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Palliative sedation in the context of COVID-19: Expert opinions from the Palliative Sedation project

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In an earlier post on the EAPC blog, we heard about a European-funded Horizon2020 Research Project, Palliative Sedation, which is investigating clinical and ethical aspects of providing palliative sedation to dying patients across Europe.

*Now, writing on behalf of the Palliative Sedation Consortium, **Dr Jeroen Hasselaar**, (Project Coordinator), **Prof Dr K Vissers** (Netherlands), **Prof Dr S Mercadante** (Italy), **Prof Dr C Centeno** (Spain), **Prof S Payne** (UK), **Prof N Preston** (UK), **Prof Dr L Radbruch** (Germany), **M van der Lee, MSc** (Netherlands), **Dr A Csikós**, (Hungary) and **Prof Dr J Menten** (Belgium), explain more in the context of COVID-19.*

Top row, clockwise: Kriss Vissers, Jeroen Hasselaar, Johan Menten, Sebastiano Mercadante, Maaikevan der Lee, Carlos Centeno, Ágnes Csikós, Lukas Radbruch, Sheila Payne and Nancy Preston.

COVID-19 is spreading globally, with Europe particularly hard hit. Many hospitals are overcrowded with acutely ill patients with severe respiratory needs, and rapidly worsening symptoms that may result in a distressing death. A pandemic like this is unprecedented in modern times and healthcare systems are extremely stretched and challenged. In these circumstances, the need for palliative care increases dramatically but lack of staff, time, and the rapid disease progress, make this a difficult job. We are aware that for some patients there will be a clinical need for palliative sedation to relieve severe refractory symptoms. In this blog, we try to capture some current developments and challenges and offer initial advice on this difficult topic based on expert opinion of collaborating partners in a European research project on palliative sedation.

Definition of palliative sedation

The European Association for Palliative Care (EAPC) Framework defines palliative sedation as 'the monitored use of medications intended to induce a state of decreased or absent awareness (unconsciousness) in order to relieve the burden of otherwise intractable suffering in a manner that is ethically acceptable to the patient, family and health-care providers'. However, this Framework was

developed largely in the context of palliative sedation for advanced cancer patients and other non-communicable diseases.

Refractory suffering during COVID-19

In COVID-19, the overall clinical picture is that an overwhelming number of patients suffer from extreme dyspnea. When patients manifest dyspnea and anxiety during the aggravation of the process of the pulmonary infection, opioids will be effective for symptom relief in most patients. In case of severe tachypnea, morphine is the drug of choice. Patients with progressive disease may require mechanical ventilation in the intensive care unit (ICU); however, bad prognosis in patients with comorbidities such as cancer or heart or lung failure may prevent these escalations. Some patients eventually recover but, for others, dying trajectories can be very short and intensely distressing. Such patients often suffer in isolation since family members are not allowed to visit and dying rituals are limited. The main symptom qualifying for palliative sedation in this context is mostly refractory dyspnea, combined with severe anxiety. Also, refractory delirium has been reported. The process of palliative sedation, however, is potentially different from a cancer care context in which most of our current evidence is built in three main ways: decision-making, medication options, and care for families.

Decision-making process

If patients are not responsive to supportive therapy and the clinical picture worsens, at some point palliative sedation may be considered as a last resort to provide comfort. However,the decision-making process for palliative sedation can be severely hampered because advance care planning is difficult in this acute situation that can deteriorate over hours; the family is not allowed to be present; and the stress of numerous demands on staff and resources is all around. Caregivers may need to act out of 'best interest for the patient', rather than by informed (proxy) consent from patient or family in case the latter is not possible.

It is important to distinguish between sedation for COVID-19 in the ICU and outside the ICU. In the ICU, intensivists (critical care physicians) have the knowledge and skills to apply sedation techniques for patients receiving mechanical ventilation, and even for those for whom mechanical ventilation is withdrawn. At the present time, palliative care teams may more likely be involved before patients are intubated in the ICU, for example including assistance for triage and pain and symptom management of COVID patients in the wards. Physicians and nurses who take care of these COVID patients in acute wards may not have received palliative care training and are not used to seeing so many patients deteriorating in a short time, which is very stressful and can add to a heavy care load. They may need daily clinical coaching by experienced caregivers who are used to working in a palliative care context.

Medication and administration

Providing comfort is the aim during palliative sedation. Midazolam is widely recommended as a first-line medication for palliative sedation because it is relatively easy to titrate due to its fast onset of action and short half-life. However, we are aware of situations in hospitals, e.g. in the Netherlands, Spain, Switzerland, and elsewhere,where other demands are exhausting their supply of midazolam. In the Netherlands and in Spain, levomepromazine is recommended as a second-line drug and can be used as an alternative for midazolam. But we are also hearing about the use of diazepam and other benzodiazepines for this purpose. Early experiences are that sedation trajectories are relatively brief and that lower dosages may be sufficient. In case the availability of subcutaneous/intravenous infusion pumps is currently limited, medication can be administered by repeated bolus injections. Availability and use of personal protective equipment (PPE) is pivotal when caregivers need to enter the room.

Regarding family communication

If patients start to die, try to have a licence of exception (if possible), enabling at least a few family members to say goodbye for 15-30 minutes provided they take account of all protection guidelines. In some countries, the family needs to be told that it is not possible to see their loved ones postmortem in case of COVID-19. Once testing for COVID-19 antibodies is available, it may be possible to test family members to check if they have already acquired immunity, and thus they may be allowed to be with the patient without any health hazards.

Options for communication by phone or via WhatsApp, Skype or similar apps will be important, and should be actively encouraged. Palliative care services, including spiritual and psychological support, should be aware of the technical support needed for such communication channels. Family members who cannot be with their dying loved ones need compassionate support through this period, probably by phone or videocalls.

Final remarks

It is important to share and spread knowledge about palliative care to support care for dying patients with COVID-19. Although we realize that palliative sedation can be a sensitive topic, and should remain an option of last resort, we thought it might be helpful to collect and share some expert-based opinions. We don't claim these are fully comprehensive, but given the acute situation that many colleagues are experiencing we hope they may be helpful.

Acknowledgement
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Links

- Contact Jeroen Hasselaar by email.
- 'Palliative Sedation' – Project website: https://palliativesedation.eu/
- **Coronavirus and the palliative care response**: EAPC web page to source and share information, which is regularly updated. Links to publications and resources including national guidelines, training courses, videos and scientific journal collections. Please email us if you have new or updated resources to share.
- Latest news will continue to be shared on EAPC Twitter , Facebook and LinkedIn. Join the conversation at **#pallicovid**

Read more posts about palliative sedation and coronavirus on the EAPC blog. Look out for the next post in the 'Coronavirus and Palliative Care' series from the team at ***King's College London, Cicely Saunders Institute****: What's the role of palliative care and hospices in the COVID-19 pandemic? Evidence from a systematic review.*