



Ethical Care: Managing an End-Stage Symptom Control Crisis

Symptom control crisis is morally compelling for the patient, family and health-care team. Effective management requires medication, support for patient and family, and knowledge of symptom control and ethical principles which guide care.

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Mr. L, 54, has renal cell cancer with metastases to the lungs, adrenal glands and bones. He has been increasingly ill in recent weeks. Recurring episodes of dyspnea have required repeated thoracentesis for pleural effusion. The tumour masses in his lungs are seen to be increasing in size with each chest X-ray. He and his family are aware of the situation and goals of care have been established with them. There is an emphasis on physical comfort and quality of life, orders for no cardiopulmonary resuscitation, and a peaceful death when the time comes.

Having experienced several episodes of severe dyspnea, Mr. L and his family have been particularly fearful of a struggle in his final hours. The health-care team reassured them they will provide comfort. Mr. L has arrived at the emergency room in severe respiratory distress.



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Caring for people in symptom crisis

Severe out-of-control intractable pain, suffocation due to airway obstruction, pleural effusion or massive pulmonary embolus and severe agi-

Palliative Care



tated delirium are examples of symptom control crises that can occur in palliative care. These are very challenging situations to assess and manage. Often, physicians and nurses may fear that medication in the doses required to achieve comfort may shorten a patient's life. Such fear may lead to inaction on the part of the physician and team, to the detriment of the patient and the great distress of his/her loved ones.

Urgent management is required. The physician will need to be in active attendance until comfort and a restful state are restored. Families require explanation of the nature of the crisis problem, the steps being taken to alleviate it and the risk of death if such exists. They and the patient also require comforting and on-going support from all team members.

The actual medical management of each patient will be unique to their particular situation.¹ Medications like opioids and sedatives may be required at the same time as assessment is being carried out. Doses of medication required for comfort may vary greatly from patient to patient depending on their physical condition, degree of fragility, stage in their illness, overall goals of care and current medication program.

Medications such as opioids, sedatives and others may need to be repeated and doses increased as required if no positive effect in terms of comfort is obtained. The types and doses of medications given, their observed effect on the distressing symptoms, the physical state of the patient and the ongoing medical assessment and clinical judgments of the physician, should be recorded in the chart notes. Dialogue with nursing and other team colleagues ensures the goals of care and reasons for medications are understood by all.

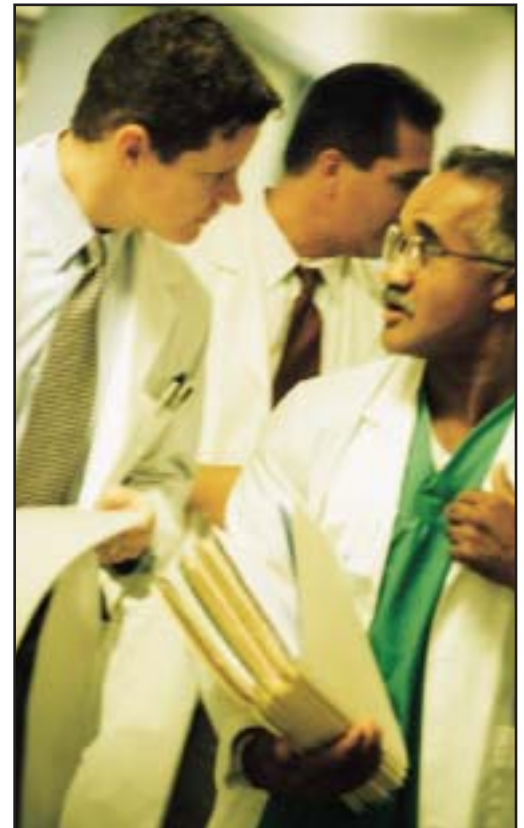
Guiding ethical principles

The biomedical ethical principles of beneficence (doing good, relieving the distressing symptom) and nonmaleficence (doing no harm to the patient) are primary guides to practice. Respect for autonomy is also important in outlining the approach to care, goals of care, patient wishes and family understanding.

The meta-ethical principle of double effect, with beneficence and nonmaleficence, will assist in delineating the ethical basis of the use of medications in symptom cri-

sis.^{2,3,4} This principle requires there be a morally compelling reason to act (*e.g.*, severe distress of the patient), that failure to attempt to help would be a moral failure, and that the physician does not intend to bring about the death of the patient by his/her actions in treatment.^{2,3,4}

When managing symptom control crisis, the physician does not intend to hasten the death of the patient.² Rather, he/she will be working towards the relief of distress through medications and such procedures that may help (*e.g.*, thoracentesis for effusion). However, it must be recognized that, during the management of symptoms resulting from a crisis problem, death may occur because of the life-threatening pathological process that has developed. The treatment of dyspnea secondary to extensive tumour mass, or a large pulmonary embolus in a fragile palliative care patient, are examples of such situations.



Anticipating a crisis

If the possibility of a symptom control crisis can be anticipated, for example, in the patient with tumour pressure and airway obstruction from head and neck malignancy or the patient at risk for respiratory crisis from endstage heart failure, emergency symptom control orders should be left on the chart. Orders should include specific detailed instructions about the purpose of the medications and how to use them in a crisis situation. This will alleviate suffering until the physician can attend the patient, which should occur as soon as possible.



Sedation may be necessary

In certain intractable situations, the most compassionate approach to care may require the patient be sedated until death occurs from the underlying disease process. Severe endstage dyspnea, agitated endstage delirium and intractable pain are three problems which may necessitate sedation when all other methods of

symptom control have proven to be ineffective.^{1,2} The family (and patients themselves, if they are able) should be a part of decision-making about this approach to compassionate care. Because the burden of such decisions can be stressful, the physician and health-care team may wish to review the approach to managing the patient with a colleague or a clinical ethics committee. The doses of medication required for peaceful rest should be utilized. Attempts to reduce medication from time to time may be warranted, but only if they do not result in patient distress and agitation or the return of the symptom for which the sedation is required.

Caring for Mr. L

Mr. L is given morphine sulphate 2 mg intravenously in the emergency room and this is repeated after 30 minutes. His breathing eases somewhat. Chest X-ray reveals lung fields obscured almost completely with tumour. There are small pockets of loculated fluid which are not amenable to thoracentesis. The situation is explained to him and his family. The goals of care for comfort are reconfirmed.

The medication plan includes dexamethasone 4 mg intravenously at once, and four times daily thereafter to try to reduce tumour pressure; intravenous furosemide to reduce fluid in the lungs; and regular doses of morphine sulphate 2 mg subcutaneously via butterfly every four hours with 1 mg to 2 mg every 30 minutes if needed. Over the next one to two hours, he seems to require frequent “as needed” doses of morphine and is still quite dyspneic and frightened. The regular morphine dose is raised to 5 mg every four hours. Midazolam is added to the plan: 1 mg by subcutaneous butterfly at once, then every eight hours regularly, and 1 mg every hour if needed to relieve fearfulness, distress or agitation. With these changes, although he remains somewhat tachypneic, his breathing is no longer laboured. He rests comfortably, lying down in a light sleep, and is able to speak a bit with his family who remain at his side. He passes away peacefully the following morning. **Dx**

References

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