Psychedelics in the Hospice Care Toolkit: A Bioethical Review

Introduction

Throughout the past five decades in the United States, advancements in hospice care have provided integral medical and psycho-social support for terminally ill patients by providing comfort and healing in the absence of a cure; goals that have been fundamental to medical practice since ancient times. Hospice and palliative care teams intentionally coalesce medical management of symptoms with attention to the spiritual dimensions of care during the final days of a patient's life.

Today, terminally ill patients at the end of life have choices in amelioration of suffering with the current medical regimes of symptom management with opiates, anxiolytics, antiemetics, or for intractable symptoms, the use of palliative sedation. For some patients, their terminal suffering is profound enough to choose a lethal prescription from their physician. Nine states in the United States have legalized physician aid in dying for terminally ill patients. Perhaps the medical community needs to look for other options for soothing patient suffering at the end of life: a therapy that assuages and integrates mind, body, and spirit, and confronts demoralization of terminally ill patients. Demoralization is defined by Kissane et al. as "a syndrome characterized by hopelessness, loss of meaning, and existential distress" (qtd. in Grob, Bossis, Griffiths, 297). Suffering at the end of life is not solely a physical experience, but a metaphysical one which can cause existential distress; a symptom that is difficult to manage with the current medical toolkit.

Psychoactive substances, also called psychedelics from the Greek, "mind manifesting" or entheogens, from the Greek, "generating the divine from within" have recently re-emerged in clinical research and are proving to be safe and effective therapies for post-traumatic stress disorder

(PTSD), alcoholism, nicotine cessation, depression, anxiety, and demoralization at the end of life (Griffiths et al. 2016, Grob et al. 2011, Johnson et al. 2017, Pollan, 19). Psychedelics include psilocybin, colloquially known as "magic mushrooms", lysergic acid diethylamide, or LSD, and other psychoactive substances that can induce expansion in consciousness, create a feeling of connectedness and meaning, facilitate a dissolution of ego, and produce a generalized euphoric state of being (Griffiths et al. 2016, Grob et al. 2011, Johnson et al. 2017, Byock 2018). Indigenous people have been using plant-based psychedelics in ceremonies for thousands of years to connect with the scared, expand consciousness, and were also used for healing physical and spiritual suffering (Grob et al. 2011, Pollan 2019, Byock, 2018). In light of the auspicious research demonstrating efficacy and safety, the clinical use of psychedelics in a controlled therapeutic setting needs legal and ethical reconsideration for patients who suffer at the end of life.

This paper attempts to explore the ethics of using psychedelics as a therapeutic option for ameliorating suffering associated with the end of life. I will argue that the use of psychedelics should be medically available in hospice and palliative care settings for patients experiencing end of life anxiety, depression, and existential suffering. I will argue that the therapeutic use of psychedelics is ethically grounded in the rule of medical parsimony, which contends that a one-time psychoactive "trip" would be a less radical medical intervention than high dose opiates, palliative sedation, or physician assisted suicide. A patient choosing a psychedelic as treatment for suffering is more parsimonious than choosing sedation or a lethal prescription (Barilan, 2004).

Psychedelics as a Safe and Effective Therapy

Research on psychedelics sponsored by the National Institute of Mental Health in the 1950s-1960s demonstrated promising results for alleviating anxiety, depression, and existential

suffering. (Pollan 2019, Byock 2018). Other studies during this time showed positive outcomes using psychedelics in the treatment of addictions, post-traumatic stress disorder, as well as auspicious outcomes in a more obscure area of clinical psychology investigating the "mystical-type experiences" produced by psilocybin which created "sustained, meaningful and spiritual significance" allowing patients to transcend suffering and find meaning in their lived experience (Griffiths et al. 2016, Grob et al. 2011, Johnson et al. 2017). During the late 1960s, misuse and abuse of "street" psychedelics was seen in the counter-culture revolution and was promoted in the media as a denigration of society. "Moral panic" and a "war on drugs" prompted the federal government to criminalize the use of psychedelics, categorizing the substances as Schedule I Drugs which designates them as addictive drugs of abuse with no accepted medical use. (Pollan, 2019). As a result of the FDA's Schedule I classification, psychedelics could no longer be permitted in research and much of the promising studies were suppressed (Pollan, 2019).

Then in the early 2000s there was a renewed medical interest in the benefits of psychedelics, and the FDA granted the use of psilocybin in clinical research for three academic institutions: Harbor UCLA, New York University, and John Hopkins University. These studies have demonstrated striking evidence that when psilocybin is used in a controlled therapeutic "set and setting" it is safe and highly effective for ameliorating anxiety, depression, and existential suffering associated with terminal disease. (Byock, 2018,Griffiths et al. 2016, Grob et al. 2011, Johnson et al. 2017). Almost no side effects were reported in the studies, and some research demonstrated that 70-80 percent of patients reported substantial sustained relief a year after taking one dose of psilocybin (Byock, 2018,Griffiths et al. 2016, Grob et al. 2011, Johnson et al. 2017). Many of the research participants in the three academic studies reported their experience as one of

the most meaningful experiences in their life (Byock, 2018, Griffiths et al. 2016, Grob et al. 2011, Johnson et al. 2017).

In the research environment, psychedelics involve more than just a therapist handing a patient a drug. The therapeutic process involves a focus on "set and setting." "Set" refers to the patient's mindset going into the therapy, and "setting" entails the safe and comfortable environment the patient will receive in therapy while taking the psychoactive substance (Byock, 2018,Griffiths et al. 2016, Grob et al. 2011, Johnson et al. 2017). Participants are carefully screened for the studies and are excluded if they have histories of schizophrenic tendencies, borderline personality disorders, or conditions or cognitions with diminished egos (Byock, 2018). The patient is prepared and counselled weeks before the psychoactive substance is given, thereby establishing trust and an open mindset before the treatment session. During the therapeutic session, the patient listens to soothing music on headphones, lies on a couch in a comfortable room, and is guided through the treatment by two different sex mental health professionals throughout the session.

The Bioethical Use of Psychedelics in End of Life Care

Hospice and palliative care physicians and their health care teams focus on patient comfort, alleviation of symptoms, and care of the whole person—mind, body, and spirit. When a cure is no longer possible, care and comfort become the priority. Medications such a opioids, sedatives, antiemetics, diuretics, steroids, and other medications are used to manage symptoms that a terminal illness can cause, such as pain, anxiety, edema, shortness of breath, and other symptoms. For some patients with refractory physical symptoms or intractable existential distress, end of life suffering may become so burdensome to request a lethal prescription from a physician as a mode to end their suffering. Other patients might require high doses of opiates or sedation, given in what's known as terminal sedation; a medical induction of deep sleep that can sometimes hasten patient

death. If irrevocable options such as lethal prescription and terminal sedation have become choices in end of life care, it seems that patients need alternatives for alleviating suffering at the end of life; an alternative that aligns with hospice care goals of embracing the whole person- mind, body, and spirit.

Barilan describes the concept of "terminal elation" as an alternative to terminal sedation, in which mind-altering substances are used to elevate consciousness in a suffering patient without the use of sedatives or pain medications (Barilan, 2004). Terminal elation, it is argued by Barilan, would allow patients to detach from their physical or existential suffering while inducing a euphoric state and eliciting an expansion of consciousness that might allow patients to connect to meaning of their end of life experience (Barilan,2004). "Elated" patients who have a renewed sense of meaning and connection to the universe may not need to be "snowed" with sedation and may be less inclined to request a lethal prescription from the doctor. If terminal elation, I would argue, could transcend suffering, shift a patient's perspective about the end of their life, and open a door imbued with meaning, its use is ethical and in fact may be an imperative for patients who wish to end their life.

Allowing psychedelics into the palliative and hospice care medical toolkit is ethically grounded in the rule of medical parsimony which promulgates that a one-time psychoactive "trip" would be a less radical medical intervention than high dose opiates, palliative sedation, or physician assisted suicide (Barilan,2004). Barilan writes: "The maxim of medical parsimony, therefore, states that physicians who face equally effective strategies have a prima facie duty to recommend the most parsimonious one" (Barilan, 153). Terminal elation is more parsimonious than terminal sedation or a lethal prescription. Psychedelics may not have the mechanism of action to alleviate physical suffering as morphine does, but it may provide a detachment of one's pain

experience, thus lessening the severity of physical pain and addressing the demoralized state of the patient before symptoms reach levels of intractability (Byock, 2018, Barilan, 2004). Furthermore, terminal elation is an ethical treatment for hospice and palliative care patients because it could increase patient autonomy by providing calm and clarity in decision making and perspective, thereby increasing quality of life. "Loss of autonomy" is one of the most common reasons terminally ill patients request a lethal prescription from their doctor in Oregon, a state were physician aid in dying has been legal since 1998 (Oregon Health Authority, 2019). In addition to promoting patient autonomy, psychedelics could be beneficent for the patient by improving quality of life and would be a beneficent act by the clinician prescribing a therapy that is safe, effective, and transformative for a patient.

The use of psychedelics should be treated with caution and used under controlled medical supervision but should nonetheless be considered an ethical alternative treatment for demoralization at the end of life. For some demoralized patients, the irrevocable alternative is to end their life.

The Right To Try and The Right To Die

In 2018 the Right To Try Act was signed into law in the United States allowing people diagnosed with a life-threatening illness to apply for access to treatments that have not been approved by the FDA. The FDA has a similar program called Expanded Access, or Compassionate Use (Byock, 2018). Terminally ill patients currently do not have the right to try psychedelics, paradoxically they do have the right to die by lethal prescription. This moral impasse illuminates a need for change in our health care system.

Nine states in the United States have legalized physician aid in dying in response to terminally ill patients who wish to end their life. The Oregon Public Health Department's *Death With Dignity Act Annual Report of 2019* details the reasons patients requested lethal prescriptions from their doctors. In order from most requested to lowest, the following are reasons that patients requested a lethal prescription from a doctor in 2019: "less able to engage in activities that make life enjoyable, loss of autonomy, loss of dignity, burden on family and friends, losing control of bodily functions, inadequate pain control or concern about it, and lastly, financial implications of treatment" (Oregon Health Authority, 2019). Notably, pain is listed as the sixth reason to request physician aid in dying, while the top five requests are due to patient non-physical suffering or demoralization (Byock, 2018).

An Objection

An objection to using psychedelics in palliative and hospice care is that an unapproved Schedule I drug given to terminally ill people could be exploitive of a vulnerable population. "Moral panic" set in the 1960s-1970s associated with the misuse and abuse of psychedelics should be reconfronted by society and scientists alike (Pollan,2019). I would argue that programs such as the FDA's Expanded Access, or the recent Right To Try Act are in place to allow patients who have no other choices for treatment or care, and that by denying patients safe alternatives to ameliorating suffering is unethical and heedlessly protracts their suffering. Vulnerable populations can participate in research when the standard of care no longer provides a benefit and although psychedelics are not a cure for terminal disease, they could change a patient's mind about choosing a lethal prescription. I contend that giving hospice patients psychedelics is not exploitive because three academic research studies have demonstrated safety and efficacy of the use, propelling the FDA to establish psilocybin in a break-through drug designation.

The dying patient resides in a special circumstance that is limited by time. Terminal elation could provide a space to make this time meaningful. A phenomenological account of a patient elucidates the need for using psychedelics in end of life care. Roy, a 53-year-old man diagnosed with bile duct carcinoma with metastasis to his lung was a research participant in the John Hopkins study on psilocybin use at the end of life. He provides insight into his transcendent experience with the following journal entry:

"From here on love was the only consideration. Everything that happened, anything and everything that was seen or heard centered on love. It was the only purpose. Love seemed to emanate from a single point of light…It was so pure. The sheer joy…the bliss was indescribable… I was beginning to wonder if man spent too much time and effort at things unimportant…trying to accomplish so much…when really, it was all so simple. No matter the subject, it all came down to the same thing. Love. Earthly matters such as food, music, architecture, anything, everything…aside from love, seemed silly and trivial. I thought about my cancer… I took a tour of my lungs…I remember breathing deeply to help facilitate the "seeing". There were nodules, but they seemed unimportant. I was being told, without word, not to worry about the cancer…it's minor in the scheme of things…simply an imperfection in your humanity and that the more important matter…the real work to be done is before you. Again love." (Grob, Bossis, Griffiths, 2013, p.64).

Conclusion

A drug that transcends suffering so that one can find meaning in dying, experience elation, and embrace spiritual levity is not a novel therapy, but one that needs ethical reconsideration for patients at the end of life.

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