Ethical Considerations for Sedation of Terminal Wean Patients

Introduction and Background

The purpose of this paper is to examine the ethical concerns involved with the sedation of a terminal wean patient. Terminal weaning is the process of removing a patient from a ventilator (a form of life support) by removing the endotracheal tube. Prior to this procedure, the determination has been made that the patient has either a terminal illness and will not recover or will have to remain on life support to sustain life (Keene, Samples, Masini, & Byington, 2006). The determination to remove a patient from the ventilator is usually one made between the health care team, family member or surrogate, and ideally the patient themselves. Treatment focus switches from the cure of disease to comfort care at the end of life. Death can cause unbearable distress and suffering for a patient. Dyspnea, feelings of suffocation, severe fatigue, nausea, vomiting, anxiety, delirium, intractable pain, and incontinence are several of the issues a dying patient may experience (Tomko & Maxwell, 1999). Despite all efforts to comfort the patient with analgesics, anxiolytics, family support or spiritual services, the patient may continue to suffer. Palliative sedation is used to decrease the level of consciousness in these patients and to help relieve their distress and suffering (Van Wijlick, 2011). Prior to the removal of the endotracheal tube for a terminal weaning process, a patient who has been living on ventilator support may already be receiving sedatives to keep him or her comfortable. A major ethical consideration in using palliative sedation is the determination that it is different from physician-assisted suicide or euthanasia (Belgrave & Requena, 2012).

Analysis Using Ethical Principals

Patient autonomy is a major bio-ethical principle guiding treatment at the end of life (Civetta, 1999). Ideally, the patient will be awake, alert and oriented enough to make his or her wishes known or has at least completed an advance directive. Therefore, if a patient wishes to receive palliative sedation to overcome his suffering, who is to argue with him? Kant offers the idea that when a person commits suicide, they are abandoning their own autonomy (Boer, 2013). It can be argued that consenting to palliative sedation is no different than suicide. This is because a patient under palliative sedation will have a decreased level of consciousness and will no longer be able to make his or her own decisions.

A patient who is critically or terminally ill may not be competent enough to execute their own autonomy to determine the plan of care they wish. The determination of care, in this instance, must come from the patient's health care team, family or surrogate. The decision maker must be able to provide a justice decision for the patient when determining the way he or she will die. If the patient had informally made his or her wishes known to a surrogate for their end of life treatment, it is the ethical responsibility of that person to follow the patient's wishes.

When making a decision for others, one must use the ethical principles of beneficence and non-maleficence. In other words, the decision maker must do what is best for the patient while making sure that they suffer no harm. In the case of palliative sedation, this is ethically difficult to accept for some. It is important to determine your goal or purpose when considering palliative sedation, relief of existing suffering, or accelerating the dying process (Cassell & Rich, 2010). To sedate someone as a relief of suffering may be morally accepted; however, to sedate someone with the intent to hasten death is not as acceptable. The concept of double effect explains the difference: an action has an intended effect while also having an unintended effect (Boer, 2013). When a physician sedates a terminal patient to relieve the suffering he is currently

enduring, and the patient subsequently dies from the side effects of the medication, the physician is not to blame (Berger, 2010). The physician's intent was not to cause death or harm. The intention to do what was best for the patient at that time; relieve his or her suffering with sedation. However, if the physician administered a large amount of sedative with the intent of immediate death of the patient, this would be considered euthanasia and ethically much different than palliative sedation.

Presentation of Comprehensive Stakeholder Perspectives

A patient's perspective of sedation during and after a terminal wean should be the driving force in the plan of treatment. If a patient is awake, alert, and oriented prior to removal of life support, it is very important to determine their level of pain, anxiety, and discomfort. It is not unthinkable that a patient may request to be sedated to hasten their own death, rather than live knowing that they are going to die. Explanations need to be given to the patient on all treatment options and the patient should be given the opportunity to decide which level of treatment is appropriate for him or her, including the right to be sedated if needed. The legality and morality of patient's decisions should be explored.

If the patient is unable to make their own end of life decisions, a surrogate may make decisions for them (Fulton, 2003). A surrogate may be a family member, significant other, friend, or even a court appointed power of attorney. Treatment goals need to be discussed with the health care team. To meet the defined goals, the health care team should explain all possible combinations of treatments, as well as, what to expect as the patient goes through these treatments (Gupta, Goyal, Chauhan, Mishra & Bhatnagar, 2007). When making the decision to sedate a patient at the end of life, a level of guilt can be experienced from the patient's surrogate.

The surrogate may wonder if the decision to use sedation medication caused the death. The medications and side effects should be thoroughly explained and discussed prior to initiation of palliative sedation so all involved will know what to expect.

Prior to removing a patient from life support, while intubated and critically ill, the patient may already be receiving a continuous dose of sedation and analgesia for their comfort. For these patients, the discontinuation of medications could be considered unethical. Essentially, the patient would be awakened to die. Family members, friends, or surrogates close to the patient may request for the patient to be same as above so they can say their goodbyes. All possible circumstances need to be explained to the patient's loved ones for informed decisions to be made about taking the patient off of sedatives. Prior to the removal of life support, a patient could be taken off of sedation to determine his or her level of consciousness and discomfort. However, this too could be considered unethical.

Implications for Multiple Health Care Professionals

Members of the health care team should receive special training and support throughout the entire process of withdrawing life support from a patient (Kirchhoff & Kowalkowski, 2010). Each member, often forming a bond with the patient and family members, is subject to multiple emotions and moral dilemmas. The three main team members involved in the removal of a patient from life support is the physician, the intensive care nurse, and the respiratory therapist. They work together with the patient's loved ones to determine if the patient will need palliative sedation at the end of life.

The initial explanation of palliative sedation comes from the physician. If a patient requests to be sedated when he or she is suffering, the physician has to discuss and determine

what the patient's ultimate goal is for the end of their life. The physician must allow for patient autonomy while still honoring the ethical principles of beneficence and non-maleficence. The ethical dilemmas that may arise from these decisions may be challenging (Smith, 2013). Let us examine the physician's role. The physician is caring for a patient who appears to be in no pain or distress after the removal of life support. The patient indicates that he or she is suffering greatly and would like to be sedated. The patient is already receiving pain medication. What is the morally right thing to do? Part of assessing for pain is accepting that the pain is what the patient says it is. Pain is subjective, not objective. Another example, a patient is unable to make his or her own decisions, appears miserable, and is in respiratory distress. Pain medicine does not seem to be working. After a discussion with the family, a decision to start palliative sedation has been made. The physician wants the patient to become sedated as quickly as possible to relieve their suffering. Should he or she order a dose of sedation on the higher side of normal, knowing that it will take effect quickly, relieve the suffering, but may possibly hasten the patient's death? What is the physician's ultimate goal, comfort or death? Once again, the theory of 'double effect' comes into play. The goal may be to comfort the patient, but in doing so, death occurred. Now add another factor. What if other patients need to be admitted to the intensive care unit and there are no beds available? The physician orders a dose of medication, knowing the effect will hasten the patient's death and free up an intensive care bed. What is the goal now?

Another member of the health care team facing ethical dilemmas surrounding the terminal wean process of patients is the intensive care nurse. The nurse is available at the bedside for the patient and their loved ones throughout the end of life process. Being at the bedside subjects the nurse to constantly witness the pain and suffering the patient may go

through. The end of life discussions with the patient and family can affect the morality of the nurse, especially if the treatment decisions will lead to continued pain and suffering of the patient. A nurse may have to continue to perform painful or bothersome treatments and procedures for the patient, who they may have become close with.

If the decision for palliative sedation has been made, the order for sedation medication will come from the physician. However, the nurse will be the one to administer the medication. There are also instances when the physician will order a medication with a range of dosage options. For example, the order may be for a continuous drip of the sedative, Midazolam, to titrate to patient's comfort level. The nurse has to make the ethical decision of how much sedative to administer. This creates an ethical dilemma similar to the physician. Death may occur after this administration, naturally or as a side effect. When this happens, the nurse may have thoughts or feelings of guilt regarding the dosage selection.

The respiratory therapist also plays an important role in the terminal wean process. The physician writes the order for the removal of the endotracheal tube and ventilator. The respiratory therapist actually does the removal. The physical act of removing a patient from a ventilator, knowing it can cause their death and potentially pain, and suffering can be emotionally and ethically troubling (Keene et al, 2006). Knowing that a patient can be sedated through this process can ease some of the emotional and ethical turmoil the respiratory therapist may encounter. Once again, we have to determine what the goal is for the patient? Is it relief of suffering for the patient, or the respiratory therapist, nurse, or physician?

Conclusion

Determining when, how, and why to initiate the terminal wean process for a patient is ethically difficult. Making the decision to sedate a patient through the process can be difficult as well. Ultimately, the decision must be made based upon the end of life goal set forth by the health care team, patient, family members, or surrogates. This decision can have multiple physical, psychological, and emotional effects on the patient, their loved ones, and the health care team.

References

Belgrave, K. & Requena, P. (2012). A primer on palliative sedation. *National Catholic Bioethics Quarterly, 12*(2), 263-281. Retrieved from http://ezproxy.indstate.edu:2048/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=86173659&site=eds-live

Berger, J. T. (2010). Rethinking guidelines for the use of palliative sedation. *Hastings Center Report, 40* (3), 32-38. Retrieved from http://ezproxy.indstate.edu:2048/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=bmh&AN=51832922&site=eds-live

Boer, T. A. (2013). Palliative sedation: An exploration from a Christian ethical point of view. *Currents of Encounter, 48,* 227-241. http://ezproxy.indstate.edu:2048/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=hus&AN=93580716&site=eds-live

Cassell, E. J., Rich, B. A. (2010). Intractable end-of-life suffering and the ethics of palliative sedation. *Pain Medicine, 11,* 435-438. doi: 10.1111/j.1526-4637.2009.00786.x

Civetta, J. (1999). Patients are talking – and we'd better listen! *The Internet Journal of Anesthesiology, 4*(1). Retrieved from http://ispub.com/IJA/4/1/5112

Fulton, G. B. (2003). Removing the mask. *Hastings Center Report, 33*(2), 12-13. Retrieved from http://ezproxy.indstate.edu:2048/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=bmh&AN=9625493&site=eds-live

Gupta, D., Goyal, G., Chauhan, H., Mishra, S., & Bhatnagar, S. (2007). An initiative to end-of-life decisions in cancer care. *The Internet Journal of Pain, Symptom Control and Palliative Care, 6*(1). Retrieved from http://ispub.com/IJPSP/6/1/4805

Keene, S., Samples, D., Masini, D., & Byington, R. (2006). Ethical concerns that arise from terminal weaning procedures of a ventilator dependent patient a respiratory therapist's perspective. *The Internet Journal of Law, Healthcare and Ethics, 4*(2). Retrieved from http://ispub.com/IJLHE/4/2/10885

Kirchhoff, K. T. & Kowalkowski, J. A. (2010). Current practices for withdrawal of life support in intensive care units. *American Journal of Critical Care, 19*(6), 532-541. doi: 10.4037/ajcc2009796

Smith, W. J. (2013). The road to backdoor euthanasia. *Human Life Review, 39*(1), 63-72. Retrieved from http://ezproxy.indstate.edu:2048/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=f5h&AN=87047751&site=eds-live

Tomko, L., & Maxwell, T. (1999). Beyond pain management: A primer for providing quality end-of-life care. *The Internet Journal of Family Practice, 1*(2). Retrieved from http://ispub.com/IJFP/1/2/12026

Van Wijlick, E. (2011). Palliative Sedation in the Netherlands. *World Medical Journal, 57*(2), 67-70. Retrieved from http://ezproxy.indstate.edu:2048/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=a2h&AN=65166055&site=eds-live