Consciously Choosing Unconsciousness: Clinical Decision-Making with Palliative Sedation

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INTRODUCTION

"Because there are no laws barring palliative sedation, the dilemma facing doctors who use it is moral rather than legal." Dr. Timothy Quill, a professor of psychiatry, bioethics, and palliative care concisely articulates an ethical intricacy in end-of-life care. In a Washington Post article titled, "Assisted suicide is controversial, but palliative sedation is legal and offers peace," the discussion revolves around the ethical challenges encountered by physicians when deciding to employ palliative sedation, particularly when faced with terminal illnesses causing unbearable physical and existential suffering. Palliative sedation is defined as the intentional lowering of awareness towards, and including, unconsciousness for patients with severe and refractory symptoms.[1] While assisted suicide remains embroiled in legal debates, palliative sedation emerges as a legally sanctioned alternative, thereby burdening medical practitioners with a moral quandary; while the boundary between assisted suicide and palliative sedation is arguably blurred, intent seems to distinguish the two choices– both aim to reduce suffering, but palliative sedation does not have death as the goal. This leads to the ethical question on the permissibility of hastening or causing unconsciousness in dying patients, rather than the issue of whether causing death is ethically justifiable. The absence of explicit laws governing palliative sedation places the ethical dilemma squarely on the shoulders of healthcare professionals, who must grapple with the responsibility of determining if palliative sedation is in the best interest of the patient. Evidently, the choice the clinician makes crucially impacts the patient's quality of life moving forward, demonstrating the far-reaching consequences of palliative sedation in not just individual experiences in healthcare, but in shaping the future of how palliative care is handled. By integrating clinical and neuroscience knowledge, an argument can be made that the optimal clinical decision is reached by considering the subjective value of consciousness for each individual patient, with candor and transparency being the basis of all counseling approaches to prioritize patient advocacy.

ANALYSIS

Drawing on the precedent of assisted suicide, a major concern physicians have when debating the use of palliative sedation is the clause to "do no harm", a principle fundamental to their profession in healthcare. A paradoxical dilemma arises when reducing the pain of a patient may come at the cost of their consciousness– which is more harmful? Having strict guidelines on when palliative seduction is even an option alleviates some responsibility on the physician to make this choice; the choice of the patient, or

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informed consent, is preliminary for this therapy.[2] By having the patient aware of the risks, and having that patient decide what state they value more, a physician can base their decision on what "harm" means in relation to the patient's definition. Of course, there are additional considerations that must be contended with before this assumption can be reliably used, such as the state of mind of the patient when this decision is made, as well as the general consensus that exists among the patient, family, and staff about the therapy's appropriateness. Another concern then seems to be the actual practice of palliative sedation– what are the side effects and unintended consequences of this therapy? So far, the academic literature seems promising in the accuracy of the therapy; according to a review of 1,807 patients, there is no direct evidence from randomized clinical trials that palliative sedation, when appropriately indicated and correctly used to relieve unbearable suffering, has detrimental effect on the survival of patients with terminal cancer, and can be considered as part of a continuum of palliative care.[3] A more cynical viewpoint should also be considered, however, for the integration of different perspectives, possibilities, and predictions that allow for a comprehensive overview of palliative sedation. One possibility, a prospect unfortunately commonly considered in healthcare, is that palliative sedation can lead to death prematurely. This is where the clinician's knowledge comes into play, particularly their expertise in the field of neuroscience and the operational definitions of consciousness. Various medications used in palliative care may influence the brain's neurochemistry, impacting consciousness and contributing to the relief of suffering. For instance, benzodiazepines such as midazolam and lorazepam, commonly employed in palliative sedation, act as central nervous system depressants. They enhance the inhibitory effects of the neurotransmitter gamma-aminobutyric acid (GABA), leading to sedation, anxiolysis, and amnesia.[4] The neurological effects of these medications involve modulation of neurotransmitter activity, resulting in a calming effect on the brain. Midazolam, in particular, has a rapid onset of action and a short duration, making it suitable for managing acute distress in terminally ill patients.[5] As these medications induce sedation, they may contribute to the lowering of consciousness levels, while also relieving chronic suffering. Ultimately, it is up to the clinician to use their expertise to not only weigh the possible outcomes of the medications, but to also clearly communicate the potential consequences to the patients in a thoughtful manner.

The doctrine of double effect (DDE) may also help to ameliorate the ethical conundrum of whether practicing palliative sedation is ethically justifiable. In the context of palliative sedation, the application of the doctrine of double effect becomes particularly salient. According to the criteria set by the DDE, the action of administering sedative medications, such as morphine, is deemed morally permissible if certain conditions are met.[6] Firstly, the action itself, providing relief from severe and refractory symptoms through sedation, is not inherently bad—it is morally neutral or, in some cases, considered good due to its intent to alleviate suffering. The primary intention must be the relief of suffering, with the secondary and potentially adverse effect of unconsciousness or hastening death not being the desired outcome but rather an unintended consequence. The DDE thus allows healthcare professionals to navigate the ethical intricacies of palliative sedation by placing a strong emphasis on the intention behind the action. In cases where consciousness is significantly diminished, as is often the case with palliative sedation, the doctrine provides a framework for evaluating the ethical justifiability of the intervention. The principle that the good effect (relief from suffering) must outweigh the potentially adverse effect (unconsciousness or hastening death) ensures a careful and considered approach to decision-making.

The deliberation to use palliative sedation can be framed in the area of the ethics of neuroscience, as the choice to go through with palliative sedation involves the use of clinical decision-making, neuroscience, and ethical considerations related to consciousness.[7] The scientific diagnoses and definitions on how consciousness is perceived and how medications affect consciousness highlights a neuroscientific aspect; the optimal clinical decision-making process involves contemplating this variable value of consciousness. This brings in the ethical dimension, as clinicians must navigate the complexities of respecting individual perspectives and values related to consciousness, which can be influenced by neuroscientific factors such as cognitive functioning, brain health, and subjective experiences.

CONCLUSION

In summary, the ethical considerations surrounding palliative sedation compel clinicians to navigate the nuances of moral responsibility, patient advocacy, and clinical judgment. In the absence of clear legal guidelines, clinicians bear the weight of deciding the appropriateness of palliative sedation, influencing both individual patient experiences and broader palliative care practices. The doctrine of double effect provides a valuable ethical framework, emphasizing intentionality and the delicate balance between relieving suffering and unintended consequences. Ultimately, a patient-centered approach is essential to make the best decisions possible while upholding the principles of beneficence and non-maleficence, ensuring that end-of-life care aligns with the values of each individual patient.

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