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Letter to the Editor re “Four Essential Drugs Needed for Quality Care of the Dying: A Delphi-Study Based International Expert Consensus Opinion”

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Dear Editor:

The authorship team of the article “Four essential drugs needed for quality care of the dying: A Delphi-study based international expert consensus opinion”¹ are to be congratulated for undertaking work that aims to provide guidance in care of the actively dying, an area hindered by a lack of robust research. Whilst systematically documenting opinions of palliative medicine specialists who care for the dying, the article’s conclusion that this will help improve the quality of care requires consideration.

The article recommends four classes of medications be readily available to dying people with the aim of enabling optimal management of common problems experienced by dying people: pain, dyspnea, nausea, anxiety, respiratory tract secretions, and agitation at the end of life. Recommended medications include opioids, preferably morphine; benzodiazepines, preferably midazolam; an antipsychotic, preferably haloperidol; and a glycopyrronium or hyoscine formulation.

High-quality patient care can be defined as an approach that minimizes harm whilst aligning with people’s expectations.² Dying people and their relatives have articulated that they expect health care providers to manage physical and psychological symptoms well, with expectations even higher when such care is delivered by specialist services.³ Despite excellent intentions, palliative care clinicians and researchers have done little to improve systematically the evidence base for prescribing when people are actually dying. Few data exist to inform clinicians’ understanding of how people’s actual experiences align with their articulated wishes.⁴ Symptoms are managed based on relatives’ and staff’s assumptions of the experience of the dying person, with a “good death” often being seen as quiet and calm. Achieving this often requires sedation, for which the dying person will very rarely have given consent. This requires consideration, especially when evidence suggests people facing death will forgo symptom control to remain as alert and interactive for as long as possible.³ We ignore patients’ wishes at our peril if we are to be truly patient centered.

Of the symptoms listed above, only palliation of pain and breathlessness are supported by robust evidence. The rec-

ommendation that antimuscarinic agents are required to manage respiratory secretions¹ is not supported by the small number of placebo controlled observations, which suggest, at best, no benefit. Administering compounds that cross the blood-brain barrier places people at risk of adverse effects including agitation and delirium, so if a medication is to be used it should be glycopyrrolate or hyoscine butylbromide.⁵ The recommendation that there is a need for a benzodiazepine is also questioned. The choice of midazolam requires mostly parenteral administration in the absence of pharmacokinetic data for the other routes by which it is administered. In contrast, alternative benzodiazepines such as lorazepam and clonazepam can be simply administered via the sublingual route with well-defined pharmacokinetics. Principles for the choice of medications have been described in the palliative care literature,⁶ and in the 21st century we should be relying less and less on injectable medications in the last hours and days of life as other evidence-based routes of administration become available.

Improving the quality of care for the dying requires the most sophisticated and nuanced research that can possibly be designed. There is a real need for research to provide an evidence base from which to manage distressing symptoms when they occur. This must include defining the optimal approach to objectively measuring symptom burdens and managing those symptoms with the same attention paid to minimizing harm that occurs at any other point in a person’s life. Only then can quality of care for the dying be assured.

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