



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 end-of-life care. However, the suffering of some patients is intractable to such efforts. For imminently dying patients whose suffering is unrelenting and unendurable, palliative sedation may offer relief.

While there is no universally accepted definition of palliative sedation, palliative sedation is often defined as the monitored use of non-opioid medications intended to induce varying degrees of unconsciousness, but not death, for relief of refractory and unendurable symptoms in imminently dying patients.¹⁻⁹ Palliative sedation may also be termed terminal sedation, total sedation, sedation for intractable symptoms at end of life, continuous or prolonged sedation.^{1,8,10} It is distinct from procedural and respite sedation, and the sedation resulting from analgesics alone.^{7,10} The prevalence of palliative sedation in clinical practice is unknown, but reports suggest that it is used in 15-30% of dying patients.⁵⁻⁶

The use of medication to promote comfort and relieve pain in dying patients is supported by the ANA's *Code of Ethics for Nurses*¹¹ 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."

The ethical justification for this statement and palliative sedation is based in precepts of dignity, autonomy, beneficence, fidelity, non-maleficence, and the rule of double effect, which evaluates an action based on intended outcome and the proportionality of benefit and harm. These principles endorse the right of the individual to make healthcare decisions based on personal values and quality of life considerations, and the responsibility of clinicians to provide humane and compassionate care that is consistent with professional and societal norms.

Palliative sedation with its intent to relieve suffering in dying patients, but not to deliberately hasten death is seen as distinct from euthanasia, assisted suicide, or any intervention such as inappropriate escalation of analgesic or sedative doses

where the intent is solely to end life.¹² This distinction is supported by the 1997 U.S. Supreme Court decisions in *Vacco versus Quill* and *Washington versus Glucksberg* that states that 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.¹³

Interdisciplinary assessment of the patient is critical 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 a valid informed consent process, but also reduces the emotional burden for the healthcare providers.⁹ 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.⁷

Position Statement

This is the position of the HPNA Board of Directors:

- Affirm the value of end-of-life care that includes aggressive and comprehensive symptom management.
- Affirm the use of palliative sedation to manage refractory and unendurable symptoms in imminently dying patients as one method of aggressive and comprehensive symptom management.
- Assert 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.
- Direct 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.
- Honor nurses rights to transfer care.
- Affirm that consultation with, psychiatry, ethicists, chaplains, social workers, pharmacists and palliative care specialists may be needed to assure appropriateness of palliative sedation.
- Oppose active euthanasia,¹⁴ assisted suicide¹⁵ and any interventions such as the inappropriate escalation of analgesic or sedative doses that relieve suffering by means of hastening of 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. Self-determination is a legal right.¹⁶

Beneficence: an ethical duty to do well. It relates to promoting well being.¹⁶

Dignity or Respect for person: a fundamental ethical principle. Dignity is the quality or 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.^{11,16}

Rule 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 informed, autonomous decision, the person must have the capacity to understand the consequences of the decision; sufficient information about the treatment, desired outcomes, foreseeable consequences; intent to make the decision without coercion.¹⁶

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.⁵

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.^{7,16}

Proxy decision making: allowed if the person lacks capacity to make an informed choice. Written advanced directives, substituted judgment 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 based on benefits/burden weighing of recommended actions are the basis of such surrogate decisions.^{1,16}

Non-maleficence: the ethical duty to do no harm. When beneficence conflicts with non-maleficence, there is a greater duty to avoid inflicting harm.¹⁶

Palliative Sedation: the monitored use of non-opioid medications intended to provide relief of refractory symptoms by inducing varying degrees of unconsciousness, but not death in terminally ill patients.¹⁻⁹

Refractory symptom: one that cannot be adequately controlled in a tolerable time frame 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.²

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.^{9,18}

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.¹⁹⁻²¹

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