HPNA Position Statement
Palliative Sedation

It is the position of the Hospice and Palliative Nurses Association (HPNA) that:

- The goal of hospice and palliative care is to maximize comfort and minimize distressing symptoms for patients and their families across the lifespan. However, in some instances, traditional interventions for palliative symptom management may not be sufficient to bring adequate relief to dying patients (refractory symptoms).
- Palliative sedation (also called controlled sedation) can relieve intolerable and refractory symptoms (e.g., pain, delirium, dyspnea) through controlled titration of medications that decrease the level of consciousness in patients with advanced, incurable illnesses. This may be an appropriate intervention to reduce suffering for patients in their last days of life.[1-3]
- Palliative sedation differs from other interventions because of the depth and duration of the sedation (mild, intermediate, or deep), and it may be delivered intermittently or continuously.[4]
- As with any medical intervention, palliative sedation requires a medical indication,[5,6] and the following criteria should be met: (1) death is imminent; (2) symptoms are intolerable and refractory, and no other treatments can address the symptoms; (3) the plan of sedation and risks/benefits are made explicitly clear through an informed consent process with the patient or surrogate decision-maker.[4,5,7]
- As with all aspects of palliative nursing, clinicians providing palliative sedation must apply evidence-based care and principles of ethical practice.[8]
- Hospice and palliative nurses must understand:
    - The indications for and clinical use of palliative sedation, as well as the ethical and legal principles for its use.[9]
    - The intent of palliative sedation is to reduce suffering by the controlled induction of sedation to manage refractory symptoms in the dying patient.
    - It is not to be used for the purpose of hastening death.[10-12]

Background

Patients at the end of life may suffer from physical and psychological symptoms. Although palliative interventions are available to treat these symptoms, sometimes dying patients may experience intractable symptoms that are unrelieved by traditional therapies. Palliative sedation is a well-established and accepted practice to relieve these often difficult-to-manage symptoms.[13] Palliative sedation may be needed as an intervention to relieve intolerable suffering in adult and pediatric patients with advanced, incurable illnesses.[6,14] In such circumstances, palliative sedation is intended to relieve symptoms and provide comfort.[10,11]

Palliative sedation involves the administration of sedative medications to reduce consciousness, thereby alleviating refractory symptoms when other treatments have failed. This practice is primarily employed in end-of-life care for patients experiencing severe, uncontrollable symptoms. Palliative sedation is distinct from conscious sedation for procedures, respite sedation, and sedation resulting from medications alone.[15]

Previously called terminal sedation, the name was modified to more accurately reflect the intent and application of its use—to palliate the patient's experience of symptoms rather than to cause or hasten death.[10,11] Other terms include total sedation, sedation for intractable symptoms at end of life, continuous sedation, or prolonged sedation.[16] The use of terms other than palliative sedation is guided by the specific clinical context (emergent versus planned), the expected duration of sedation (temporary versus continuous until death), and the depth of the sedation required (mild/conscious versus deep sedation). The lack of use of consistent terminology may lead to ambiguity, confusion, and controversy in clinical practice, research, and societal discussions.[5,17]

Palliative sedation can be delivered in a variety of settings, and administration is dependent upon the clinical situation and wishes of the patient/surrogate decision-maker[18,19] The use of palliative sedation requires discussion with a multidisciplinary team of professionals with different areas of expertise who are working together to treat a patient's condition, as well as prudent application, broad clinical experience, and good practice.[4,20,21] The prevalence of palliative sedation varies widely, ranging from about 5% to more than 50% of terminally ill patients.[22-25] The wide variation in reported prevalence is likely due to factors such as a lack of a uniform definition of palliative sedation, differences in clinical practices and attitudes, religious and cultural factors, and variations among healthcare institutions and countries.[5]

Palliative sedation can be used for children.[3,9,23] Parents and guardians have the legal authority to make decisions regarding treatment for their children younger than 18 years if the parents or guardians are considered to have their children's best interest at heart. Thus, palliative sedation may be part of conversations with pediatric patients and their families. However, the child's views and preferences for medical care, including assent and refusal for treatment (when developmentally appropriate), should be documented and given appropriate weight in decision-making about palliative sedation. When the child's wishes differ from those of the adult decision-maker, an ethics committee may be utilized to assist the child as well as the family.[26]

In recent years, the use of palliative sedation has gained increased attention in medical literature and clinical practice. A study published in 2023 revealed that the median survival time after initiating palliative sedation was 25 hours, with an interquartile range of 8–48 hours.[27] This finding highlights the typically short duration between the start of sedation and the patient's death, emphasizing its application in the final stages of life. However, it is important to note that palliative sedation is not intended to hasten death but rather to provide relief from unbearable suffering.

The practice of palliative sedation may be distressing for families and staff,[6] particularly if it reduces consciousness to a point where the patient cannot interact with others and/or nutrition and hydration are withheld.[28] Ethical concerns may be alleviated through shared decision-making with the patient (if able), family/surrogate decision maker, and the team, reiterating that palliative sedation does not shorten survival and explaining the difference between palliative sedation and euthanasia.

Practice of Palliative Sedation

The practice of palliative sedation is grounded in the precepts of dignity, autonomy, beneficence, fidelity, and nonmaleficence.[29] These principles support the right of the individual to make healthcare decisions based on personal values and quality-of-life considerations,[29] and they reinforce the responsibility of clinicians to provide humane and compassionate care. The practice of palliative sedation is supported by the 1997 U.S. Supreme Court decisions in Vacco v. Quill[30] and Washington v. Glucksberg,[31] which state 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.

The use of medication to promote comfort and relieve pain in dying patients is supported by the American Nurses Association's *Code of Ethics for Nurses with Interpretive Statements*, which states, "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, a nurse may not act with the intent to end a patient's life even if motivated by compassion, respect for patient autonomy, and quality-of-life considerations."[32]

The process of palliative sedation first requires a comprehensive assessment of the patient by the interdisciplinary team to determine the refractory nature of symptoms and subsequent suffering.[33] Communication with the patient, family/significant other/surrogate decision-maker, and other healthcare providers about the use and levels (mild, intermediate, deep) of palliative sedation is essential.[34] Collaboration with the multidisciplinary team validates the appropriateness of palliative sedation and reduces the emotional burden for all involved.[4,20,21] Much like other palliative procedures, palliative sedation requires formal informed consent. Patients and/or their surrogates should receive a full explanation of the goal of palliative sedation, what it is and isn't, medications used, and expected outcomes.[28] The possibility of death should be discussed, and the informed consent process should be documented.[35]

Patient comfort is the priority with palliative sedation.[36] The process focuses on using sedative and analgesic medications to treat refractory pain and symptoms. Attempts at resuscitation are generally viewed as inconsistent with palliative sedation; however, decisions to withhold or withdraw other life-sustaining therapies or nutrition and hydration are best made separately from the decision to use palliative sedation.[28] Such discussions should occur prior to initiating palliative sedation.[37] It is important to recognize that although reliable strategies

exist to assess and treat physical suffering, when a patient is experiencing existential suffering, other interventions may be needed to lessen the patient's distress. In all cases, the sources of suffering should be assessed and should guide recommended treatments. Inclusion of chaplaincy, social work, and other disciplines may be needed to address suffering.

There should be clear documentation during the use of palliative sedation that it is a last-resort therapy. Documentation should include pain or other symptoms that are intractable; previously tried and failed treatments (e.g., medications and interventions); multidisciplinary consultations (e.g., chaplaincy, psychiatry, social services, pain services) to help manage pain and symptoms; elements of informed consent; the plan for palliative sedation, focusing on the medication(s); and the actual process that occurred, including which medications were used, the dosages, the patient's response to medications, and the family's or community's coping process.[35,38]

Education

- Hospice and palliative nurses must possess sufficient knowledge about the clinical aspects, procedures, and ways to support families regarding the use of palliative sedation to inform patients, families, and other healthcare providers in making decisions about its use.
- Adequate knowledge of correct medications and co-medications, in addition to hydration and nutrition therapies, used during palliative sedation is critical.[39]
- Educational efforts are needed regarding the intent and practice of palliative sedation[37], as a lack of familiarity leads to discomfort and reluctance to participate in palliative sedation, creating a barrier that crosses all practice settings.[37]

Clinical Practice

- Interventions and appropriate escalation of analgesic and/or sedative doses should be used to relieve suffering without the intention of hastening death.
- Optimal care includes consultation with palliative care specialists prior to the decision to implement palliative sedation to ensure the appropriateness of this intervention. Hospice and palliative nurses should consult with interdisciplinary colleagues, including physicians, advanced practice registered nurses (APRNs), psychiatrists, psychologists, ethicists, chaplains, social workers, and pharmacists, to ensure that all potential treatment options are explored and trialed and that no further options exist except palliative sedation.[16]
- A planned interruption of sedation is recommended, whenever possible, to reassess the patient and their ongoing need for palliative sedation.[13]
- A nurse or other clinician may object to the use of palliative sedation and have the right to abstain from care. However, nurses who choose not to participate in palliative sedation are directed to continue to provide care until responsibility for care is transferred to an equally competent colleague to avoid abandonment of the patient.

Policy

- Hospice and palliative registered nurses (RNs) and APRNs should understand their scope of practice within their organization and state in terms of care delivery.[12,40]

- When palliative sedation is offered as part of the plan of care, organizational policies and procedures are in place to establish a consistent and agreed-upon process. At a minimum, these policies and procedures should include the roles of the bedside RN, APRN, physician, and pharmacist, as well as the requirement of a palliative care consultation or a pain consultation.
- Nurses should participate in the development of policies and procedures to treat refractory symptoms.
- It is the nurse's role to provide information about palliative sedation and how it differs from hastening death or medical aid in dying to the patient and their family/support persons.
- Informed consent must be used for palliative sedation. Patients who lack decision-making capacity and who do not have a previously designated surrogate decision-maker should have such a person named in accordance with state, local, and institutional regulations who can assist with informed consent for palliative sedation.

Leadership

- Hospice and palliative nurses should support patients, families, and colleagues in the decision-making process of palliative sedation.
- It is also the role of hospice and palliative nurses to advocate for care that is consistent with the stated wishes of the patient and their surrogates, whereby palliative sedation may be appropriate to treat intolerable suffering, promote comfort, and optimize dignity.[12]

Research

- Exploring the influence of culture on refractory symptoms and the use of palliative sedation is an important area of research.
- Studies that identify patients who are most likely to benefit from palliative sedation could facilitate early identification of high-risk patients with refractory symptoms in practice.[41]
- Examining healthcare professionals' perspectives about facilitators and barriers to implementing palliative sedation can guide practice improvement.
- Research is needed on the use of palliative sedation to treat existential suffering,[8] determinants of palliative sedation that can facilitate early identification of patients with refractory symptoms who might benefit from this treatment,[42] and the ethical challenges associated with all forms of palliative sedation.[7]
- Research should move from generalized or descriptive accounts of reasons for sedation, medications used, and modes and duration of sedation to more nuanced studies related to specific indications, approaches, and outcomes.[43]

References

1. Cherny NI, Radbruch L, Board of the European Association for Palliative Care. European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care. *Palliat Med*. 2009;23(7):581-593. doi: 10.1177/0269216309107024.
2. Surges SM, Garralda E, Jaspers B, et al. Review of European guidelines on palliative sedation: a foundation for the updating of the European Association for Palliative Care framework. *J Palliat Med*. 2022;25(11):1721-1731. doi: 10.1089/jpm.2021.0646.
3. Peláez Cantero MJ, Morales Asencio JM, Parra Plantagenet-Whyte F, et al. Sedation in pediatric palliative care: the role of pediatric palliative care teams. *Palliat Support Care*. Published online July 28, 2023:1-5. doi: 10.1017/S1478951523000846.
4. Beauverd M, Mazzoli M, Pralong J, et al. Palliative sedation—revised recommendations. *Swiss Med Wkly*. 2024;154(2):3590-3590. doi: 10.57187/s.3590.
5. Tomczyk M, Jaques C, Jox RJ. Palliative sedation: ethics in clinical practice guidelines—systematic review. *BMJ Support Palliat Care*. 2023;13(e3):e651-e663. doi: 10.1136/spcare-2023-004266.
6. Palliative sedation. UpToDate. Accessed October 1, 2024. https://www.uptodate.com/contents/palliative-sedation
7. Tomczyk M, Jaques C, Jox RJ. Ethical challenges in palliative sedation of adults: protocol for a systematic review of current clinical practice guidelines. *BMJ Open*. 2022;12(7):e059189. doi: 10.1136/bmjopen-2021-059189.
8. American Nurses Association. *ANA Code of Ethics for Nurses*. 2023. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/
9. Cuviello A, Johnson LM, Morgan KJ, et al. Palliative sedation therapy in pediatrics: an algorithm and clinical practice update. *Child Basel Switz*. 2022;9(12):1887. doi: 10.3390/children9121887.
10. Schildmann J, Schildmann E. Clinical and ethical challenges of palliative sedation therapy. The need for clear guidance and professional competencies. *Int J Clin Pract*. 2013;67(11):1086-1088. doi: 10.1111/ijcp.12227.
11. Guité-Verret A, Boivin J, Hanna AMR, et al. Continuous palliative sedation until death: a qualitative study of palliative care clinicians' experiences. *BMC Palliat Care*. 2024;23(1):104. doi: 10.1186/s12904-024-01426-2.
12. American Nurses Association. Nurses' roles and responsibilities in providing care and support at the end of life. Published 2024. Accessed October 1, 2024. https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/nurses-roles-and-responsibilities-in-providing-care-and-support-at-the-end-of-life/
13. Surges SM, Brunsch H, Jaspers B, et al. Revised European Association for Palliative Care (EAPC) recommended framework on palliative sedation: an international Delphi study. *Palliat Med*. 2024;38(2):213-228. doi: 10.1177/02692163231220225.
14. Arantzamendi M, Belar A, Payne S, et al. Clinical aspects of palliative sedation in prospective studies. a systematic review. *J Pain Symptom Manage*. 2021;61(4):831-844.e10. doi: 10.1016/j.jpainsymman.2020.09.022.

15. Palliative Care Network of Wisconsin. Controlled Sedation for Refractory Suffering—Part 1. Accessed September 30, 2024. https://www.mypcnow.org/fast-fact/controlled-sedation-for-refractory-suffering-part-1/
16. Collett D, Baxter K. Palliative sedation. In: Dahlin C, Coyne P, Dahlin C, Coyne PJ (Eds.), *Advanced Practice Palliative Nursing* (2nd ed.). Oxford University Press; 2021. doi: 10.1093/med/9780197559321.003.0057.
17. Kremling A, Schildmann J. What do you mean by "palliative sedation"? *BMC Palliat Care*. 2020;19:147. doi: 10.1186/s12904-020-00635-9.
18. Twycross R. Regarding palliative sedation. *J Pain Symptom Manage*. 2017;53(6):e13-e15. doi: 10.1016/j.jpainsymman.2017.01.002.
19. Twycross R. Reflections on palliative sedation. *Palliat Care*. 2019;12:1178224218823511. doi: 10.1177/1178224218823511.
20. Cuviello A, Ang N, Morgan K, et al. Palliative sedation therapy practice comparison—a survey of pediatric palliative care and pain management specialists. *Am J Hosp Palliat Care*. 2023;40(9):977-986. doi: 10.1177/10499091221138298.
21. Tomczyk M, Jaques C, Jox RJ. Clinical practice guidelines on palliative sedation around the world: a systematic review. *J Palliat Care*. Published online November 28, 2022. doi: 10.1177/08258597221138674.
22. Mercadante S, Villari P, David F. Palliative sedation outside a palliative care unit. *BMJ Support Palliat Care*. 2023;13(e2):e297-e299. doi: 10.1136/bmjspcare-2020-002494.
23. Chen Y, Jiang J, Peng W, et al. Palliative sedation for children at end of life: a retrospective cohort study. *BMC Palliat Care*. 2022;21:57. doi: 10.1186/s12904-022-00947-y.
24. Marinelli D, Ravoni G, Fusilli M, et al. Palliative sedation and time to death in home palliative care: retrospective analysis. *BMJ Support Palliat Care*. 2024;13(e3):e890-e893. doi: 10.1136/spcare-2023-004377.
25. Hedman C, Rosso A, Häggström O, et al. Sedation in specialized palliative care: a cross-sectional study. *PLOS One*. 2022;17(7):e0270483. doi: 10.1371/journal.pone.0270483.
26. National Consensus Project for Quality Palliative Care. *Clinical Practice Guidelines for Quality Palliative Care* (4th ed.). Published online 2018. Accessed October 1, 2024. https://www.nationalcoalitionhpc.org/ncp
27. Lojo-Cruz C, Mora-Delgado J, Rivas Jiménez V, et al. Survival outcomes in palliative sedation based on referring versus on-call physician prescription. *J Clin Med*. 2023;12(16):5187. doi: 10.3390/jcm12165187.
28. American Academy of Hospice and Palliative Medicine. Palliative Sedation. Accessed October 1, 2024. https://aahpm.org/advocacy/where-we-stand/palliative-sedation/
29. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics* (8th ed.). Oxford University Press; 2019.
30. *Vacco v. Quill*. US 793 (United State Supreme Court 1997).
31. *Washington v. Glucksberg*. US 702 (United States Supreme Court 1997).
32. American Nurses Association. Code of Ethics for Nurses. Published online October 26, 2017. Accessed October 1, 2024. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/

33. Rosa WE, Ferrell BR. *The Nature of Suffering and the Goals of Nursing* (2nd ed.). Oxford University Press; 2023.
34. de Graeff AD, Dean M. Palliative sedation therapy in the last weeks of life: a literature review and recommendations for standards. *J Palliat Med*. 2007;10(1):67-85. doi: 10.1089/jpm.2006.0139.
35. Kauzner S, Heckel M, Ostgathe C, et al. Documentation of sedation in palliative care: a scoping review of requirements, recommendations, and templates. *J Palliat Med*. 2023;26(9):1277-1284. doi: 10.1089/jpm.2022.0476.
36. Rijpstra M, Vissers K, Centeno C, et al. Monitoring the clinical practice of palliative sedation (PALSED) in patients with advanced cancer: an international, multicentre, non-experimental prospective observational study protocol. *BMC Palliat Care*. 2023;22(1):8. doi: 10.1186/s12904-022-01125-w.
37. Nolen A, Selby D, Qureshi F, Mills A. Practices of and perspectives on palliative sedation among palliative care physicians in Ontario, Canada: a mixed-methods study. *Palliat Med Rep*. 2024;5(1):94-103. doi: 10.1089/pmr.2023.0081.
38. Ferrell BR, Paice JA. *Oxford Textbook of Palliative Nursing* (5th ed.). Oxford University Press; 2019.
39. Pozsgai É, Garralda E, Busa C, et al. Report on palliative sedation medication usage: a survey of palliative care experts in eight European countries. *BMC Palliat Care*. 2024;23(1):154. doi: 10.1186/s12904-024-01484-6.
40. American Nurses Association. The Nurse's Role in Ethics and Human Rights: Protecting and Promoting Individual Worth, Dignity, and Human Rights in Practice Settings. Published online 2016. Accessed October 1, 2024. https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/the-nurses-role-in-ethics-and-human-rights/
41. Guité-Verret A, Boivin J, Hanna AMR, et al. Continuous palliative sedation until death: a qualitative study of palliative care clinicians' experiences. *BMC Palliat Care*. 2024;23(1):104. doi: 10.1186/s12904-024-01426-2.
42. Tan F, Li N, Wu Y, et al. Palliative sedation determinants: systematic review and meta-analysis in palliative medicine. *BMJ Support Palliat Care*. 2024;13(e3):e664-e675. doi: 10.1136/spcare-2022-004085.
43. Thomas C, Alici Y, Breitbart W, et al. Addressing challenges with sedation in end-of-life care. *J Pain Symptom Manage*. 2024;67(4):346-349. doi: 10.1016/j.jpainsymman.2023.12.016.

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This statement reflects the best available evidence at the time of writing or revisions.

Approved by the HPNA Board of Directors month year

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