical standards of palliative guidelines, two main criteria are needed to decide on using palliative sedation; refractory symptoms and limited life expectancy. Pain, delirium, and dyspnea are the most common symptoms managed by palliative sedation.⁵

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Palliative sedation is estimated to be administered in 10% to 18% of all deaths in Europe.⁶ The goal of palliative sedation is to respect the dignity of the dying patient. It aims to avoid situations where a patient's wrists and feet are tied to the hospital bed during hyperactive delirium, prevent the use of an oxygen face mask to conceal delusional speaking and deter ICU admissions at the request of families who cannot cope with the suffering of end-of-life patients. Palliative sedation is considered a last-resort therapeutic tool for these circumstances.

Different medications and guidelines are primarily referenced in palliative care. The main categories of sedative medications include benzodiazepines, neuroleptics/antipsychotics, barbiturates, and general anesthetics.⁷ It's important to note that opioids are not typically used as sedative medications⁸ and should only be prescribed for managing pain and severe dyspnea at the end of life.

In regard to palliative sedation, there are the most important questions; is it a kind of euthanasia? Does palliative sedation hasten death? Can we call palliative sedation an example of the doctrine of double effect? Is palliative sedation mandatory or an arbitrary choice of the physician?

Intention is indeed the key word that distinguishes the concept of euthanasia (killing the patient) from palliative sedation (alleviating the patient's suffering). It is not necessary to titrate, calculate, or maintain minimum doses for comfort during euthanasia since the goal is death rather than comfort.⁹ Many other medical interventions that include a kind of forgoing life-sustaining interventions could be labeled as euthanasia. To improve the justification of palliative sedation, we can recommend that any limitations on interventions such as artificial ventilation, nutrition or hydration be discussed in separate contexts and not mixed in the discussions around palliative sedation.

The doctrine of double effect refers to the concept that any adverse outcomes of one's actions (or prescribing a medication) are less morally problematic if they are unintended. It is usually argued that the number of medical treatments and procedures that are entirely without risk is very small. Every physician should carefully weigh the advantages and disadvantages and the potential harms and benefits of every intervention (procedure or prescription) beforehand.⁷ But the question about the doctrine of double effects is basically built upon an empirical claim. It is important to clarify that in the absence of clear empirical evidence, this doctrine could not be used to defend the ethical permissibility of palliative sedation and could even have a counter-productive effect. So, it seems that this kind of

terminal sedation should be discussed as a medical intervention to alleviate suffering.

In such situations, an interdisciplinary team evaluates the patient's symptoms and considers treatment options. In the best-case scenario, the team discusses the necessity of sedation for both the patient and the family. In the case presented earlier, the patient's awareness was unsuitable for such a discussion. This makes the decision difficult, especially when advanced directive planning is not available in most developing countries.

We decided to prescribe propofol after consultation with an anesthetist. Based on the patient's medical history, we initiated propofol at a rate of 300 mg/h. After 20 hours, she appeared more comfortable but still experienced occasional dyspnea. Ultimately, she passed away two hours after we increased the propofol infusion rate to 400 mg/h, in peace and in the presence of her family.

Considering the above-mentioned conceptual ambiguities and legal uncertainties, the palliative sedation process could be distressing for the staff members. In the presented case, one of the nursing staff approached the doctor in charge and expressed that she felt bad, as she was the last person to provide the medication to Mrs. J. She thought it was the main reason for her death. Therefore, all participating staff members need to understand the rationale for sedation and the goals of care and have an opportunity to express themselves.

While palliative sedation is an option, it should be seriously considered for relieving intolerable suffering in the last hours and days of life. Palliative sedation must be initiated with informed consent, and ethical or religious concerns should be addressed before the sedation process. In cases where the patient lacks the capacity to make decisions, as in the present case, discussions should be held with the family. As a last resort, the responsible physician could seek guidance from either the hospital ethics committee or an appropriate source of clinical ethics advice.⁵

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CONFLICT OF INTEREST

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