Background

Patients at the end of life may suffer an array of physical, psychological symptoms and existential distress that, in most cases, can be 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.

Palliative sedation is the monitored use of medications intended to induce varying degrees of unconsciousness, but not death, for relief of refractory and unendurable symptoms in imminently dying patients.\(^1\)\(^-\)\(^6\) The prevalence of palliative sedation in clinical practice is unknown but reports suggest that it is used in 15-30\% of dying patients.\(^5\)\(^-\)\(^7\) Palliative sedation may also be termed terminal sedation, total sedation, sedation for intractable symptoms at end of life, continuous or prolonged sedation.\(^1\)\(^,\)\(^8\) It is distinct from procedural and respite sedation.\(^8\)

The ethical justification for palliative sedation is based in precepts of dignity, autonomy, beneficence, fidelity, non-malefience, and the rule of double effect. These principles endorse the right of the individual to make health care 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.

The use of medication to promote comfort and relieve pain in dying patients is supported by the American Nurses Association (ANA)\(^6\) who state, “achieving adequate symptom control, even at the expense of life, thus hastening death is ethically justified.” This statement is reiterated in the ANA’s Code of Ethics for Nurses\(^10\) which also states that nurses may not act with the sole intent to end a patient’s life even if motivated by compassion and concern for dignity and quality of life. Thus, palliative sedation with its intent to relieve suffering in dying patients but not to deliberately hasten death is seen as distinct from euthanasia or assisted suicide where the intent is solely to end life.\(^11\) These statements reflect the rule of double effect.
Interdisciplinary assessment of the patient to determine the refractory nature of his/her suffering and communication with the patient, family/significant other/surrogate decision maker, and other health care providers is critical to determine the appropriateness of palliative sedation and assure a valid informed consent process.

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.\(^\text{12}\)

**Position Statement**

The Hospice and Palliative Nurses Association (HPNA) is committed to compassionate care of persons at end of life. It is the position of the HPNA Board of Directors to:

- 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 health care 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\(^\text{13}\) and assisted suicide\(^\text{14}\) as a means to relieve suffering.

**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.\(^\text{15}\)

*Beneficence:* an ethical duty to do well. It relates to promoting well being.\(^\text{15}\)

*Dignity or Respect for person:* a fundamental ethical principle. Dignity is the quality or state or 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.\textsuperscript{10,15,16}

**Double Effect:** an ethical principle based in Roman Catholic theology that is used when it is not possible to avoid all harmful effects. For an action to be ethically permissible under the principle of double effect, the act itself must be good or at least neutral (e.g. administering analgesic or sedative medication); the intention of the act is to produce a good effect (i.e., relief of suffering) even though a harmful effect (i.e. death) is foreseeable in some circumstances; the harmful effect of the act must not be the means to the good effect (i.e., death is not the means to relief of suffering); the good effect must outweigh or balance the harmful effect.\textsuperscript{4,15}

**Fidelity:** the ethical imperative to keep promises. For health care providers, fidelity includes the promise not to abandon the patient.\textsuperscript{15}

**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.\textsuperscript{15}

**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.\textsuperscript{5,17}

**Intent:** the purpose or state of mind at the time of an action. Intent of the patient/proxy and health care 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.\textsuperscript{4,15}

**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.\textsuperscript{1,15,16}

**Non-maleficence:** the ethical duty to do no harm. When beneficence conflicts with non-maleficence, there is a greater duty to avoid inflicting harm.\textsuperscript{15,16}

**Palliative Sedation:** the monitored use of medications intended to provide relief of refractory symptoms by inducing varying degrees of unconsciousness but not death in terminally ill patients.\textsuperscript{1-6}

**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.\textsuperscript{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.\textsuperscript{8,12,18}

Suffering: a phenomenon of conscious existence. It is an aversive emotional experience brought on by an enduring perceived or actual threat to physical, psychological, social, spiritual well-being.\textsuperscript{19}

Withholding and withdrawing life sustaining therapy (LST): is legally and ethically permissible if it is the patient’s fully informed and freely made wish; or such therapy is causing or will cause harm to the patient; or the therapy is not or will not benefit the patient in the future. Artificial hydration and nutrition may be withheld or withdrawn based on the same grounds.\textsuperscript{16}

References


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Approved by the HPNA Board of Directors
June 2003

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