

The Use of Sedation in Palliative Care

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The use of sedation for palliation is underpublicized and as such is also in danger of being underutilized. Guidelines involving its use should take into account patient needs and choice that properly reflect and encompass respect for autonomy. The public in general and patients in particular are not adequately informed of all the sedative options available to them in palliative care, from mild and intermittent all the way through to and including continuous deep sedation (CDS). Given the fact that in most places it is illegal for a health care practitioner to intentionally and directly hasten the death of a patient, sedation may be the only possible means to achieve palliative ends consistent with the wishes of the patient. The decision in *Washington v Glucksberg* (521 U.S. 702, 1997) upheld a ban on physician assisted suicide based in part on the fact that palliative care options are sufficient for dying patients dealing with refractory symptoms. This cannot be the case if all of those options are not made available to dying patients.

Mild and intermittent sedation pose almost no moral difficulties. Sedation levels are used which maximize patient awareness while minimizing symptom discomfort. Continuous deep sedation (CDS) raises new moral concerns since the patient is projected to never return to a conscious state. Current guidelines regarding the use of CDS developed by the American Medical Association (AMA) refer to it as an option of "last resort" in order to alleviate refractory symptoms. (CEJA Report 5-A-08, Levine 2008). These guidelines properly reflect the profound ramifications of CDS. Still, the AMA guidelines show little regard for patient choice. The trouble is not with the terms (last resort/refractory) themselves. Troubling is how patients evolve to stages that

can be characterized by these terms. Patients too often must endure symptoms they may rather have been spared as they progress to the level of what the health care team deems to be refractory thus justifying a "last resort" option. It would be more appropriate and consistent with the goals of palliative care medicine to have discussions with patients regarding the use of all levels of sedation, up to and including CDS, at the earliest feasible opportunity once palliative care has been initiated. The AMA model inappropriately restricts patient choice by keeping patients unaware of sedative options until the health care team thinks it appropriate to consider sedation based on the severity of the symptoms the patient may be experiencing. Often pain and suffering make it difficult for patients themselves to participate, further reducing their autonomy and empowerment. Patients should be kept fully empowered by being thoroughly informed of all means available to reduce their symptoms and maximize their comfort at the earliest possible stage of their palliative care.

Dying patients in palliative care settings deserve to have maximum control over their futures. This includes full disclosure on the use and effectiveness of sedation for palliative ends. Allowing patients more decision-making power in choosing various levels of sedation through to CDS would significantly improve the dying process while maintaining ethically sound practices as viewed by all parties concerned. Health care practitioners would not have to feel that they are hastening death. Patients would have greater control over their symptoms. Family members would not have to watch their loved ones endure dysteleological suffering. It is the best we can do when facing our finitude, and dying patients deserve our best.

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