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Commentaries

Hastening death due to administration of sedatives and opioids after withdrawal of life-sustaining measures: even in the absence of discomfort?

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In a previous issue of the Journal, the Belgian Society of Intensive care Medicine publishes a statement concerning “end-of-life” care in the intensive care [1]. They describe three principles. First, suffering should be avoided at all times. In addition they add an important statement to this first principle: A treatment considered to be without any meaningful perspective by the intensive care team will no longer bring benefit to the patient and might in addition even cause harm to the patient. Second, with the availability of modern organ support, most deaths in the intensive care unit (ICU) are preceded by a withhold/withdraw decision. And third, relatives should be informed of prognosis and end-of-life decisions at all times. We fully agree with these three generally well-accepted principles.

Furthermore they propose 10 general complementary principles that they believe should be adopted. Notably, the authors see no clear ethical distinction between withholding/withdrawing supportive therapy of vital systems and increasing the dose of sedatives and/or opioids in patients in whom further treatment is no longer considered beneficial (complementary principle 2). They also state that “shortening of the dying process with use of medication, *such as sedatives and opioids may sometimes be appropriate, even in the absence of discomfort*” (complementary principle 6) arguing that actions *like these* can actually improve the quality of dying and also can help relatives accompany their dying relative through the dying process (complementary principle 6). These actions should be regarded as *not intended to end the life* of the patient, but as a humane act to support the patient at the end of his/her life (complementary principle 9). The proposed principles apply to pediatric and adult patients (complementary principle 10) (*italics from us*).

Although the intention of these principles may be morally right-supporting dying patients and their loved ones and limiting and shortening suffering of a dying process, there is nevertheless a clear ethical dilemma in this. Is there a moral distinction between allowing a patient to die after withdrawal of life-sustaining measures and the deliberate termination of life? Is there a difference between allowing a patient to die following withdrawal of a life-support system on the one hand and shortening the dying process by increasing analog-sedation in a comfortable dying patient on life-support on the other hand? Does it make a difference when the doctor does not have the intention to kill the patient in this process?

Many doctors hold the conviction that a ventilator-dependent patient is allowed to die after withdrawal of mechanical ventilation when further treatment is no longer appropriate. In this case the underlying condition of the patient or the organ failure causes the death of the patient. However, others regard the withdrawal of the ventilator or the vasopression as the immediate cause of death. Although the latter is emphasized by the fact that most of these patients die within 30 minutes following withdrawal [2], there is a moral obligation to anticipate on distressing symptoms for comfort during the dying process, but there is no moral obligation to hasten it [3]. Some patients, in whom mechanical ventilation is withdrawn, usually patients with catastrophic cerebral damage but with intact respiratory drive, will remain stable for hours or days. It is our moral obligation to anticipate on and treat distressing symptoms, not to deliberately end their lives. With adequate anticipation on death rattle, stridor, and dyspnea-associated distress, these patients can be extubated and kept comfortable easily till their death [3].

What is our intention when we decide to withdraw life-sustaining measures? Bosshard et al [4] reported that 66% of 3795 European physicians stated that they had the explicit *intention* of hastening death in cases in which they withdrew mechanical ventilation.

In fact, withdrawal of mechanical ventilation in a ventilator-dependent patient is both causing death and allowing dying combined. Common sense notion of causation imply an equally causal role for doing and allowing in such a case.

Those who state that this is not the case defend a moral fiction [5]. If removing the ventilator causes the death of the patient, which is in most cases immediately [2], it is mistaken to suggest there is a moral difference between this action and deliberate termination of life by the administration of lethal medication, just on the basis that the withdrawal is seen as allowing and the administration of lethal medication as doing [6]. Both actions end suffering and incurable illness in a patient by the death of this patient. Death is the intended consequence of the action. There is no intensivist nor intensive care nurse who will be surprised that the patient dies within minutes after withdrawal of life-sustaining measures.

When the intended consequence of withdrawal of mechanical ventilation in a ventilator-dependent patient with multiple organ failure is death within minutes, why is the administration of high-dose sedatives and opioids a problem? With or without the administration of high-dose sedatives and/or opioids, the patient dies shortly. We do not think that the problem with the statement lies

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in the administration of high-dose sedatives and/or opioids, but in the fact that it is recommended by the authors to administer them “*even in the absence of discomfort*”. The action is then intended as deliberate termination of life without the consent of the patient. This is illegal, even in Belgium. Intensivists should follow the statements in the law regarding deliberate termination of life (euthanasia), and this is for good reason. In this light we do not see the rationale of this complementary principle. Why should we do an intervention that is against the law? Furthermore, there is no need to do this. In most cases the patient is not suffering, he/she is in the dying-process and will die within a short time period. We see no rationale to shorten this, in most cases, already short dying process in the absence of suffering.

The authors (complementary principle 8) state that an individual's dignity must always remain a priority. In this context we see prolongation of disproportionate use of ICU resources (eg, in patients without any prospect of survival outside the ICU) as violation of an individual's dignity.

Deliberate termination of life without request of the patient is forbidden in both the Netherlands and Belgium. When such a case would come to court, judges could only see this as a criminal deviation of good clinical practice in palliative care [7]. Another troublesome part in the sixth principle is the addition “*such as*”. The authors mention analgesics and sedatives, but what other kinds of medication would be applicable? There is an ongoing discussion if neuromuscular blockers have a place in palliative care, especially in pediatric end-of-life care [8,9]. We think administration of neuromuscular blockers will also be judged as deliberate termination of life without request of the patient as they end life immediately by causing paralysis. They only have a place in voluntary euthanasia. Administration of neuromuscular blockers is defended as means to relieve the suffering of parents in case their dying newborn lies gasping in their arms [10]. This forms a troublesome part of the whole discussion on end-of-life care in pediatrics and neonatology. The Dutch Groningen protocol of deliberate termination of life in newborns has given rise to heated debates in the international medical, ethical and societal communities. In this line, causing general paralysis with neuromuscular blockers as part of “normal” palliative care will not easily be accepted.

In conclusion, we think the authors provide us a practical statement with workable principles, with the exception of the sixth complementary principle in which they state that it is appropriate to administer sedatives and opioids (and other medication?) in the

absence of discomfort of the patient. With this principle the authors shoot themselves in the foot and could hurt the feelings of many colleagues in other European countries. With such a principle they will maneuver themselves in the same position as the authors of the Groningen protocol of deliberate termination of life of severely handicapped newborns [11]. Moreover they motivate colleagues to deliberately disobey the law, with the risk of lawsuit and subsequent conviction. And that is outside the commonly well-accepted principles of the highly sensitive position of end-of-life care in which society has an important judgmental voice.

Physicians and nurses have the moral obligation to relieve suffering, but they do not have the moral obligation to do so by shortening life. They should have the knowledge to anticipate on distressing symptoms that could occur after withdrawal of life-sustaining measures. In this perspective high-dose sedatives and opioids are only indicated in end-of-life care in acute situations as pulmonary hemorrhage or choking. Increasing the doses of analogo-sedation to shorten the dying process, especially when the patient is already comfortable, should not have a place in end-of-life care on the ICU.

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