ÉTICA EN CUIDADOS PALIATIVOS

SEDACIÓN TERMINAL
Y OTRAS FORMAS DE MUERTE ASISTIDA

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(MENUDA CHORRADA...
...ESO NO PUEDE FUNCIONAR BIEN NUNCA)

Juicios

Clínicos

Razonados

Razonables

Probables

Experienciales

Prudentes

Responsables

Éticos

Razonados

Razonables

Probables

Experienciales

Prudentes

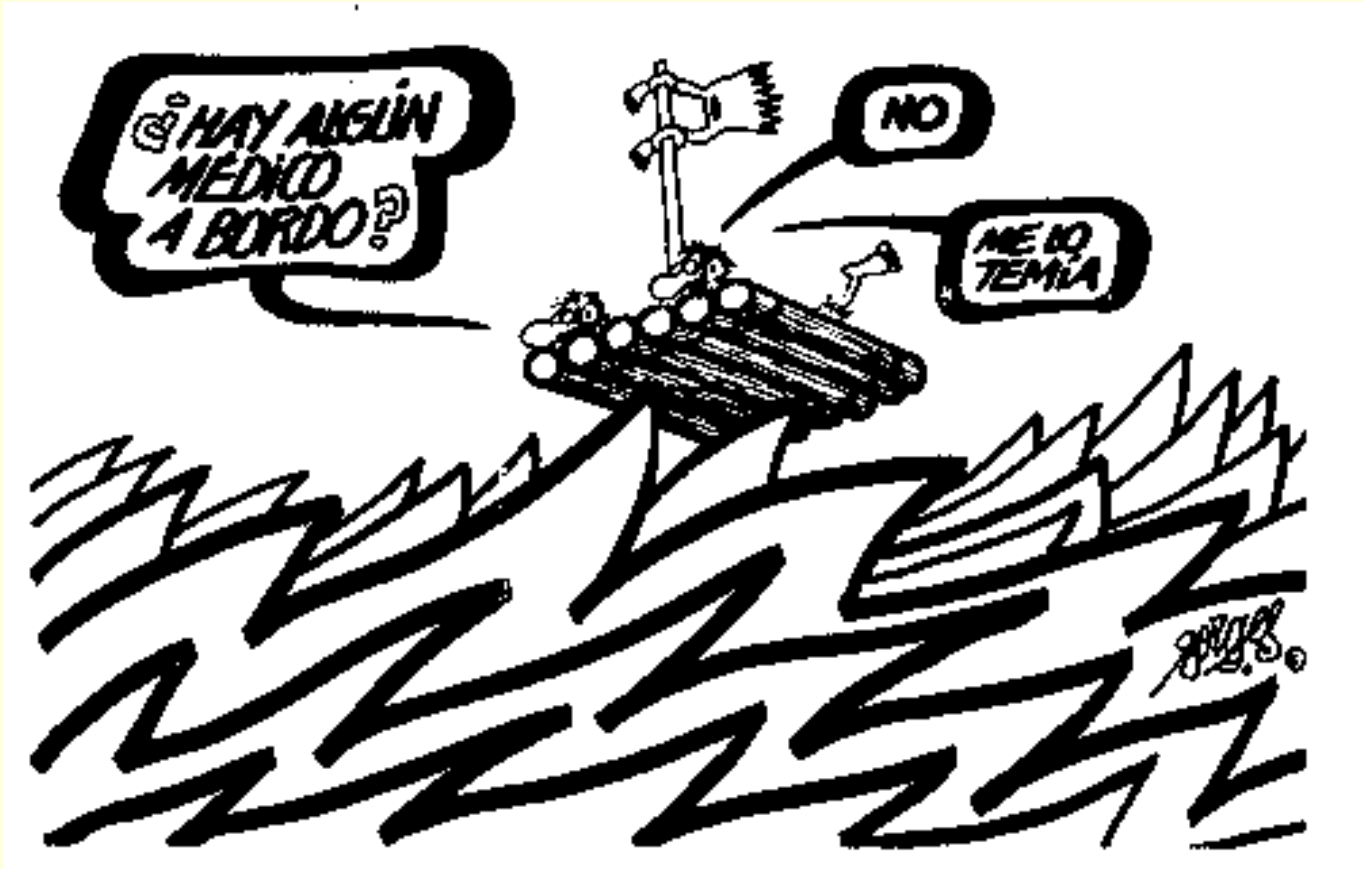
Responsables

El final de la vida

- **Decisiones difíciles**
  - **Emocionalmente**
  - **Intelectualmente**

- **Basadas en la incertidumbre**

Conceptos claros


¿HAY ALGÚN MÉDICO A BORDO?
NO
ME LO TEMÍA

Enfermedad terminal

- **Enfermedad avanzada en fase evolutiva e irreversible, que afecta a la autonomía y a la calidad de vida (sínt., impacto emocional, pérdida de autonomía), con muy escasa o nula capacidad de respuesta al tratamiento específico y con un pronóstico de vida limitado a meses, en un contexto de fragilidad progresiva.**

Sedación terminal

- Enck RE. Drug-induced terminal sedation for symptom control. *Am J Hosp Palliat Care* 1991;8:3-5
  - Ventafridda. *J Palliat Care* 1990;6:7-11
  - Greene, Davis. *South Med J* 1991;84:332-337
- **No definición consensuada…**
  - Paciente terminal con enf. incurable y avanzada
  - En fase agónica
  - Síntomas agudos o refractarios
  - No responden a tto. convencional
  - Sedación químicamente inducida por no opioide
  - No intención de matar (Pº del doble efecto)
    - Cowan, Walsh. *Support Care Cancer* 2001;9:403-407

Principio de doble efecto

Abandonarlo

- Una acción con dos o más efectos posibles, incluyendo al menos uno bueno y otros malos, es moralmente permisible si cumple todas estas condiciones sin excepción:
  - La acción no es en sí misma inmoral
  - La intención busca el efecto bueno
  - No se consigue el efecto bueno a través del mal
  - La acción cumple la regla de la proporcionalidad
  - Las consec. positivas pesan más que las negativas

Sedación terminal

- **Control de síntomas**
- **Pacientes viven > 1 día**
  - Ramani, Karnad. *South Med J* 1996;89:1101-1103
  - Fainsinger, Miller, Bruera, et al. *J Palliat Care* 1991;7:5-11
  - Ventafridda, Ripamonti, et al. *J Palliat Care* 1990;6:7-11

Es posible controlar los síntomas

sin causar muerte prematura.

Sedación terminal

1. **Paliativa:**
   - **Administración de fármacos a un paciente en situación terminal en las dosis y combinaciones requeridas para reducir su conciencia todo lo que sea preciso para aliviar adecuadamente uno o más síntomas refractarios que le causan sufrimiento, contando para ello con su consentimiento informado y expreso o, si esto no es factible, con el de su familia o representante.**

2. **Terminal:**
   - **Muerte próxima (agonía)**

Sedación terminal

- **Requisitos:**
  1. **Profesionales expertos, tras deliberación.**
     1. **Indicaciones clínicas**
     2. **Prescripciones técnicas**
  2. **Consentimiento informado expreso.**
     1. ¿Quién?
     2. ¿Cuándo?
        1. Rol del médico
        2. Voluntades anticipadas

Eutanasia

- **Actuación que:**
  - **produce directamente la muerte del paciente**
    - **relación causa-efecto única e inmediata**
  - **a petición expresa, reiterada, e informada del pacte.**
  - **en un contexto de sufrimiento o de “dolor total”, debido a una enfermedad incurable**
    - **que el paciente experimenta como inaceptable y**
    - **que no ha podido ser mitigado por otros medios, y**
  - **es realizada por un PS que le conoce y mantiene con él una relación clínica significativa.**

Suicidio asistido

- **Cuando, en este contexto, la actuación del profesional se limita a proporcionar al paciente los medios imprescindibles para que sea él mismo quien se produzca la muerte.**

Terminal Sedation and Euthanasia

A Comparison of Clinical Practices

Judith A. C. Rietjens, PhD; Johannes J. M. van Delden, MD, PhD; Agnes van der Heide, MD, PhD; Astrid M. Vrakking, MSc; Bregje D. Onwuteaka-Philipsen, PhD; Paul J. van der Maas, MD, PhD; Gerrit van der Wal, MD, PhD

Arch Intern Med. 2006;166:749-753

Table 1. Characteristics of Patients Who Received Euthanasia or Terminal Sedation*

Characteristic	Terminal Sedation (n = 211)	Euthanasia (n = 123)	*P* Value†
Age, mean (SD), y	72.0 (14.0)	62.5 (14.2)	<.001
Sex			
Men	99 (47)	69 (56)	.11
Women	112 (53)	54 (44)	
Main diagnosis			
Cancer	113 (54)	108 (88)	<.001
Cardiovascular diseases	51 (24)	5 (4)	
Other	47 (23)	10 (8)	
Specialty‡			
General practitioner	53 (25)	68 (55)	<.001
Nursing home physician§	55 (26)		
Clinical specialist	103 (49)	55 (45)	
Decision‖			
Discussed with patient	128 (61)	123 (100)	<.001
Requested by patient	72 (34)	123 (100)	<.001
Discussed with relatives¶	196 (93)		

Table 2. Symptoms and Availability of Other Treatment Options at the Time of the Decision-Making Process*

Symptom†	Terminal Sedation (n = 211)	Euthanasia (n = 123)	*P* Value‡
Pain	120 (57)	63 (51)	.29
Dyspnea	90 (43)	40 (33)	.06
Coughing	53 (25)	29 (24)	.82
Nausea	49 (23)	46 (38)	.005
Vomiting	22 (10)	27 (22)	.004
Constipation	37 (18)	22 (18)	.90
Bedsores	29 (14)	4 (3)	.002
Not active	185 (88)	91 (74)	.001
Felt very ill	181 (88)	107 (87)	.82
No appetite	176 (85)	88 (72)	.003
Fatigue	150 (71)	99 (80)	.07
Unclear consciousness	59 (28)	0	<.001
Anxiety	78 (37)	20 (16)	<.001
Confusion	51 (24)	2 (2)	<.001
Depression	36 (17)	12 (10)	.06
Absence of other treatment options§	182 (86)	95 (77)	.04

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Arch Intern Med. 2006;166:749-753

Table 3. Most Important Reasons* for Patients' Requests for Euthanasia or Terminal Sedation, According to Physicians

Reason	Terminal Sedation Patients Involved in Decision-Making Process (n = 72)	Euthanasia (n = 123)	*P* Value†
Suffering without improving	41 (60)	101 (82)	.001
Loss of dignity	12 (18)	77 (63)	<.001
Weakness and fatigue	26 (36)	53 (43)	.76
Meaningless suffering	21 (31)	46 (37)	.27
Pain	39 (57)	44 (36)	.005
Dependency	4 (6)	41 (33)	<.001
Fear of suffocating	17 (25)	30 (24)	.88
Did not want to bother relatives	6 (9)	19 (15)	.16
Sense of immobility	5 (7)	22 (18)	.04
Vomiting	10 (15)	13 (11)	.45
Being tired of living	8 (12)	7 (6)	.16
Depression	1 (1)	1 (1)	>.99
Dyspnea‡	34 (50)		
Other reasons	10 (14)	20 (16)	.66

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Arch Intern Med. 2006;166:749-753

Table 4. Drugs Used, Intention of the Physician, Estimated Shortening of Life, and Time Between Administering Drugs and Death*

Variable	Terminal Sedation (n = 211)	Euthanasia (n = 123)
The decision was made with the explicit intention of hastening death†‡	36 (17)	123 (100)
Drugs administered†		
Neuromuscular relaxants or barbiturates	0	108 (94)
Benzodiazepines (potentially combined with morphine but not with muscle relaxants or barbiturates)	128 (60)	3 (3)
Morphine (not combined with benzodiazepines, muscle relaxants, or barbiturates)	76 (36)	3 (3)
Other drugs	6 (3)	1 (1)
Time between administering drugs and death†		
<1 h	2 (1)	115 (94)
1-24 h	77 (37)	7 (6)
1-2 d	58 (28)	0
3-7 d	60 (29)	0
>1 wk	9 (4)	0
Estimated shortening of life†		
No shortening or <24 h	81 (40)	1 (1)
1-7 d	67 (33)	31 (26)
1-4 wk	44 (21)	60 (51)
>1 mo	13 (6)	26 (22)

End-of-Life Practices in the Netherlands under the Euthanasia Act

Agnes van der Heide, M.D., Ph.D., Bregje D. Onwuteaka-Philipsen, Ph.D., Mette L. Rurup, Ph.D., Hilde M. Buiting, M.Sc., Johannes J.M. van Delden, M.D., Ph.D., Johanna E. Hanssen-de Wolf, M.Sc., Anke G.J.M. Janssen, M.A., H. Roeline W. Pasman, Ph.D., Judith A.C. Rietjens, Ph.D., Cornelis J.M. Prins, M.Sc., Ingeborg M. Deerenberg, M.Sc., Joseph K.M. Gevers, Ph.D., Paul J. van der Maas, M.D., Ph.D., and Gerrit van der Wal, M.D., Ph.D.

N Engl J Med 2007;356:1957-65.

Table 1. Frequencies of Euthanasia, Assisted Suicide, and Other End-of-Life Practices in the Netherlands, According to Year.*

Variable	1990	1995	2001	2005
No. of studied deaths†	5197	5146	5617	9965
No. of questionnaires	4900	4604	5189	5342
Most important practice that possibly hastened death — % (95% CI)				
Euthanasia	1.7 (1.5–2.0)	2.4 (2.1–2.6)‡	2.6 (2.3–2.8)‡	1.7 (1.5–1.8)
Assisted suicide	0.2 (0.1–0.3)	0.2 (0.1–0.3)	0.2 (0.1–0.3)‡	0.1 (0.1–0.1)
Ending of life without explicit request by the patient	0.8 (0.6–1.0)‡	0.7 (0.5–0.9)‡	0.7 (0.5–0.9)	0.4 (0.2–0.6)
Intensified alleviation of symptoms	18.8 (17.9–19.9)‡	19.1 (18.1–20.1)‡	20.1 (19.1–21.1)‡	24.7 (23.5–26.0)
Withholding or withdrawing of life-prolonging treatment	17.9 (17.0–18.9)‡	20.2 (19.1–21.3)‡	20.2 (19.1–21.3)‡	15.6 (15.0–16.2)
Total	39.4 (38.1–40.7)‡	42.6 (41.3–43.9)	43.8 (42.6–45.0)	42.5 (41.1–43.9)
Continuous deep sedation§	NA	NA	NA	8.2 (7.8–8.6)

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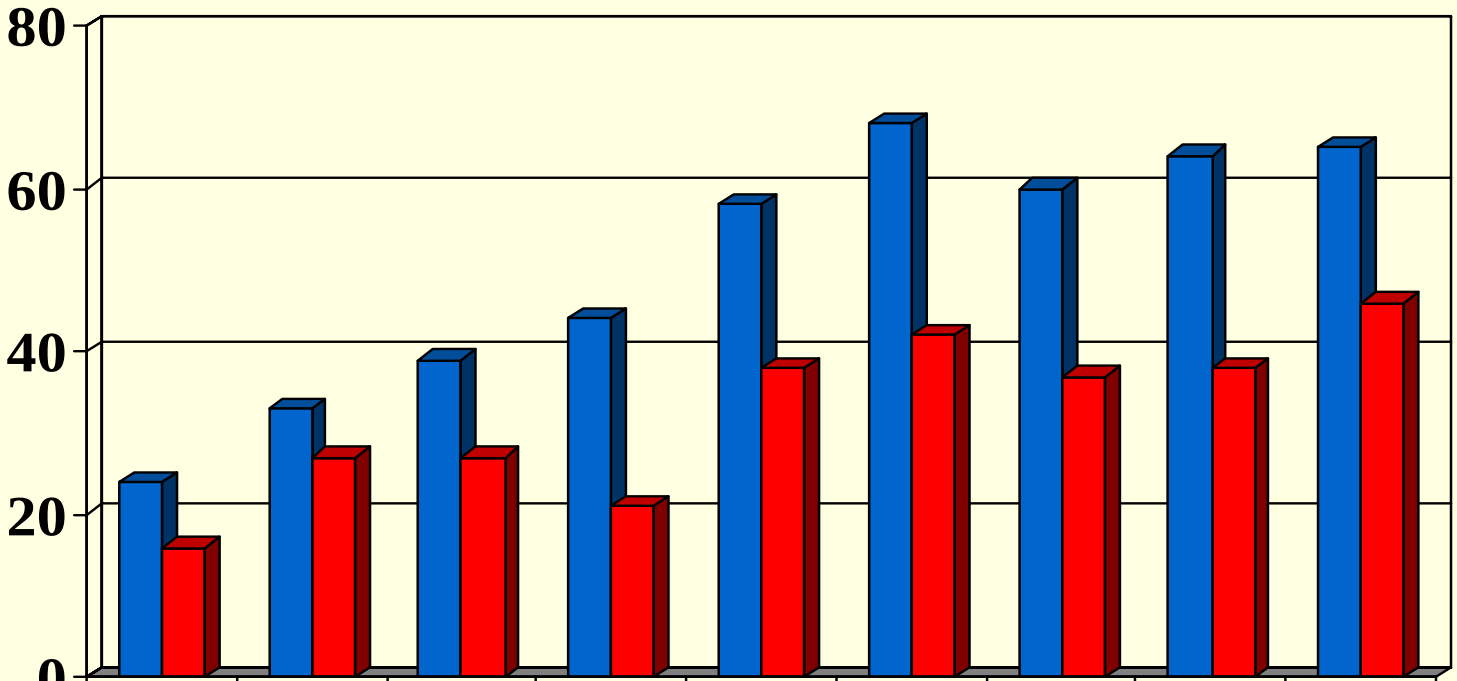
N Engl J Med 2007;356:1957-65.

Table 2. Rates of Euthanasia or Assisted Suicide, Ending of Life without an Explicit Request by the Patient, and Continuous Deep Sedation in 2001 and 2005, According to Characteristics of Patients.*

Characteristic	Deaths in 2005 Studied†	Percentage of All Deaths	Euthanasia or Assisted Suicide		Ending of Life without Explicit Request by Patient		Continuous Deep Sedation‡	
			2001	2005	2001	2005	2001	2005
	no.		*percent*					
Age								
0–64 yr	2583	19.2	5.0	3.5	1.0	1.0	5.9	9.0
65–79 yr	3462	32.4	3.3	2.1	0.4	0.3	6.9	7.4
≥80 yr	3920	48.4	1.4	0.8	0.7	0.2	3.3	5.4
Sex								
Male	5371	49.7	3.1	2.0	0.7	0.4	5.2	7.2
Female	4594	51.3	2.5	1.5	0.7	0.4	4.9	6.4
Cause of death								
Cancer	2760	28.8	7.4	5.1	1.0	0.3	5.7	10.8
Cardiovascular disease	4882	31.9	0.4	0.3	0.6	0.2	2.4	3.5
Other or unknown	2323	39.3	1.2	0.4	0.5	0.6	6.2	6.5
Type of physician§								
General practitioner	5135	41.3	5.8	3.7	0.6	0.2	2.9	9.1
Clinical specialist	2891	32.3	1.8	0.5	1.2	0.7	7.9	5.5
Nursing home physician	1458	24.5	0.4	0.2	0.4	0.3	7.4	6.2
Total	9965	100.0	2.8	1.8	0.7	0.4	5.1	6.8

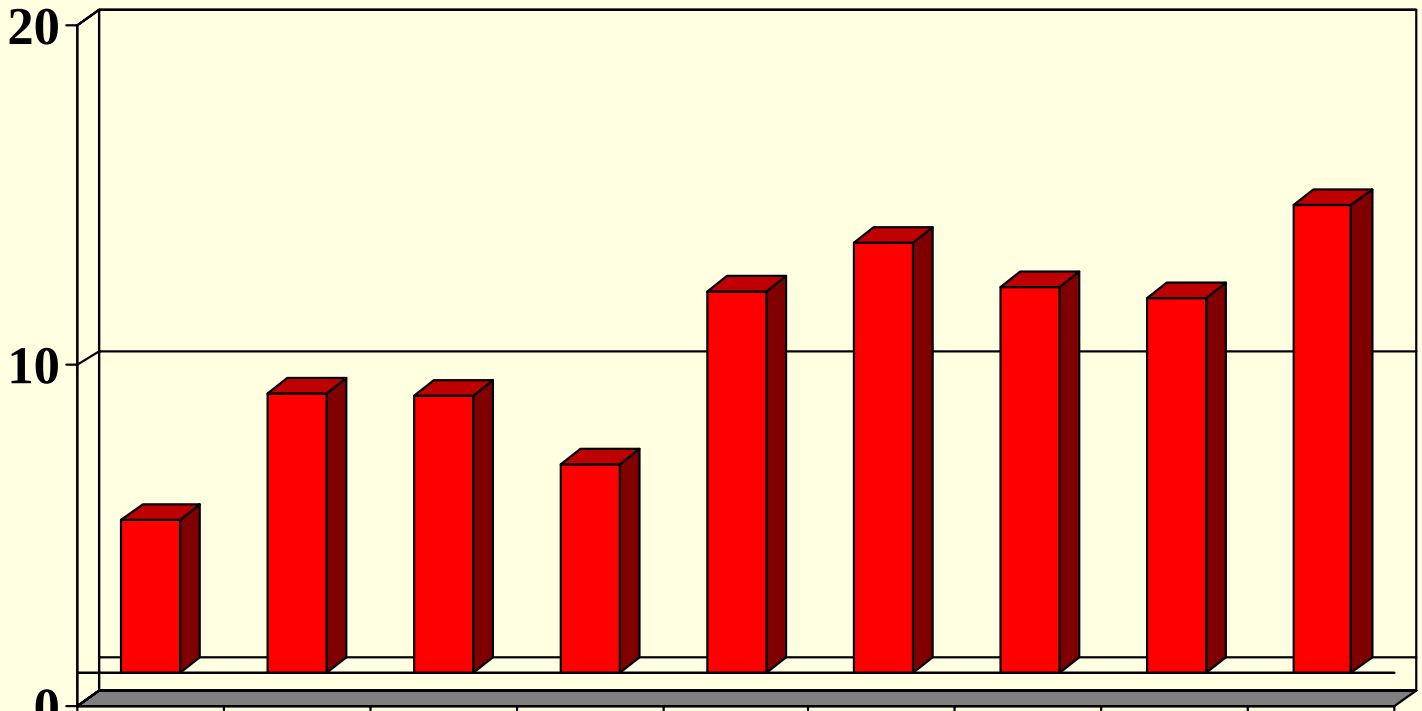
¿Sedación terminal?

DWDA Oregon.
Recetas y Muertes (1998-2006)



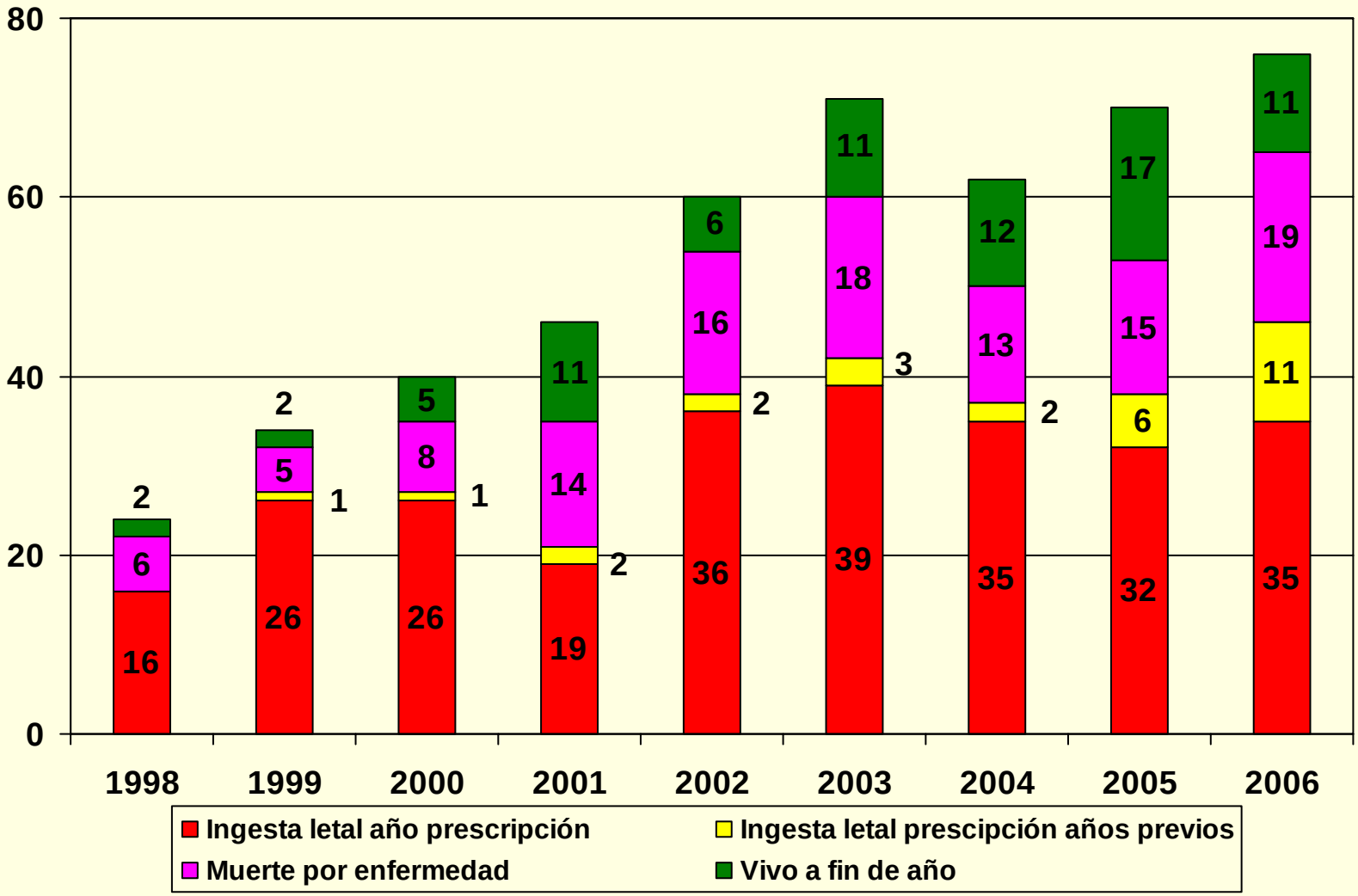
	1998	1999	2000	2001	2002	2003	2004	2005	2006
Recetas	24	33	39	44	58	68	60	64	65
Ingesta	16	27	27	21	38	42	37	38	46

DWDA Oregon.
Tasa de muertes SMA (1998-2006)



	1998	1999	2000	2001	2002	2003	2004	2005	2006
SMA/10000	5,5	9,2	9,1	7,1	12,2	13,6	12,3	12	14,7

DWDA Oregon. (1998-2006)



Quill TE. # Physician assisted death in vulnerable populations

Claims of increased risk in these groups are not supported by evidence

BMJ 2007;335:625-6

Physician assisted death (both voluntary active euthanasia and physician assisted suicide) has been openly practised in the Netherlands for more than 25 years and formally legalised since 2002. The practice has been analysed in four major national studies between 1990 and 2007.[1 2] A more restricted form of physician assisted death (physician assisted suicide only) was legalised in Oregon in 1997 and is the subject of an annual report (www.oregon.gov/DHS/ph/pas/index.shtml). Although these studies do little to resolve the moral and religious questions surrounding these practices, they do answer the following questions about the risks and benefits of legalisation.

Will these practices become more common over time in a permissive environment? In Oregon, physician assisted death accounts for around one in 1000 deaths each year, with no significant change in frequency over nine years. All patients have met the necessary criteria, and more than 85% were also enrolled in hospice programmes. In Oregon, one in 50 dying patients talk to their doctors about assisted death and one in six talk to family members.[3] There seems to be much conversation about end of life options, therefore, but relatively few cases of assisted death. Oregon is among the nation's leaders in other markers of good end of life care, including deaths at home, opioid prescribing, hospice enrolment, and public awareness about end of life options.[4] The Dutch practices of physician assisted death have also remained stable over the duration of four studies,[2]

Quill TE. **Physician assisted death in vulnerable populations**

Claims of increased risk in these groups are not supported by evidence

BMJ 2007;335:625-6

these concerns.[5] They found no increased incidence of physician assisted death in elderly people, women, people with low socioeconomic status, minors, people in racial and ethnic minorities, and people with physical disabilities or mental illness. The one exception was people with AIDS, and studies from San Francisco completed before protease inhibitors were used also showed a high prevalence of physician assisted death in this population.[6] These findings call into question the claim that the risks associated with legalisation will fall most heavily on potentially vulnerable populations.

A NATIONAL SURVEY OF PHYSICIAN-ASSISTED SUICIDE AND EUTHANASIA IN THE UNITED STATES

DIANE E. MEIER, M.D., CAROL-ANN EMMONS, PH.D., SYLVAN WALLENSTEIN, PH.D., TIMOTHY QUILL, M.D., R. SEAN MORRISON, M.D., AND CHRISTINE K. CASSEL, M.D.

N Engl J Med 1998;338:1193-201

Tasas de práctica secreta (e ilegal) de suicidio asistido en USA: 1 por cada 50 muertes…

Battin MP, van der Heiden A, Ganzini L, van der Wal G, Onwuteaka-Philipsen BD. Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups.

***Journal of Medical Ethics* 2007;33:591-597**

Conclusions:

Where assisted dying is already legal, there is no current evidence for the claim that legalised PAS or euthanasia will have disproportionate impact on patients in vulnerable groups. Those who received physician-assisted dying in the jurisdictions studied appeared to enjoy comparative social, economic, educational, professional and other privileges.

Juicios éticos sobre muerte asistida

- Qué es
- Quién la hace
- A quién se le hace
- Cómo se hace
- Cuándo se hace
- Para qué se hace
- Por qué se hace
- Sus consecuencias

DELIBERACIÓN

Deliberar es un arte, basado en el respeto mutuo, cierto grado de humildad intelectual, y el deseo de enriquecer la propia comprensión de los hechos, mediante la escucha y el intercambio de opiniones y de argumentos con el resto de personas involucradas en el proceso.

Reflexión ética

- **Intento de comprensión libre de prejuicios de una cuestión, de sus condiciones y de sus consecuencias, la evaluación de las acciones posibles y de las que no lo son, la deliberación y la decisión, provistas de sus justificaciones siempre plurales, siempre incompletas.**

Esker aunitz!

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