



ADVANCING EXPERT CARE IN SERIOUS ILLNESS

HPNA Position Statement Palliative Sedation

Background

Patients at the end of life may suffer an array of symptoms and existential distress that, in most cases, can be prevented or relieved through optimal palliative care. However, the suffering of some patients is intractable to such efforts. When imminently dying, some conscious patients may experience intractable symptoms that are intolerable and that cannot be relieved by expert palliative care. Palliative sedation involves administering sedatives in doses to relieve awareness of suffering that may induce unconsciousness.¹

While there is no universally accepted definition, palliative sedation can be understood as the controlled and monitored use of non-opioid medications intended to lower the patient's level of consciousness to the extent necessary, for relief of awareness of refractory and unendurable symptoms. Previously, palliative sedation was termed terminal sedation; however, the term palliative sedation more accurately describes the intent and application to palliate the patient's experience of symptoms rather than to cause or hasten the patient's death.² Other terms include total sedation, sedation for intractable symptoms at end of life and continuous or prolonged sedation.³⁻⁵ Palliative sedation is distinct from procedural and respite sedation, as well as sedation resulting from analgesics alone.^{5,6} The prevalence of palliative sedation in clinical practice is unknown, but reports suggest that it is used in 1.33-51% of dying patients.^{7,8}

The use of medication to promote comfort and relieve pain in dying patients is supported by the ANA's *Code of Ethics for Nurses*, which states that "the nurse should provide interventions to relieve pain and other symptoms in the dying patient even if those interventions entail the risk of hastening death. However, nurses may not act with the sole intent to end a patient's life even if motivated by compassion, respect for patient autonomy, and quality of life considerations."^{9, p. 8}

The ethical justification that supports palliative sedation is based in precepts of dignity, respect for autonomy, beneficence, fidelity, nonmaleficence, and the principle of double effect, which evaluates an action based on intended outcome and the proportionality of benefit and harm. These principles support the right of

the individual to make healthcare decisions based on personal values and quality of life considerations, and reinforce the responsibility of clinicians to provide humane and compassionate care that is consistent with professional and societal norms.

The intent of palliative sedation is to relieve suffering in dying patients, but not to deliberately hasten death. This is distinct from euthanasia, assisted suicide, or any intervention such as inappropriate escalation of analgesic or sedative doses where the intent is solely to hasten the patient's death.¹⁰ This distinction is supported by the 1997 U.S. Supreme Court decisions in *Vacco v. Quill*¹¹ and *Washington v. Glucksberg*¹² that state a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication to alleviate that suffering, even to the point of unintentionally causing unconsciousness and hastening death.

Interdisciplinary assessment of the patient is essential to determine the refractory nature of his/her suffering, and to assure communication with the patient, family/significant other/surrogate decision maker, and other healthcare providers. Collaboration with the interdisciplinary team not only validates the appropriateness of palliative sedation and facilitates the informed consent process, but also reduces the emotional burden for the healthcare providers.¹³ The use of palliative sedation requires that comfort be the priority goal of care. The use of cardiopulmonary resuscitation is generally viewed as inconsistent with this goal. However, decisions to withhold or withdraw other life-sustaining therapies including artificial hydration and nutrition are separate from, but may be related to, the decision to use palliative sedation.⁶

Finally, it is imperative that when palliative sedation is offered as part of the plan of care, the organization have policies and procedures in place to establish the correct process. At a minimum, these should include the roles of the physician, the bedside nurse, the advanced practice nurse, and pharmacist and the role of consulting either a palliative care team or a pain team whenever possible. But most important, there should be clear documentation of the following: the reason for palliative sedation, informed consent, and the actual process followed.

Position Statement

- Affirms the value of palliative, including hospice care that includes aggressive and comprehensive symptom management.
- Affirms the use of palliative sedation to manage refractory and unendurable symptoms in imminently dying patients as one method of aggressive and comprehensive symptom management. There is no legal barrier to its appropriate use.
- Asserts that hospice and palliative care nurses must possess sufficient knowledge about the issues surrounding the use of palliative sedation to inform patients, families, and other healthcare providers in making decisions about its use.

- Allows for conscientious objection and directs those nurses who choose not to care for patient's receiving palliative sedation to continue to provide care until responsibility for care is transferred to an equally competent colleague.
- Upholds nurses' right to transfer care.
- Affirms that consultation with palliative care specialists occur prior to the decision to implement palliative sedation to assure the appropriateness of this intervention. Consultation with the interdisciplinary colleagues including psychiatry, ethicists, chaplains, social workers, and pharmacists should be considered to the extent possible.
- Opposes active euthanasia,¹⁴ assisted suicide,¹⁵ and any interventions such as the inappropriate escalation of analgesic or sedative doses that relieve suffering with the intention of hastening death.

Definition of Terms

Autonomy: a multidimensional ethical concept. It is the right of a capable person to decide his/her own course of action based on personal values and goals of life. Self-determination is a legal right.^{16,17}

Beneficence: an ethical duty to act to benefit the recipient of care. It is based on the patient's perception of benefit and relates to promoting wellbeing.^{16,17}

Dignity or Respect for person: a fundamental ethical principle. Dignity is the quality, state, of being honored or valued. Respecting the body, values, beliefs, goals, privacy, actions and priorities of an autonomous adult preserves their dignity. This is a broader concept than autonomy.^{9,16,17}

Principle of double effect: a bioethical concept that provides moral justification for an action that has two foreseen effects: one good and one bad. The key factor is the intent of the person performing the act. If the intent is good (e.g., relief of pain and suffering) then the act is morally justifiable even if it causes a foreseeable but unintended result (e.g., hastening of death).¹⁶

Fidelity: the ethical imperative to keep promises. For healthcare providers, fidelity includes the promise not to abandon the patient.¹⁶

Informed consent: a tenet of autonomy. To make an autonomous decision, the person must have sufficient and relevant information as well as capacity to make the decision. Capacity requires that the person understands the consequences of the decision; has sufficient information and understanding about the treatment, likely outcomes, and foreseeable consequences; and be able to make the decision without coercion.^{16,17}

Imminent death: refers to death that is expected to occur within hours to days based on the person's current condition, progression of disease and symptom constellation.¹⁸

Intent: the purpose or state of mind at the time of an action. Intent of the patient/proxy and healthcare providers is a critical issue in ethical decision making around palliative sedation. Relief of suffering, not hastening or causing death, is the intent of palliative sedation.^{6,16}

Proxy decision making: allowed if the person lacks capacity to make an informed choice. Proxy or surrogate decisions should be based on one or more of the following: written advance directives; substituted judgment, which is based on subjective knowledge of the person's values, views on quality of life, goals; or the "best interest" of the person whose wishes and values are unknown and based on weighing benefits/burden of recommended actions.^{3,16,17}

Nonmaleficence: the ethical duty to do no harm. When beneficence conflicts with nonmaleficence, there is a greater duty to avoid inflicting harm.¹⁶

Palliative sedation: "when terminally ill, conscious patients experience intolerable symptoms that cannot be relieved by expert palliative care, palliative sedation involves administering sedatives and non-opioid medications to relieve suffering in doses that may induce unconsciousness, but not death"^{11, p. 583}

Refractory symptom: one that cannot be adequately controlled in a tolerable time frame or at a tolerable level despite aggressive use of usual therapies and seems unlikely to be adequately controlled by further invasive or noninvasive therapies without excessive or intolerable acute or chronic side effects/complications.¹⁹

Respite sedation: the use of sedation for a brief, planned period to provide symptom relief and rest with the goal of returning to consciousness and pursuing future therapeutic and/or palliative therapies.^{13,20}

Suffering: an individual and private experience characterized by a state of severe distress induced by loss of intactness of person or threat that the person believes will result in loss of his/her intactness related to physical pain, unrelieved symptoms, spiritual distress, depression, or multiple losses.²¹⁻²³

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