Faculty/Presenter Disclosure

Presenter Name: Mervyn Dean

Relationships with commercial interests:
No current relationships or commercial interests to declare
Disclosure of Commercial Support

- None

Potential for Conflict(s) of Interest

- None
CONTINUOUS PALLIATIVE SEDATION THERAPY AND THE CANADIAN CONSENSUS

Mervyn Dean
NSHPCA Conference
09 May 2014
Why are we still talking about this?
Euthanasia

• Aim is to cause death
• Act by administering lethal medications
• Outcome death

Palliative Sedation

• Aim is to relieve suffering
• Act by administering a sedative agent
• Outcome decreased/unconsciousness
Theory v Practice

- 25% Family member distress ← PST (Claessens et al. 2008)
- 77% nurses: PST ≅ hastening death (Inghelbrecht et al. 2011)
- Quebec Medical specialists CPST ≈ euthanasia (Vogel, 2011)
Potential Contributing Factors

- Practice heterogeneity (CPST):
  - Italy 8.5%
  - Denmark 2.5%
  - UK 15.5%

- Clinical practice variance:
  - Specialist
  - Generalist/FP

Potential Contributing Factors

- Intention
- Physical versus existential suffering
- Determining “refractoriness”
- Proportionate sedation

Original Members of the CPST Working Group

- Larry Librach
- Mervyn Dean
- Doreen Oneschuk
- Victor Cellarius
- Blair Henry
Consensus Process

1. Literature review and discussion
   - Initial draft – vetted by 20 Experts in the field

2. Presentations at various conferences
   - Revisions based on feedback

3. Consensus survey – CSPCP Membership
   - Final review and acceptance by CSPCP Executive
## What’s in a name

<table>
<thead>
<tr>
<th>Conscious</th>
<th>Continuous</th>
<th>Intermittent</th>
<th>Terminal</th>
<th>Controlled</th>
<th>Total</th>
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<tbody>
<tr>
<td>Deep</td>
<td>Light/Mild</td>
<td>Reduced</td>
<td>Proportionate</td>
<td>Reversible</td>
<td>Therapeutic</td>
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<td>Palliative</td>
<td>End of Life</td>
<td>In the imminently dying</td>
<td>For intractable distress in the dying</td>
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<td>Sedation</td>
<td>Sedation Therapy</td>
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Framework Sections

- Definitions and Terms Used
- Indications
- Aims
- Ethical Considerations
- Nutrition and Hydration
- Cultural Aspects
- Decision-making and Informed Consent
- Drugs and Their Administration
- Monitoring and Outcomes
Continuous Palliative Sedation Therapy (CPST)

- The intentional lowering of a patient’s level of consciousness in the last one to two weeks of life
- To relieve refractory symptoms and intolerable suffering
- Proportional (titrated) and monitored
- Sedation as a consequence of symptom-specific medications is not regarded as CPST.
Refractory Symptom(s)

- All possible treatments ineffective or impractical
- Repeated careful assessment
- Team consensus
- No alternatives within:
  - Timeframe available
  - Risk/benefit ratio
Intolerable Suffering

- A sense of helplessness or loss in the face of a seemingly relentless and unendurable threat to quality of life or integrity of self
Patients with advanced progressive illness who may or may not have physical symptoms but report suffering that is unrelated to a psychiatric disorder or social isolation.
The aim of CPST is to adequately relieve refractory and intolerable suffering of the patient.

The aim is relief of suffering, not sedation itself. (Sedation titrated to relief of suffering).
Decision Making

- Symptom is refractory and intolerable
- Prognosis preferably less than 2 weeks
- Consulted with appropriate experts
- There is team consensus to proceed?
- Patient/family consent(s) to CPST?
- CPST for refractory and intolerable existential distress?
Conform to accepted national, provincial and institutional policies
Informed consent (law and medical ethics)
CPST & concurrent treatments
Team decision with CPST expert consultation
Cultural & religious/spiritual values, interpreter
Monitor and review: team, family, (patient?)
Decision Making

- **Specific to CPST:**
  - Consensus re refractory and intolerable suffering
  - Imminence of death
  - Aim is reduce suffering, not hasten death
  - Proportionate sedation
  - Reduced communication after initiation of CPST
  - Monitoring
  - Recurrence of symptoms (suffering) if d/c CPST
  - Concurrent treatments
Nutrition and Hydration:

- Controversial
- \( \text{CPST} \neq \text{withdrawal of N\&H} \)
- N\&H decision is independent of CPST decision
Cultural Considerations

- Value/meaning of pain/suffering
- Importance of consciousness when dying
- Family/patient decision making process
- Value of food/hydration
- Death rituals/spiritual beliefs/practices
- Communication practice (truth, disclosure/hope)
Cultural Considerations

- Meaning of death and dying
- Family/patient perception of HCP role(s)
- Cultural understanding:
  - Illness v. disease
  - Medical v. traditional
Drugs

- Benzodiazepines OR sedating antipsychotics
- Titrate to relief of suffering
- **NOT** opioids or haloperidol (but may use for other indications)
- Clinical experience/institutional policies (formularies)
- Continuous or intermittent administration?
Monitoring and Outcome

- **Patient:**
  - Relief of suffering
  - Level of consciousness/depth of sedation
  - Adverse effects

- **Family and HCPs**
  - Psychological distress
  - Spiritual distress
Monitoring and Outcome

- Relief of suffering:
  - Verbal (patient or caregivers)
  - Facial expressions
  - Body movements/postures

- Level of consciousness:
  - Response to verbal or non-painful physical stimuli

- Adverse effects:
  - Respiratory depression
  - Skin or joint injury
Monitoring and Outcome

- Frequency of monitoring:
  - Not determined
  - Influenced by location, pharmacokinetics of drug
  - More frequent at initiation

- No adequate CPST monitoring scale
  - (Other sedation scales exist)
What if the patient is a child?

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Pediatric Palliative Care Service
May 2014
DISCLOSURE

Name of Presenter: Marie-Claude Grégoire
Relationship with Commercial Interests:
I have no relationship with commercial interests.
DISCLOSURE OF COMMERCIAL SUPPORT

I HAVE RECEIVED NO COMMERCIAL SUPPORT TO PARTICIPATE IN THIS SESSION.

THERE IS NO POTENTIAL FOR CONFLICT OF INTEREST.
MITIGATION OF POTENTIAL BIAS

I HAVE RECEIVED NO COMMERCIAL SUPPORT FOR THIS SESSION AND NONE OF THE COMMERCIAL SPONSORS OF THE OVERALL CONFERENCE WERE INVOLVED IN THE CONTENT DEVELOPMENT OF THIS SESSION.
Challenges

• Family approach
• Route of administration of medications
• Compatibility of medications
• Lack of literature & Evidence-based guidelines
• Longer duration
• Difficulty of assessment
• Need for education
Medications

• Benzodiazepines: Midazolam
• Antipsychotics: Methotrimemeprazine
• General anesthetics: Ketamine, Propofol
• Very high doses may be needed
• Collaboration with Pharmacy team
References


Summary

- CPST valid but still controversial symptom management tool
- Practice within Framework
- Document discussions, intention and procedure
- Monitor
Thank You

Time for discussion

Framework for Continuous Palliative Sedation Therapy (CPST) in Canada.
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