

Palliative Sedation at End-of-Life



Comprehensive palliative care that includes pain and symptom management is the gold standard for end-of-life care. However, despite aggressive appropriate management, some patients develop intractable suffering. When all other management strategies have been exhausted, it may be appropriate to sedate the patient to the point that they are no longer aware of their symptoms/distress. This practice is referred to as palliative sedation. While palliative sedation is most commonly used for unyielding physical symptoms (pain, dyspnea, extreme delirium/agitation), it may also be appropriate for otherwise intractable psychosocial or existential distress.

The Data:

- Few patients receiving palliative care will require palliative sedation. It is seen as a last resort clinical response to extreme pain and suffering.⁴
- Palliative sedation involves the use of sedatives in doses sufficient to relieve the symptoms of suffering. The goal is to render patients unconscious and thereby unaware of extreme pain and suffering. The goal is not to hasten death.¹
- Severe pain was described by 5-35% of hospice patients in the last week of life, and 25% described their shortness of breath as “unbearable”.²
- Palliative sedation differs from euthanasia in that the dose of medication is titrated to maintain sedation, not to affect the patient’s death.
- Palliative sedation differs from physician assisted suicide in that the goal of therapy is to relieve suffering not to cause death. Physician-assisted suicide generally refers to a practice in which the physician provides a patient with a lethal dose of medication, upon the patient's request, which the patient intends to use to end his or her own life.¹⁰
- Palliative sedation is used to treat the symptoms of air hunger in dying patients during and after withdrawal of mechanical ventilation.³

Ethical/Legal Aspects:

- A 1997 US Supreme Court decision confirmed that palliative sedation is permitted under current law.⁵ Justice O'Connor's brief stated “The parties and amici agree that in these States a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death.... In this light,... I agree that the State's interests in protecting those who are not truly competent or facing imminent death, or those whose decisions to hasten death would not truly be voluntary, are sufficiently weighty to justify a prohibition against physician-assisted suicide”. In her fourth and final paragraph, she reiterated, "There is no dispute that dying patients in Washington and New York can obtain palliative care, even when doing so would hasten their deaths."⁵
- Although palliative sedation may seem to be an extraordinary measure, withholding such a treatment in certain circumstances could be considered inhumane.⁶
- Palliative sedation is considered to be a combination of ethical beneficence, aggressive symptom management and withdrawal of life-sustaining therapy.⁴

Palliative Sedation at End-of-Life

- The National Hospice and Palliative Care Organization (NHPCO) supports the use of palliative sedation and has produced a monograph detailing the medical, ethical, legal, and practical aspects of palliative sedation.¹
- American Academy of Hospice and Palliative Medicine (AAHPM) supports the use of palliative sedation in both conscious and unconscious patient's and has produced a position statement on palliative sedation.⁸

Recommended Actions:

- Palliative sedation is always an option of last resort in the palliative care continuum.
- Palliative sedation, by definition, is not immediately lethal: requires appropriate discussion with and education of the patient and/or family; and must be performed by a team experienced in the use of palliative sedation.⁴
- Practitioners must discuss the risks, benefits, and alternatives of palliative sedation with the patient or surrogate decision maker, and obtain informed consent. The discussion must take into account the patient's and/or family's mental capacity and the proportionate presence of suffering
- Although the goal of palliative sedation is to relieve suffering, the decision-making process should include acknowledgement and documentation of a clear understanding that death is inevitable. Before initiating palliative sedation, the physician must confirm an exhaustive attempt to relieve the patient's suffering by other means of palliative care.
- If a practitioner chooses not to participate in palliative sedation, he/she is obligated to search for acceptable alternatives with the patient. If a mutually acceptable approach cannot be found, the patient and family should be given the option of transferring care to another physician.⁵
- Ethics, Hospice or Palliative Care consultation may prove helpful for management of patients for whom palliative sedation is being considered.

References:

1. *NHPCO Policy Statement on Total Sedation, 2001.* www.nhpc.org/files/public/NHPCOTotalSedationSHORT.pdf.
2. Coyle N, Adelhardt J, Foley KM, Portenoy RK. Character of terminal illness in the advanced cancer patient: pain and other symptoms during the last four weeks of life. *J Pain Symptom Manage.* 1990; 5: 83-93.
3. Brody H, Campbell ML, Faber-Langendoen K, Ogle KS. Withdrawing intensive life-sustaining treatment, recommendations for compassionate clinical management. *N Engl J Med.* 1997; 336: 652-7.
4. Quill TE, Lee BC, Nunn S. Palliative treatments of last resort: choosing the least harmful alternative. *Ann Intern Med.* 2000; 132: 488-493.
5. Burt RA. The Supreme Court speaks – not assisted suicide but a constitutional right to palliative care. *N Engl J Med.* 1997; 337: 1234-6.
6. Quill TE, Byock IR. Responding to intractable terminal suffering: the role of terminal sedation and voluntary refusal of food and fluids. *Ann Intern Med.* 2000; 132: 408-414.
7. Cherny NI, Portenoy RK. Sedation in the management of refractory symptoms: guidelines for evaluation and treatment. *J Palliat Care.* 1994; 10: 31-8.
8. AAHPM Position Statements Statement on Palliative Sedation, 2006. www.aahpm.org/positions/sedation.html
9. Lo B., Rubenfeld G. Palliative Sedation in Dying Patients *JAMA.* 2005;294;1810-1816
10. University of Washington School of Medicine Ethics in Medicine <http://depts.washington.edu/bioethx/topics/pas.html>

This document may be found in the resource library on Hospice & Palliative Care Charlotte Region's Web site: <http://www.hpccr.org/about-resource-library.cfm>. For more information about Hospice & Palliative Care Charlotte Region, visit www.hpccr.org.