When I graduated from veterinary college, I knew exactly one thing about euthanasia: the pharmacologic profile of pentobarbital. I quickly forgot even that as I was thrown into the stressful world of being a new veterinarian. I hated euthanasia appointments. The tension and pressure were unbelievable. If I missed the vein, I felt terrible. And since most of my patients were awake, they didn't appreciate me fishing for a vein. If their pet showed any sign of discomfort, the owner's stress and sadness were increased.

As a shelter veterinarian, I found that euthanasia was a daily part of my life. While I didn't have to perform the procedure myself, I had to make the call for thousands of pets. I faced hostility – sometimes for euthanizing and sometimes for not euthanizing. I found ignorance about euthanasia at every turn. Even well-meaning veterinarians would send along instructions that they had worked hard on an animal, so we shouldn't “kill it”. Educating people about euthanasia became my passion. I consider euthanasia to be a sacred gift that we as veterinarians should be grateful to have at our disposal.

Euthanasia comes from the Greek and means “good death”. The AVMA guidelines state that it is and should be: "the act of inducing humane death in an animal", "done with the highest degree of respect", and "as painless and distress free as possible". Many organizations have written guidelines regarding euthanasia. AVMA released new guidelines in 2013.

According to the Florida Animal Control Association, the only legal methods of euthanasia in the state of Florida are gunshot and sodium pentobarbital. Pentobarbital is a controlled substance available as CII and CIII in different forms. Fatal Plus™ is a CII and is pentobarbital sodium. Somnasol™, Euthasol™, and Beuthanasia-D™ are CIII and are pentobarbital sodium + phenytoin (an anticonvulsant and class 1b antiarrhythmic that hastens cardiac standstill). Fatal Plus 3 (FP-3) is not on the market yet but is pentobarbital sodium + lidocaine. Following IV injection, pentobarbital quickly induces unconsciousness. This is the reason for its choice as the best euthanasia agent. Unconsciousness of the patient ensures no suffering. In
seconds, the medullary respiratory center is depressed and breathing ceases. Cerebral death occurs, followed by cardiac cessation. Contrary to popular explanation, pentobarbital does not “stop the heart”. Many clients interpret this as the drug causing a heart attack. An effective explanation for a lay person is that the drug causes unconsciousness and then stops brain function. The brain is what tells the heart and lungs to work, so they stop functioning as the signals from the brain disappear.

Pentobarbital can cause the dog or cat to proceed through the following stages of anesthesia: Stage I is Voluntary Excitement, Stage II is Involuntary Excitement, Stage III is Anesthesia, and Stage IV is Medullary Paralysis. These stages are far less dramatic when pre-euthanasia sedation is used.

Euthanasia of feti in the case of a gravid spay has been widely debated. The center of the debate has been over two issues: 1) feti have been seen to move after removal of the uterus despite the fact that they should be anesthetized and 2) feti do not breathe, so depression of the respiratory center is ineffective. The following is an excellent explanation of the fetal status of lambs which can be extrapolated to dogs and cats:

"Although the fetal neural apparatus may be able to support consciousness during late pregnancy, the evidence is that the fetal lamb remains unconscious throughout... Fetal, placental, and uterine tissues play a key role in providing chemical and physical factors that together actively maintain the fetus in a continuously unconscious state... The movements often observed before fetal death are subcortical reflex responses to the increasing hypoxaemia and hypercapnea, and are not a cause for welfare concern. If fetuses are kept in the uterus until they are dead no welfare compromise can occur.... Consciousness appears after birth only when breathing oxygenates the lamb sufficiently to remove the dominant neuroinhibitory effects of adenosine on its brain function. The lamb that never breathes will never become conscious and will die without suffering." A further summary of research on fetal consciousness explicitly refers to fetal unconsciousness during and after spay, as long as the uterus is not opened and the fetus is not allowed to breathe air.³

Pre-euthanasia sedation is another subject that has been debated for decades. Many veterinarians prefer to perform an IV injection of pentobarbital with the patient fully awake. This requires restraint, potentially subjects the owner to the visual of their dog or cat collapsing, and may result in vocalization, thrashing, or other unpleasant displays that upset the client. We are
aware that the animal is not truly experiencing distress, but to clients this is extremely distasteful.

Sedation of the pet has the wonderful secondary effect of sedating the owner. Once they see their pet peaceful, they relax and can say goodbye in a calmer state of mind. If the pet’s veins are poor, the veterinarian does not have to worry about hurting the pet with multiple needle sticks.

Some veterinarians reduce this unpleasantness by removing the pet from the owner and placing an IV catheter. Again, this puts the pet through an uncomfortable experience and breaks that bond between the owner and pet while the pet is removed from the room. Often, the owner can hear if the pet cries out, and this increases their distress. An extremely reliable sedation protocol is listed under Compassionate Closure: Hospice & Euthanasia Discussion/Q&A proceedings.

Once the pet is sleeping peacefully, pentobarbital is injected IV (intravenous), IP (intraperitoneal), IC (intracardiac), IH (intrahepatic), IR (intrarenal), or in the spleen. Anecdotal reports say vascular tumors can also be injected provided they are not showing signs of necrosis at the injection site.

Let the client know about any side effects that may occur. I tell my clients that their pet is going to start breathing heavily (“this is where they hit the Rainbow Bridge running”) and may stretch. I also place a puppy pad beneath the pet after sedation so the owner knows they may urinate or defecate during or after the process. I let them know their pet may move or make a noise, but that they are completely unconscious.

The terms “agonal breath” and “terminal gasp” are graphic and completely inappropriate for use with most clients. Instead, I tell them their pet may give a “hiccup” or have muscle twitches after death. I tell them the body is “getting rid of energy”. While I have had a few clients become upset by an agonal breath because they had experienced it negatively before, most are comfortable because I have explained it as something nonthreatening. I have also seen lip lifting after death. The lips pull into what looks like a smile. Clients love to hear that their pet is at the Rainbow Bridge smiling. A calm, open manner is very reassuring to clients. If you are calm and relaxed, most clients will follow your lead.

References:
1http://www.avma.org/issues/animal_welfare/euthanasia.pdf
Euthanasia is a subject missing from many veterinary college curricula. It is something that we avoid talking about until our patients are critically ill or are diagnosed with a terminal disease. We use softer words and phrases that “say it without saying it” to spare our clients’ feelings. Because we are trained to heal, we sometimes regard resorting to end-of-life care as a failure. The veterinarian’s oath states that one of our sworn duties is the “prevention and relief of animal suffering”. Relief of suffering may be pain medication, anti-anxiety medication, acupuncture, surgery, or euthanasia. Euthanasia is not a failure. It is a treatment option that every client should have without judgment. If they do not receive white-glove care at this critical point, they may take their business elsewhere. What we need to embrace is the fact that our relationship with our clients can be made or broken when we discuss and handle end-of-life care.

A pet’s terminal diagnosis, failure of mobility, failure of sight and hearing, or cognitive dysfunction puts our clients into “fight or flight” mode. They are as stressed as we are likely to ever see them, with peak stress occurring as they make the decision to euthanize their pet. Worse, they may end up caught in a situation where the pet goes into crisis and they are forced to watch them pass on their own. It is our responsibility to make sure our clients are properly educated and all their questions are answered. It is so important that we make sure to provide outstanding compassion and support for our clients when they face end-of-life decisions for their pets. Veterinarians, technicians, assistants, receptionists, and kennel staff should all be well-versed in how to gently handle and serve the needs of clients at this critical point.

As a hospice veterinarian, I am amazed to hear the things clients have to say about euthanasia. The most common thing I hear is how much they love their veterinarian, but how they don’t want their pet to “die in that cold, harsh place”. The veterinary hospital changes faces when clients start thinking about euthanasia. Gone are the wonderful staff and compassionate doctor. Their minds can only focus on stainless steel cages, metal tables, chaos, dogs barking, phones ringing, and people laughing as they come in for “fun” appointments with their pet.
Several clients (mostly women), have told me they want euthanasia at home, but were wondering if they needed their vet’s permission before calling me. This reinforces that we need more open communication with our clients. If our clients don’t realize that their pet belongs to them and they are the final decision-maker, then confusion results. We also need to emphasize this with our staff members. It is easy to become emotionally involved with our patients and clients. However, just because we don’t agree with a client’s decision doesn’t make it “wrong”. Each and every one of us makes decisions regularly that someone, somewhere would find inappropriate or wrong. Judgment breaks the bond between us and our clients and may cause the client to forcibly break our bond with their pet by taking them elsewhere. Yes, we should educate clients when we feel they are making a decision without all the facts. However, unless we live in their household (or in their heads, for that matter), we cannot possibly grasp every element in their lives that brings them to the decisions they make in our brief office visit.

What our clients want from us is compassion and understanding. There are situations where clients want a “convenience” euthanasia or can’t/won’t fix a fixable problem due to finances and refuse to surrender the pet to a new owner. Each veterinarian must decide for him/herself where they draw the line. Most of our clients will probably wait too long as opposed to putting their pet to sleep too soon. Asking clients “what are your fears?” can open the lines of communication. Usually their fears center upon making the “right” decision at the “right” time. I tell them that I have met very few people who feel they chose euthanasia at the “perfect” time, and that includes me. Reminding them that you have pets and go through the same agonized decision-making makes them feel more at ease. And three words every staff member should know: “I’m so sorry”. Many clients tell me that I am the first person to express sympathy. If they’ve seen or talked to someone at your office, this should never be the case!

It is uncomfortable talking to clients about euthanasia – because you don’t do it every day. In a hospice practice, we discuss it constantly. The more you make yourself talk to clients openly, gently, and honestly about euthanasia, the more finesse you will develop. If you are comfortable with the subject, you will be much more effective at helping your client make the best decision for them and for their pet.

Euthanasia should also be discussed openly with staff members, starting at their job interview. There are potential staff members out there who believe that euthanasia is never appropriate. It is in your best interests to find out how an employee feels about euthanasia before you hire
them or put them in a room with a client. Every veterinary establishment should have a euthanasia policy in place for employees to sign or have it as part of their employee handbook. Consult with your legal advisor for proper construction of this document. Make sure you are clear on your beliefs and clear about what you expect from your employees.

Everyone has patients and clients who hold a special place in their heart. Be sensitive to the needs of your staff if they are especially close to a patient or client. They may have a strong desire to be present – or to not be present at euthanasia. Do your best to respect their wishes. However, if an employee avoids euthanasia altogether, a discussion should be had with that employee immediately. Compassion fatigue, a personal matter, or other issue could be making it difficult for them to cope.

If you are a veterinarian having difficulty coping with euthanasia, talk to your colleagues, your family, or a counselor. If you have multiple veterinarians in your practice, try to even out how much euthanasia any one person has to perform. While we are not counselors, hospice veterinarians are skilled at talking to clients about euthanasia and can be an excellent resource for helping you have “the talk”.

Compassion fatigue is very real and can make people appear to be callous or uncaring. This is a serious issue that must be addressed compassionately but honestly. Be aware that clients may also suffer from “caretaker syndrome” and be overwhelmed with caring for their pet. When dealing with end-of-life issues, don’t be afraid to ask for help – especially if someone you know is acting out of character. A cry for help can come in many forms, and a simple “I’m worried about you” can open the door to better communication.

In-home euthanasia is becoming popular with clients. If you are unable or unwilling to offer this service, consider joining forces with an in-home hospice/euthanasia practice so that you can offer your clients one more benefit from your hospital. In my experience, the clients who speak most highly of their veterinarians are the ones whose veterinarians gave them my card. Referring your clients to services they need rather than just saying “no” shows your commitment to their pet’s comfort and well-being.

References:

1http://www.avma.org/about_avma/whoweare/oath.asp
The word hospice comes from Old French and Latin and is related to the words “host” and “hospitality”. In the 1800s, hospices were resting sites (usually religious in nature) for travelers.

The modern use of the term hospice as a place for terminally ill patients or the concept of palliative care for dying patients in their home began with Dame Cicely Saunders in the 1960s. She was the founder of St. Christopher’s Hospice in London².

Hospice for pets is in its infancy. Veterinarians have been using palliative care and counseling owner/caretakers, but calling this practice “hospice” is very new. One of the reasons for this is the availability of euthanasia for pets who are suffering. Hospice is not meant to be life-prolonging or promote suffering of animals until they die naturally (although this has happened with well-meaning organizations who became overwhelmed). Instead, it is meant to be a bridge between “there’s nothing more we can do” and natural death or euthanasia.

When we are faced with a pet that has a terminal disease or malfunctions of body systems that are not deadly but decrease quality of life, our tendency is to exhaust all medical options, try “alternative” options, and then euthanize. This process varies depending on the client’s wishes, the pet’s tolerance, and the physician’s familiarity with holistic medical options. We are also limited by the client’s finances and willingness to bring an elderly patient for multiple visits.

As a hospice veterinarian, I take over when clients are told there are no options but euthanasia. However, if clinicians were more comfortable with hospice care, they could not only handle this option themselves, but increase the bond with their client and patient by continuing to offer support and compassion when medical cures are impossible.

“There’s no more we can do” should be replaced by “there’s one more thing we can do”. Often, there are multiple options to keep our patients comfortable so their owners have time to make an informed decision.
The “gold standard” of medical care does not apply when a patient is on hospice. This is the time to stop looking for ideal solutions and come up with a plan that is best for our patient’s physical and mental well-being. We are taught, for instance, that NSAIDS are drugs to use with caution and that bloodwork should be performed regularly while patients are on them. This is true when our patient is fairly healthy and expected to live for years to come. When we are dealing with an elderly, ill pet that is in pain, the rules change. We need to sit and talk with our clients about transferring their pet to hospice care (be sure you use the word hospice frequently). What this means is that the pet has less than 3 months before death or unacceptable quality of life compromise. This is the point in time where we usually begin discussing euthanasia. If the client isn’t ready to say goodbye, don’t make the mistake of sending them home until they decide to euthanize. It is so important that our clients rely on us for support, comfort and advice. It is very telling that many of my hospice clients come to me from the world wide web: they are looking for help their veterinarian didn’t give them. I frequently hear “my vet said there’s nothing more we can do so I guess I have to put him down”. That level of service isn’t likely to bring them back to you with their next pet.

What will have your clients raving about you and staying with your practice is red-carpet treatment. Let them know that you are a TEAM. Have a hospice package (much like a puppy package) with all the resources they’ll need. Give them handouts on their pet’s disease. Make a plan with them and re-evaluate that plan regularly. Your responsibility for that patient isn’t over until he or she has had a peaceful passing. If you go the extra mile for your clients during the hardest part of their pet ownership, they will never forget it.

According to the AVMA, if you do not provide hospice care for your patients, you need to refer to someone who does. Hospice care is simple: do what is best for the pet’s comfort (and the owner’s sanity) with the pet leaving their home as little as possible. If you have seen the patient in the last year, schedule a hospice consult with the owners and have them leave the pet at home. You can prescribe palliative medications within the veterinarian-client-patient relationship. If you are uncomfortable prescribing medications for a patient you have not seen recently, consider an in-home consult. Charge appropriately for in-home and in-office consults ($150-200 per hour for a housecall). In-home consults give you the opportunity to observe the pet in his/her environment. Something as simple as prescribing yoga mats or non-shifting rugs to improve footing on slippery floors can improve quality of life drastically.
If the pet is painful, prescribing medications like NSAIDS (have them sign an NSAID release form – see section four for an example) tramadol, gabapentin, buprenorphine, etc can give the pet more quality time with its owner. Appetite stimulants, subcutaneous fluids, and nausea medications are also excellent tools to allow an owner to care for their pet at home.

If you are interested in setting up hospice service at your practice, please contact me (buissonvrss@gmail.com), your local hospice veterinarian, or the International Association of Animal Hospice and Palliative Care (www.iaahpc.org).

References:

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2 http://www.nhpco.org/i4a/pages/index.cfm?pageid=3285