AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(A-19)

Introduced by: Minnesota

Subject: Addressing Existential Suffering in End-of-Life Care

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

Whereas, The duty to relieve pain and suffering is central to the physician's role as healer; and

Whereas, Patients may experience both physical and existential suffering at the end-of-life; and

Whereas, Sedation to unconsciousness is an ethical practice to address refractory clinical symptoms, but is inappropriate to respond to existential suffering; and

Whereas, Existential suffering includes anxiety, isolation, loss of control, and other non-physical suffering that are serious conditions impacting patients' health; and

Whereas, Pharmacological or other clinical options short of sedation to unconsciousness may be appropriate to mitigate a patient's existential suffering; and

Whereas, Physicians have an ethical obligation to respect and consider the previously expressed wishes of a patient who has lost the ability to provide consent; and

Whereas, Existing AMA Council on Ethical and Judicial Affairs Opinion 5.6 addresses many of these issues in detail but does not expressly address two areas; and

Whereas, CEJA Opinion 5.6 states that existential suffering should be addressed through social, psychological, or spiritual support to the exclusion of other clinical options, even though there are treatments for existential suffering beyond social, psychological or spiritual support that are beneficial for patients; and

Whereas, CEJA Opinion 5.6 states that consent must be obtained from the patient or surrogate, but does not recognize or require consideration of a patient's previously expressed wishes in the case of surrogate decision making; therefore be it

RESOLVED, That our American Medical Association ask the Council on Judicial and Ethical affairs to review Ethical Opinion 5.6, "Sedation to Unconsciousness in End-of-Life Care," to address the following two issues: appropriate treatments beyond social, psychological or spiritual support to treat existential suffering, and the recognition of a patient's previously expressed wishes with end-of-life care. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 04/24/19

References:
1. N Kirk, T. W., & Mahon, M. M. (2010). National Hospice and Palliative Care Organization (NHPCO) position statement and commentary on the use of palliative sedation in imminently dying terminally ill patients. Journal of pain and symptom management, 39(5), 914-923.
2. American Academy of Hospice and Palliative Medicine Statement on Palliative Sedation, http://aahpm.org/positions/palliative-sedation.

RELEVANT AMA POLICY

E-5.6 Sedation to Unconsciousness in End-of-Life Care

The duty to relieve pain and suffering is central to the physicians role as healer and is an obligation physicians have to their patients. When a terminally ill patient experiences severe pain or other distressing clinical symptoms that do not respond to aggressive, symptom-specific palliation it can be appropriate to offer sedation to unconsciousness as an intervention of last resort.

Sedation to unconsciousness must never be used to intentionally cause a patients death.

When considering whether to offer palliative sedation to unconsciousness, physicians should:

(a) Restrict palliative sedation to unconsciousness to patients in the final stages of terminal illness.

(b) Consult with a multi-disciplinary team (if available), including an expert in the field of palliative care, to ensure that symptom-specific treatments have been sufficiently employed and that palliative sedation to unconsciousness is now the most appropriate course of treatment.

(c) Document the rationale for all symptom management interventions in the medical record.

(d) Obtain the informed consent of the patient (or authorized surrogate when the patient lacks decision-making capacity).

(e) Discuss with the patient (or surrogate) the plan of care relative to:

(i) degree and length of sedation;

(ii) specific expectations for continuing, withdrawing, or withholding future life-sustaining treatments.

(f) Monitor care once palliative sedation to unconsciousness is initiated.

Physicians may offer palliative sedation to unconsciousness to address refractory clinical symptoms, not to respond to existential suffering arising from such issues as death anxiety, isolation, or loss of control. Existential suffering should be addressed through appropriate social, psychological or spiritual support.

AMA Principles of Medical Ethics: I,VII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016