Correspondence

SEDATION FOR THE IMMINENTLY DYING: SURVEY RESULTS FROM THE AAN ETHICS SECTION

To the Editor: The variability of terms describing different sedation practices in end-of-life care poses major ethical and legal challenges in US medical practice. Russell et al.[1] used the term sedation for the imminently dying (SFTID) in a survey of neurologists to determine its acceptability as an end-of-life intervention.

Although continuous deep sedation (CDS) until death is a more accurate descriptor of this intervention than SFTID, the authors do not use this term in their survey. Pharmacologic agents are administered including sedative drugs, opioids, and general anesthesia, and their dosage titrated to induce and maintain a state of deep coma until death.[2] The metabolic and cardiopulmonary complications from dehydration and medication effects can accelerate the dying process and become the proximate cause of death rather than the underlying illness.

CDS may control physical symptoms or subjective symptoms such as psychosocial and existential distress. Some patients, families, and physicians view that consciousness in the final stages of a debilitating disease or terminal illness is also a form of suffering. We have argued that CDS intended to relieve this type of suffering conflicts with the principle of double effect and should be considered as physician-assisted death.[2] Methodologic differences for the types of medication (thiopental vs potassium chloride) or the time to death (hours vs minutes) do not distinguish CDS from other types of physician-assisted death.[3]

Ambiguous terms about end-of-life practices should be avoided in clinical surveys. Scientific accuracy of descriptors is vital when assessing the ethical and legal permissibility of a specific end-of-life intervention. Physicians' labeling of end-of-life interventions as either physician-assisted death or palliation is not uniform in similar cases.[4] Differences in the labeling of similar acts impede societal control even where physician-assisted death has been legalized.

Considering that patient suffering is subjective, and physicians' intentions are private, the ethical and legal appropriateness of end-of-life interventions is ultimately determined by specific physician standards of personal and professional integrity.

Mohamed Y. Rady, Joseph L. Verheijde, Phoenix, AZ

Disclosure: The authors report no disclosures.

Reply from the Authors: We appreciate Drs. Rady and Verheijd's attention and response to our article. Recognizing the multiple synonyms for SFTID, we purposely avoided the term continuous sedation until death because this would preclude the provision of sedation on an intermittent or interrupted basis, which is a recognized and potentially valuable delivery method that allows for proportional administration of sedation until there is external evidence that patient distress is alleviated.

SFTID should be ideally performed with drugs where the primary action is to sedate (i.e., midazolam). Avoiding drugs such as opioids, with the potential for both unwanted side effects and ambiguous motive, is prudent. As we referenced, there is no evidence to support Rady and Verheijde's contention that monitored and titrated sedation accelerates death. Although SFTID is often accompanied by a patient or surrogate decision to withhold nutrition and hydration, the physiologic consequences of this action, which falls within the boundaries of the patient's autonomy, is independent of the provision of sedation itself.

We also do not believe that SFTID represents disguised suicide. As we suggested, it is not necessary to invoke the doctrine of double effect to defend SFTID if performed in a titrated, monitored, and transparent manner to patients during the last days of their lives. There is no reason to believe or evidence to support that anything other than the underlying disease is the cause of death in patients treated in this manner.

In addition, we disagree that "the ethical and legal appropriateness of end-of-life interventions is ultimately determined by specific physician standards of personal and professional integrity." The ethical and legal appropriateness of end-of-life interventions is clearly guided by the law in all jurisdictions, as well as ethical standards promulgated by medical professional societies, including the American Academy of Neurology.[5]

We agree that patient suffering and physician intent do not lend themselves to metric analysis. For this reason, we support the Dutch guidelines that serve to protect the interests of both the public and individual patient by ensuring that refractory suffering can be addressed by a mechanism that is transparent, measurable, and both morally and methodologically distinct from assisted suicide.[6]

James A. Russell, Burlington, MA; Michael A. Williams, Baltimore, MD

Disclosure: See original article for full disclosure list.

1. Russell JA, Williams MA, Drogan O. Sedation for the imminently dying: survey results from the AAN Ethics Section. Neurology 2010;74:1303–1309.
2. Rady MY, Verheijde JL. Continuous deep sedation until death: palliation or physician-assisted death? Am J Hosp Palliat Care 2010;27:205–214.
3. Syme R. Necessity to palliate pain and suffering as a defence to medical homicide. J Law Med 2009;17:439–451.
4. Buiting HM, van der Heide A, Onwuteaka-Philipsen BD, et al. Physicians' labelling of end-of-life practices: a hypothetical case study. J Med Ethics 2010;36:24–29.
5. The American Academy of Neurology Code of Professional Conduct. Neurology 1993;43:1257.
6. Royal Dutch Medical Association (KNMG). Guideline for Palliative Sedation 2009. English document available at: http://knmg.artsennet.nl/dossiers/Dossiers-opthema/levenseinde/euthanasieenpalliatievesedatie.htm via the link titled "Guideline for Palliative Sedation" under subheading "Publicaties KNMG." Accessed September 28, 2009.

CORRECTION

What does the pedunculopontine nucleus do?

In the editorial "What does the pedunculopontine nucleus do?" by Joseph Classen and Alfons Schnitzler (*Neurology*® 2010;75:944–945), there is an error on page 1. In column 2, the second and third sentences ("When Tsang and coworkers . . . only in the medication ON state.") were inadvertently duplicated (they appear correctly in the next paragraph). Those sentences should be replaced with the following sentence: "Tsang and coworkers[1] managed to record LFPs not only when patients performed movements or rested, but, in several patients, also in medication ON and OFF states." The Editorial Office regrets the error.