Neuromuscular blockers—a means of palliation?

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As we die, our respiratory pattern is altered and we seem to gasp and struggle for each breath. Such gasping is commonly seen as a clear sign of dyspnoea and suffering by families and loved ones, however, it is unclear whether it is perceived at all by the dying person. Narcotics and sedatives do not seem to affect these gasping respirations. In this issue of the Journal of Medical Ethics, we are asked to consider whether the last gasp of a dying patient could be or, perhaps, even should be avoided by administering neuromuscular blockers to palliate dying patients. For many reasons, such as our current failure to alleviate pain and distress, stories of inadequate analgesia and sedation in critically ill paralysed patients and the inability to know the intent—whether to palliate or to euthanise—it would seem that administering neuromuscular blockers should not be ethically permissible.

In this issue of the journal, Perkin and Resnik propose another perspective, not previously elucidated: that the intent of the physician administering neuromuscular blockers is not to kill but to palliate. They argue that since we are not sure how much a dying patient actually perceives, and since large doses of analgesics and sedatives do not alleviate gasping, the physician should use neuromuscular blockers to paralyse respiratory muscles and alleviate dyspnoea—once appropriate doses of narcotics/benzodiazepines have been given. This is indeed an interesting viewpoint. Before consideration is given to using neuromuscular blockers, one must first ask what is an appropriate amount of analgesics and sedatives. Research has revealed that the management of pain and suffering at the end of life is not well taught and sources of distress are too often not alleviated. Health care providers’ perceptions of what constitutes an appropriate amount of analgesia vary widely for a given situation. Such perceptions of adequate amounts of drug can indeed be questioned by ICU survivors, who describe severe pain while their caregivers felt adequate pain relief had...
been achieved. We seem to have strayed so far from the teaching: “a patient’s pain is what he/she says it is”, that one could ask the question whether we as health care providers truly have any idea how much pain and discomfort our patients tolerate.

Gasing respirations, while upsetting to the family and health care team, are perhaps akin to other alterations in respiratory pattern seen after strokes—for example, Cheyne Stokes respirations, which, while they might signify neurological injury or altered physiology are not necessarily perceived as dyspnoea by the patient. Such respiratory patterns—when the result of neurological injury—are not treated as signs of dyspnoea by health care providers, yet such patterns look equally uncomfortable. Moreover, if a patient is paralysed to prevent gasing and we are uncertain how much they perceive, how do we know that we have not worsened their suffering since they may then be aware of their inability to breathe or move despite still having a desire and a drive to do so? After reading the chilling stories of ICU survivors who recall what it was like to be awake and paralysed, are we willing to take this chance with even one dying person?

It is a certainty which we cannot prevent or avoid no matter what action is taken or not taken, moral harms cannot be avoided. Since much of their article supporting the use of neuromuscular blockers to palliate dyspnoea hinges on the principle of double effect, it is worth exploring this principle in more detail. The principle of double effect arises from Catholic deontological theory in which some acts, either of commission or omission, are absolutely forbidden.7–9 However, situations in which it is impossible to avoid all moral harms arise.7–12 The principle of double effect was developed to set limits on such absolutism in situations in which no matter what action is taken or not taken, moral harms cannot be avoided.9–12

In these circumstances, acts—for example, administering analgesics, and through them causing a state of affairs—for example, death, ordinarily prohibited, can be ethically accepted, since both are voluntarily brought about, and perhaps even just.7–12

The principle of double effect is used to permit the administration of analgesics and sedatives in order to alleviate the dying patient’s distress even though such administration could foreseeably hasten his/her death.10–12 While the current literature would seem to refute that such hastening actually occurs,13,14 arguably, the administration of narcotics and sedatives may shorten time to death. Recently, the principle of double effect was given legal sanction in an United States Supreme Court decision prohibiting physician assisted suicide: if the intent in administering analgesics and sedatives is clearly to palliate, physicians do not need to fear being charged with murder or assisting suicide.11,12

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Intents are different from motives—motives can be thought of as “ulterior” intents—for example, in euthanasia, the motive is compassion. While they are less important from a legal point of view, in ethics, motives are as important as intentions since our motives also reveal our true character and determine virtue.12 While what one intends, one generally acts to bring about,16–18 we do not always act on an intention (in Perkin and Resnik’s article this would be referred to as a “want”) and particular acts are not always clear indications of intent.19–21

What is often misunderstood is that the principle of double effect does draw a distinction between what is intended and what is only foreseen.7–12 While the principle does hold us morally responsible for both what we intend and for what we only foresee,7–12 since both are voluntarily brought about, it makes a distinction based on the fact that one does not act for the sake of what is foreseen—in other words, one does not administer analgesics to cause death.20 Moreover, some question whether bringing about these “side effects” (hastening death) is fully voluntary: do the “side effects” instead represent important considerations in spite of which one acts?7–12 So, if one accepts that neuromuscular blockers are the only way of palliating dyspnoea and the intent is not to cause death, using the principle of double effect to justify the foreseeable hastening of death would seem to hold merit. To the extent that it is impossible to know what someone intends versus what he/she only foresees, however, the border between palliative care and euthanasia, may never be completely clear.7–12 The intent of a health care provider who administers neuromuscular blocking agents to eliminate gasing respirations is easily questioned in today’s world, since the health care provider is a member of a profession which seems to have devalued, and perhaps even lost, virtue.20 Even if it is accepted that gasing respirations are a source of distress for the dying, and that neuromuscular blockers are needed to alleviate this distress, how can we distinguish the physician who uses neuromuscular blockers to palliate from the one who uses them to cause death? Or to use Perkin and Resnik’s example: how can we know that smothering the dying patient is different from paralysing him? Their notion of assessing regret and remedy would be difficult to apply since neuromuscular blockers and the resulting inability to breathe will cause death with absolute certainty.

In Perkin and Resnik’s two case descriptions, the family recall as a last terrible memory the gasing of their dying children. No one among us should be unmoved by the families’ recollections. However, questions remain: were the families prepared for what was going to happen? Did the intensivists explain how the breathing pattern of their children would change as the ventilator was withdrawn—how pain and any signs of distress would be treated? Health care providers are very ill-prepared to facilitate decision making at the end of life, never mind to communicate about death and dying. Such open discussions of what to expect during the dying process rarely occur and families and loved ones are left unsure and frightened about what they will see happen to their loved one at a time of overwhelming grief. Gentle explanation of how
life-sustaining treatments will be withdrawn, what they will see, how they can help alleviate distress, and how they can be with their loved one during his/her last few moments is needed to help ease their suffering. Families should be encouraged to ask questions and express their fears. The families described by Perkin and Resnik are haunted from watching the gasping of their dying children. The death of a loved one is devastating and our last memories, perhaps especially if we are present while a loved one dies, are always painful. We need to ask ourselves whether, if we prevent or eliminate gasping respirations—even if we accept that this is being done with the intent to palliate—we would not be equally haunted by images of the syringe being inserted? Would these painful images of the last moments sear our minds, as memories of our own anguish and suffering over the loss of someone precious always do?

Perkin and Resnik have given us a new perspective to ponder as we seek to improve the quality of end of life care. Can we accept that neuromuscular blockers are needed to palliate gasping respirations? We do not know that such gasps are perceived as uncomfortable by dying patients and, for many reasons, it would seem that administering neuromuscular blockers should not be ethically permissible.

REFERENCES

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