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Palliative Sedation and Existential Suffering: Real-World Diagnostic and Therapeutic Considerations in Applying Hippocratic Wisdom

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Editor's Note: Martin and Ramirez refine and apply Bryce Asberg's work in "Palliative Sedation for Existential Suffering: The Enduring Wisdom of the Hippocratic Oath," *Dignitas* 32, no. 1-2 (2025): 6-9, www.cbhd.org/dignitas-articles/palliative-sedation-for-existential-suffering-the-enduring-wisdom-of-the-hippocratic-oath.

We deeply appreciated Bryce Asberg's essay, "Palliative Sedation for Existential Suffering: The Enduring Wisdom of the Hippocratic Oath," and enjoyed reading it with profound engagement and resonance. It is a beautifully written piece, composed with clarity and elegance. He concisely addresses the relevant moral and ethical concerns that arise with the use of palliative sedation as a therapeutic approach for suffering that stems from non-physical causes. The authors of this response piece are in general agreement with both of Asberg's main theses—namely, that "because existential suffering is not . . . a physical phenomenon, it should not be treated with a physical intervention," and furthermore that "the practice of palliative sedation for existential suffering

undermines [its] validity."¹

To highlight our agreement with these core premises, we affirm that a fitting treatment is necessarily proper only when it is appropriate for a given diagnosis. While we agreed broadly with Asberg's theses and arguments, and certainly also with the Christian Hippocratic tradition underpinning his premises, this piece also provoked some questions for us as medical professionals—namely, as a palliative medicine attending physician (Rebecca Martin, RM), and as a third-year medical student (David Ramirez, DR)—that we felt worthy to raise, in the dialogical spirit of *Dignitas*. These questions arise primarily out of my (RM's) specific context of practice, which will be

elucidated shortly.

In our response, we will frame our considerations in the form of two questions: (1) Diagnostically, can a clear distinction reliably and practically be made between physical and existential suffering at the end of life, particularly in the face of significant symptom burden? And (2) therapeutically, how can clinicians best address existential suffering at the end of life, whether presenting in pure form or as a contributor to suffering more broadly, when time is short and symptom burden may preclude necessary therapeutic engagement?

In our first part, then, we will consider diagnostic challenges posed in the real-world application of Asberg's analysis, where distinguishing between physically and existentially mediated suffering is not always clear-cut. In the second part, we will explore some of the practical challenges

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that arise when seeking to offer appropriate therapeutic approaches to existential suffering at the end of life. We will also offer one potential path forward in the form of a middle-ground approach to addressing existential distress—namely, respite sedation. We will then conclude with a reflection on how Catholic Christian theology uniquely informs an approach to existential distress.

Diagnostic Considerations:

Distinguishing Physical and Existential Distress at the End of Life

In my (RM's) experience as a palliative medicine attending practicing in a large, acute-care, tertiary hospital context, refractory end-of-life suffering is fortunately more the exception than the rule. The overwhelming majority of patients cared for by palliative medicine teams have generally well-controlled symptoms, including appropriate management of pain, dyspnea, and anxiety, in their final hours and days before natural death.² I have, however, attended rare but memorable cases in which terminal agitation and/or severe, intractable pain persisted despite escalating doses of myriad medications intended to offer relief. These medications are typically some combination of opioids, such as morphine or hydromorphone; benzodiazepines, such as lorazepam or diazepam; and first-generation antipsychotics, such as haloperidol. Furthermore, physical symptom burden has long been known to interact meaningfully and be modulated by psychological/existential distress, and vice versa.³

A number of years ago, as a family medicine resident, I (RM) attended a Christian Medical & Dental Associations retreat presentation given by Dr. James Avery, a Christian palliative medicine physician. As I recall that lecture, Dr. Avery shared the story of a young girl in his pediatric intensive care unit who was suffering terribly with intractable pain that was refractory to all approaches he and his team had thought to try. Despite their best efforts, she was suffering immensely, requiring massive doses of intravenous hydromorphone—until, he said, someone on his team found her a “puppy.” With this “intervention,” the child's pain scores (and hydromorphone usage) plummeted exponentially.

The response was so dramatic, in fact, that when it was related during their team interdisciplinary rounds, Dr. Avery initially took

“PUPPI” to be an acronym for some kind of new medical device and asked for clarification. Yet it was, indeed, simply the introduction of a young dog—and a new relational dynamic. In this case, the patient received a small animal that could offer safe physical touch and unconditional companionship in the isolating, fearful, painful environment of a hospital ICU—that made a dramatic difference in her organically rooted, physical symptomatology. Dr. Avery's point in sharing this anecdote was to always bear in mind that suffering is multifactorial; when physical pain seems intractable, consider what other factors might be contributing to, and modulating, the total experience of a patient's suffering.

This story echoes other experiences observed clinically, where the etiologies of suffering may not be readily sorted into clean, binary categories of “physical” and “existential.” Consider “terminal hyperactive delirium,” for instance—that state of marked confusion/altered sensorium, restlessness/agitation, and hallucinations that can occur in a patient's final hours or days. Is that condition purely physical, or can existential aspects contribute to this presentation? Current evidence suggests that hyperactive delirium afflicts 14% of patients in palliative care settings⁴ and up to 88% of patients in palliative care inpatient units in their final hours to weeks of life.⁵

A retrospective matched-cohort analysis of hospice patients exploring rates of terminal delirium showed that nearly 47% of the sample had documented symptoms of hyperactive terminal delirium.⁶ Approximately 48% of that same sample self-identified as being spiritually active, and there were no statistically significant differences between patients who had delirium and those who did not with regard to physical, psychological, or spiritual factors. Interestingly, a slight majority of patients who displayed hyperactive terminal delirium (52%) endorsed having significant fears upon their admission to hospice, raising the question whether existential and/or spiritual distress may play a role in such presentations, but it was by no means an overwhelming proportion. In that same study, logistic regression analysis showed that place of death was the most significant driver, with a 2.3 times greater risk of hyperactive terminal delirium for patients who died in the hospice inpatient unit setting compared to those who died at home ($p < 0.05$); subsequent studies, however, have

demonstrated mixed results with regard to this finding.⁷

For some patients suffering with severe/intractable end-of-life pain and/or terminal agitation, particularly those with identified risk factors—young age, military veterans with a history of combat, prior history of trauma with associated PTSD⁸—there can be meaningful overlap, and interplay, between these two causal realms. There is not always a clear separation.⁹ In fact, as we have seen, the presence of refractory end-of-life suffering is itself often a clue to the astute palliative clinician that underlying existential (emotional, mental, relational, spiritual) distress may be contributing, at least in part, to challenges in adequately controlling a patient's physical symptoms.

This overlap and complex interplay is also alluded to in emerging evidence on the treatment of complex chronic pain presentations, where multimodal approaches employ a combination of pharmacologic, psychotropic, and psychological modalities.¹⁰ Studies have demonstrated benefit from protocolized use of low-dose psychedelics such as MDMA, psilocybin, and ketamine for treatment-resistant mood disorders,¹¹ as well as chronic pain presentations;¹² similar to certain SNRIs,¹³ these new applications of psychotropic medications offer relief in both physical and psychological/existential domains. At the very least, it is understood that psychiatric distress plays a role in modulating the refractoriness of physical symptoms.

Therapeutic Considerations: Addressing Existential Suffering at the End of Life

We now arrive at the second front—namely, questions pertaining to real-world challenges in therapeutically addressing end-of-life refractory suffering. Let us posit for the moment that there exists a clean, readily diagnostic approach to distinguishing between physical and existential distress, and furthermore that a patient presenting with terminal agitation at the end of life lacks any clear physical cause for their distress. While this is unlikely in the actively dying patient, it is, perhaps, theoretically possible. If that were the case, and we could confidently assess a patient as suffering from distress that is purely existential in nature, we would want to provide that sufferer with appropriate treatment. If clinicians with experience in this area have had success

with such treatment approaches, this would be an area for further education and clinical professional development offered through peer-based trainings, potentially coordinated through national professional organizations such as the American Academy of Hospice and Palliative Medicine (AAHPM), the Center to Advance Palliative Care (CAPC), or the Hospice and Palliative Nurses Association (HPNA).

The core premise of this distinction, of course, is entirely reasonable and appropriate—namely, that any proposed treatment should fit the diagnosis. Psychiatric disorders warrant psychiatric approaches from evidence-based mental health best practices, just as physical treatments should be employed to address somatic complaints. Thus, existential (spiritual, relational, meaning-making) treatments that seek to make meaning and achieve reconciled relationships with God, self, and others are appropriate for those suffering existentially. And current evidence suggests that such approaches exist; when patients disclose statements indicative of existential suffering, demoralization, and loss of meaning, psychotherapeutic modalities such as Meaning-Centered Psychotherapy (MCT) and Dignity Therapy (DT) offer fitting approaches. High-quality evidence supports the use of MCT for improving quality of life and reducing psychological stress, particularly for those expressing existential disarray, described in the literature as “meaning-centered concerns,” when facing serious or life-threatening illness.¹⁴ Similarly, DT has also been found beneficial in the palliative population,¹⁵ particularly in improving quality of life and alleviating dignity-related distress,¹⁶ through the process of a long-form interview and creation of a legacy document that “effects a sense of generativity, meaning, and acceptance near the end of life.”¹⁷

Unfortunately, however, these modalities are not well-suited for the particular population at hand—namely, those experiencing refractory end-of-life distress, even if that distress *were* known to be purely existential in origin. As we have seen, both in anecdotal experience as well as in the current evidence, those with PTSD—patients suffering from effects of trauma that has perhaps gone unaddressed for years or even decades, whether owing to insufficient resources, inadequate inner distress tolerance, or a lack of appropriate culturally mediated

frameworks to support healing—are more likely to have severe, refractory, terminal delirium in their final hours to days of life. For such patients, the time-limited nature of this end-of-life distress would obviously preclude any ability to adequately address such longstanding and complex trauma. This is both because time is short (perhaps only hours to days, in the acute-care context), and also because a patient’s end-of-life symptom burden (including somnolence, which is part of the normal dying process) is likely to be significant enough to preclude any ability of the patient to attend well to such end-of-life tasks as unearthing and resolving whatever complex trauma history is contributing to their terminal delirium.

The assertion that existential distress should be addressed through existential interventions of meaning-making and spiritual care, while valid, also assumes that such interventions are likely to be successful. When we are dealing with challenging physical symptoms, even the best clinicians in the best hospitals face limits in their ability to resolve physical pain and restore function. How much more so for existential distress, when we are seeking to bring restoration to patients at the level of one’s spirit, their relationship with the transcendent, their sense of being and meaning? We should absolutely try, no doubt; this is as much within the purview of whole-person medical care as is the use of anti-platelets in the treatment of cardiovascular disease. Yet we should also be circumspect and avoid the temptation to triumphalism, as if our efforts will inevitably be successful. That is not true for the alleviation of existential despair any more than it is for physical symptoms.

Respite Sedation: An Approach Warranting Further Exploration

One area that may warrant more exploration, however, is the use of respite sedation, which refers to the use of sedative agents for a brief, time-limited period (usually 24–48 hours) aimed at alleviating physical symptoms such as pain, nausea, and agitation, followed by sedative weaning and return of consciousness thereafter.¹⁸ The aim of respite sedation is to “break a cycle of anxiety and distress that precipitated the request for [palliative sedation] and nullify the need for further sedation.”¹⁹ In fact, in their published 2009 guideline for the use of sedation in palliative medicine, the European Association for Palliative Care states that

“continuous deep sedation until death should only be considered after repeated trials of respite sedation,”²⁰ a position statement that was upheld in their 2024 revised EAPC guideline with increased emphasis on the principle of *proportionality* in palliative sedation use.²¹

Newer pharmacologic agents may also offer a promising middle-ground approach in addressing existential distress at end of life, including terminal delirium. Conscious sedation using IV dexmedetomidine, a relatively new alpha-2 agonist with analgesic and sedative properties, has been used successfully in the management of refractory end-of-life symptoms, including that of severe anxiety and psychological distress.²² This application of dexmedetomidine permits patients to be lightly sedated while remaining communicative, in a state that has been termed *cooperative sedation*, where the patient is awake or lightly sleeping but also able to remain calmly interactive.²³ Several published case reports describe marked benefit for management of not only pain but also anxiety, insomnia, and agitation at end of life, using an approach that minimizes opioid usage and permits sufficient wakefulness for patients to interact with loved ones.²⁴

While dexmedetomidine holds appeal for this clinical application because of its potential to preserve some degree of wakefulness, its requirement for continuous intravenous (IV) infusion can restrict widespread use. For clinical settings in which maintaining IV access is either overly burdensome or infeasible, current guidelines for palliative sedation also offer protocols for the use of subcutaneous benzodiazepines including lorazepam and midazolam, or non-IV phenothiazines such as subcutaneous levomepromazine and intramuscular or rectally administered chlorpromazine, for enhanced ease of access.²⁵

At the risk of oversimplification, might one think of respite sedation as analogous to the restorative role played out in each night’s sleep cycle. Consider how often the end of a day can leave one feeling discouraged, stressed, or fearful in the face of personal challenges or shortcomings. In these moments, sleep makes an attractive offer: Close your eyes and things may seem better when you wake up. Sometimes, the same obstacles are viewed the next day in a more hopeful and healthy perspective, allowing

one to face the day with newfound confidence. In fact, palliative medicine physician Paul Rousseau makes a case that “because many dying patients are afflicted with existential turmoil that engenders fear, fatigue, and insomnia, respite sedation may break a cycle of sleep deprivation and existential distress and allow such patients the opportunity to regain psychological strength and assuage the existential issues that precipitated the need for palliative sedation.”²⁶

If a patient suffering from purely existential distress is placed in a state of permanent sedation until death, there can be no opportunity to attend to existential concerns. If sedation is maintained through natural death—even if death that is neither hastened by, nor aimed at through, palliative sedation (scenarios that would clearly lie far outside the bounds of the Christian Hippocratic ethic)—a patient is still deprived of any potential opportunity to attend to end-of-life priorities and tasks, as they might following a time-limited period of respite sedation. In this way, respite sedation may offer a categorically different approach from that of typical palliative sedation, insofar as it has the potential to alleviate symptoms of fatigue, agitation, and anxiety contributing to existential distress at end of life.

How Catholic Christian Theology Informs an Approach to Existential Distress

Questions about the appropriateness of palliative sedation to address existential suffering touch upon the very heart of medicine’s purpose. Granted, there is surprisingly little consensus in our modern medical context around what, even, is the purpose of medicine.²⁷ A Christianly understanding of medicine’s purpose might propose that the role of medicine is to restore a person to right relationships—most fundamentally, relationships within the physical body, when those have been disrupted by illness or injury, but also relationships between the sufferer self and body, as well as self and other selves, and ultimately, self and God. The final line of one unattributed prayer for medical clinicians reads: “And when I cannot heal them, Lord, let me lead them on at least to a deeper faith and resignation in Your love.” Through medical care, then, clinicians are granted an opportunity to treat patients in order to put them in a better position to improve their relationships with their own selves, with others, and with God.

How, therefore, do we help facilitate healing and relational connection with God and others, as we seek to address existential distress, whether in its pure form or insofar as it is contributing to physical suffering? Is permanent sedation until natural death really the best route to this, even in cases where time is short? The concept of cultivating one’s capacity for “growth at the end of life,” posited by palliative medicine physician Ira Byock, is a powerful way of thinking about the potential for transformation, growth, restoration, and reconciliation at every stage of life, right through to the very end.²⁸

I (RM) have personally witnessed such transformation and reconciliation in the most unlikely of places, where siblings reconnect after decades of estrangement—not in spite of death’s looming shadow, but precisely *because* of it, and the humanly fragile limits on time that it portends. When existential distress is contributing to suffering, we do not serve our patients well by robbing them of the opportunity for such growth, eliminating any chance for them to weave new fabric in places of relational fray or to write new narratives in their final chapter of life.²⁹

One additional word of caution in the context of any discussion on palliative sedation: Regardless of the reason for administering sedation—even for physical suffering, and even for brief, circumscribed periods—we must be extremely circumspect in how we use this intervention. The Roman Catholic Church teaches that taking away one’s consciousness takes away the person’s right to prepare for his or her death, including the opportunity to participate in and sanctify personal suffering.³⁰ This teaching is rooted in an understanding that even in the midst of great personal suffering, human activity can be reoriented from that corporal, outward-looking glance to an inward, spiritually-directed transcendence. This inward movement of our being in our final days and hours can involve a kind of transformation or conversion, sometimes quite dramatic, as in the case of the good thief. . . . [involving] a contemplative internalization of the mysteries of human existence, a stripping away of everything, and a period of “rending naked” the soul.³¹

For this reason, the USCCB Ethical and Religious Directives for Catholic Health Care Services assert that “since a person has the right to prepare for his or her death

while fully conscious, he or she should not be deprived of consciousness without a compelling reason.”³² There is no way to predict the grace that can come from cooperating with God’s will, even if it means enduring some degree of pain. One cooperates best by engaging the human faculties of consciousness and reason. Just as numbing consciousness avoids the spiritual root of existential suffering, so does it avoid the spiritual aspect of physical suffering. The same spiritual awareness that enriches the Christian approach to existential suffering may inform the approach to physical suffering with regards to palliative sedation.

At the same time, the authors of this essay agree that God, in his sovereignty, is able to minister through his Spirit to patients even when rendered unconscious by human medications or by the natural dying process (where somnolence is an expected part of that). We can commit even these patients into his good hands for spiritual communion and communication that is possible even when human communion and communication is not. Furthermore, we believe the Lord is extremely generous with his graces towards individuals who are close to death. The extraordinary administration of sacraments for the dying, as well as the promise made to the good thief, reveal this generosity.

Conclusion

Returning to the original essay by Bryce Asberg, we recall three central assertions underpinning his thesis, namely that (1) palliative sedation undermines the validity of existential suffering, (2) the act of sedating existential suffering diminishes its significance, and (3) the Christian approach uniquely takes existential suffering seriously. In order to encompass the complexity of real-world clinical care of patients experiencing existential distress at the end of life, maintaining an awareness of the aforementioned diagnostic and therapeutic challenges inherent therein, we might revise his first two assertions as follows: (1) *reflexively implementing* palliative sedation undermines the validity of existential suffering, and (2) the act of sedating existential suffering *in the absence of exhaustive attempts at otherwise ameliorating it* diminishes its significance.

Regarding Asberg’s third assertion, we would prefer his language to acknowledge

the legitimate and well-intentioned care of atheist colleagues towards the dying, while also expressing the Christian's appropriate humility towards our God-given faith, by grace. As Asberg points out, proponents of palliative sedation claim to take existential suffering seriously. They are sensitive to the severity of existential suffering and employ all available and acceptable tools to combat it. While the atheist's approach does not

acknowledge the full scope of spiritual realities operative in a Christian understanding, it is no less serious in its effort, concern, and good will. To say only a Christian view takes it seriously may be dismissive of their own good-faith care for the dying.

Christian faith and its magnificent theology is a gift that disciples of Christ are blessed, by his costly grace, to possess and share.

While we admire the holy boldness that likely motivates the author, a gentler approach would highlight our shared humility in possessing the greatest gift of our lives and invite non-believers into graceful dialogue.

References

1. Bryce Asberg, "Palliative Sedation for Existential Suffering: The Enduring Wisdom of the Hippocratic Oath," *Dignitas* 32, no. 1–2 (2025): 7, <https://www.cbhd.org/dignitas-articles/palliative-sedation-for-existential-suffering-the-enduring-wisdom-of-the-hippocratic-oath>.
2. Christel Hedman, Per Fürst, Peter Strang et al., "Pain Prevalence and Pain Relief in End-of-Life Care: A National Registry Study," *BMC Palliative Care* 23, no. 1 (2024): 171, <https://doi.org/10.1186/s12904-024-01497-1>; Jonas Smedbäck, Joakim Öhlén, Kristofer Årestedt et al., "Palliative Care During the Final Week of Life of Older People in Nursing Homes: A Register-Based Study," *Palliative & Supportive Care* 15, no. 4 (2017): 417–24, <https://doi.org/10.1017/S1478951516000948>; Ingela Henoch, Ann Ekberg-Jansson, Claes-Göran Löfdahl, and Peter Strang, "Benefits, for Patients with Late Stage Chronic Obstructive Pulmonary Disease, of Being Cared for in Specialized Palliative Care Compared to Hospital: A Nationwide Register Study," *BMC Palliative Care* 20, no. 1 (2021): 130, <https://doi.org/10.1186/s12904-021-00826-y>.
3. Peter Strang, "Cancer Pain: A Provoker of Emotional, Social and Existential Distress," *Acta Oncologica* 37, no. 7–8 (1998): 641–44, <https://doi.org/10.1080/028418698429973>.
4. Christine L. Watt, Franco Momoli, Mohammed T. Ansari et al., "The Incidence and Prevalence of Delirium Across Palliative Care Settings: A Systematic Review," *Palliative Medicine* 33, no. 8 (2019): 865–77, <https://doi.org/10.1177/0269216319854944>.
5. Annmarie Hosie, Meera Agar, Elizabeth Lobb et al., "Improving Delirium Recognition and Assessment for People Receiving Inpatient Palliative Care: A Mixed Methods Meta-Synthesis," *International Journal of Nursing Studies* 75 (2017): 123–29, <https://doi.org/10.1016/j.ijnurstu.2017.07.007>.
6. Jeannette Kates, "Hyperactive Terminal Delirium in Hospice Patients: A Retrospective Cohort Study," *Journal of Hospice & Palliative Nursing* 22, no. 2 (2020): 95–100, <https://doi.org/10.1097/NJH.0000000000000631>.
7. Jun Hamano, Masanori Mori, Taketoshi Ozawa et al., "Comparison of the Prevalence and Associated Factors of Hyperactive Delirium in Advanced Cancer Patients Between Inpatient Palliative Care and Palliative Home Care," *Cancer Medicine* 10, no. 3 (2021): 1166–79, <https://doi.org/10.1002/cam4.3661>; Angela Recchia, Barbara Rizzi, Alessandra Favero et al., "Prevalence of Delirium in End-of-Life Palliative Care Patients: An Observational Study," *Medical Principles and Practice* 31, no. 2 (2022): 118–24, <https://doi.org/10.1159/000521994>.
8. Xi Yang, Fang Chen, Zhixia Jiang et al., "Association of Delirium with Post-Traumatic Stress Disorder: A Systematic Review and Meta-Analysis," *Frontiers in Psychiatry* 16, no. 1654136 (2025): <https://doi.org/10.3389/fpsy.2025.1654136>; Kathleen E. Bickel, Richard Kennedy, Cari Levy et al., "The Relationship of Post-Traumatic Stress Disorder to End-of-Life Care Received by Dying Veterans: A Secondary Data Analysis," *Journal of General Internal Medicine* 35, no. 2 (2020): 505–13, <https://doi.org/10.1007/s11606-019-05538-x>; Alan T. Bates and Julia A. Kearney, "Understanding Death with Limited Experience in Life: Dying Children's and Adolescents' Understanding of Their Own Terminal Illness and Death," *Current Opinion in Supportive and Palliative Care* 9, no. 1 (2015): 40–45, <https://doi.org/10.1097/SPC.0000000000000118>.
9. Tamara Sacks, David E. Weissman, and Robert M. Arnold, "Opioid Poorly-Responsive Cancer Pain," Fast Fact #215, *Palliative Care Network of Wisconsin*, February 26, 2025, <https://www.mypcnow.org/fast-fact/opioid-poorly-responsive-cancer-pain/>.
10. Ryan S. D'Souza, Brendan Langford, Rachel E. Wilson et al., "The State-of-the-Art Pharmacotherapeutic Options for the Treatment of Chronic Non-Cancer Pain," *Expert Opinion on Pharmacotherapy* 23, no. 9 (2022): 1037–50, <https://doi.org/10.1080/14656566.2022.2060741>; John A. Sturgeon, "Psychological Therapies for the Management of Chronic Pain," *Psychology Research and Behavior Management* 7 (2014): 115–24, <https://doi.org/10.2147/PRBM.S44762>.
11. Heather Stringer, "The Emergence of Psychedelics as Medicine," *Monitor on Psychology* 55, no. 4 (2024): <https://www.apa.org/monitor/2024/06/psychedelics-as-medicine>.
12. Farah Z. Zia, Michael H. Baumann, Sean J. Belouin et al., "Are Psychedelic Medicines the Reset for Chronic Pain? Preliminary Findings and Research Needs," *Neuropharmacology* 233, no. 109528 (2023): <https://doi.org/10.1016/j.neuropharm.2023.109528>.
13. Hollie Birkinshaw, Claire M. Friedrich, Peter Cole et al., "Antidepressants for Pain Management in Adults with Chronic Pain: A Network Meta-Analysis," *Cochrane Database of Systematic Reviews* 5, no. CD014682 (2023): <https://doi.org/10.1002/14651858.CD014682.pub2>.
14. Joël Vos and Diego Vitali, "The Effects of Psychological Meaning-Centered Therapies on Quality of Life and Psychological Stress: A Meta-Analysis," *Palliative & Supportive Care* 16, no. 5 (2018): 608–32, <https://doi.org/10.1017/S1478951517000931>; N. van der Spek, J. Vos, C. F. van Uden-Kraan et al., "Efficacy of Meaning-Centered Group Psychotherapy for Cancer Survivors: A Randomized Controlled Trial," *Psychological Medicine* 47, no. 11 (2017): 1990–2001, <https://doi.org/10.1017/S0033291717000447>; William Breitbart, Barry Rosenfeld, Christopher Gibson et al., "Meaning-Centered Group Psychotherapy for Patients with Advanced Cancer: A Pilot Randomized Controlled Trial," *Psycho-Oncology* 19, no. 1 (2010): 21–28, <https://doi.org/10.1002/pon.1556>.
15. Marina Martínez, María Arantzamendi, Alazne Belar et al., "'Dignity Therapy,' a Promising Intervention in Palliative Care: A Comprehensive Systematic Literature Review," *Palliative Medicine* 31, no. 6 (2017): 492–509, <https://doi.org/10.1177/0269216316665562>; Harvey Max Chochinov, Linda J. Kristjanson, William Breitbart et al., "Effect of Dignity Therapy on Distress and End-of-Life Experience in Terminally Ill Patients: A Randomised Controlled Trial," *Lancet Oncology* 12, no. 8 (2011): 753–62, [https://doi.org/10.1016/S1470-2045\(11\)70153-X](https://doi.org/10.1016/S1470-2045(11)70153-X).
16. Bertha Tesma Wulandari and Erna Rochmawati, "Effectiveness of Dignity Therapy on Well-Being Among Patients Under Palliative Care: A Systematic Review and Meta-Analysis," *International Journal of Nursing Studies* 149, no. 104624 (2024): <https://doi.org/10.1016/j.ijnurstu.2023.104624>.
17. Dean Vuksanovic, Heather J. Green, Murray Dyck, and Shirley A. Morrissey, "Dignity Therapy and Life Review for Palliative Care Patients: A Randomized Controlled Trial," *Journal of Pain and Symptom Management* 53, no. 2 (2017): 162, <https://doi.org/10.1016/j.jpainsymman.2016.09.005>.
18. Poonam Bhyani, Utsav Shrestha, Caroline Schoo, and Amandeep Goyal, "Palliative Sedation in Patients with Terminal Illness," in StatPearls [Internet] (StatPearls, 2024), <https://www.ncbi.nlm.nih.gov/books/NBK470545/>; Guido Miccinesi, Augusto Caraceni, and Marco Maltoni, "Palliative Sedation: Ethical Aspects," *Minerva Anestesiologica* 83, no. 12 (2017): 1317–23, <https://doi.org/10.23736/S0375-9393.17.12091-2>.
19. Paul Rousseau, "Existential Suffering and Palliative Sedation: A Brief Commentary and a Proposal for Clinical Guidelines," *American Journal of Hospice and Palliative Care* 18, no. 3 (2001): 153, <https://doi.org/10.1177/104990910101800303>.
20. Nathan I. Cherny and Lukas Radbruch, on behalf of the Board of the European Association for Palliative Care, "European Association for Palliative Care (EAPC) Recommended Framework for the Use of Sedation in Palliative Care," *Palliative Medicine* 23, no. 7 (2009): 588, <https://doi.org/10.1177/0269216309107024>.
21. Séverine M. Surges, Holger Brunsch, Birgit Jaspers et al., "Revised European Association for Palliative Care (EAPC) Recommended Framework on Palliative Sedation: An International Delphi Study," *Palliative Medicine* 38, no. 2 (2024): 213–28, <https://doi.org/10.1177/0269216323120225>.
22. Luiz Guilherme L. Soares, Cláudia Naylor, Maurílio A. Martins, and Geralda Peixoto, "Dexmedetomidine: A New Option for Intractable Distress in the Dying," *Journal of Pain and Symptom Management* 24, no. 1 (2002): 6–8, [https://doi.org/10.1016/S0885-3924\(02\)00423-2](https://doi.org/10.1016/S0885-3924(02)00423-2).
23. Russell Jeffrey Seymore, Melanie M. Manis, and Patrick J. Coyne, "Dexmedetomidine Use in a Case of Severe Cancer Pain," *Journal of Pain & Palliative Care Pharmacotherapy* 33, no. 1–2 (2019): 34–41, <https://doi.org/10.1080/15360288.2019.1629520>.
24. Soares et al., "Dexmedetomidine"; Seymore et al., "Dexmedetomidine Use in a Case of Severe Cancer Pain"; Jennifer M. Byrne, Paula Mesarwi, Kyle P. Edmonds, and Rabia S. Atayee, "Dexmedetomidine Continuous Infusion for Refractory Cancer Pain at End of Life: A Case Report," *Journal of Pain & Palliative Care Pharmacotherapy* 36, no. 3 (2022): 200–206, <https://doi.org/10.1080/15360288.2022.2102705>; Nathalie Dieudonné Rahm, Tijani Kemicha, Lida Papasokrati, and Sophie Pautex, "Long-Term Dexmedetomidine Use and Safety Profile in Palliative Care: A Case Report," *Journal of Palliative Medicine* 26, no. 6 (2023): 882–86, <https://doi.org/10.1089/jpm.2022.0496>.

References (continued)

25. Seymore et al., "Dexmedetomidine Use in a Case of Severe Cancer Pain."
26. Paul Rousseau, "Existential Distress and Palliative Sedation," *Anesthesia & Analgesia* 101, no. 2 (2005): 611, <https://doi.org/10.1213/01.ANE.0000159014.71321.A2>.
27. Josh Briscoe, "Limits and Goals in Medicine: Or, Monsters in the Basement and Wizards in the Kitchen," Notes from a Family Meeting, September 13, 2024, <https://familymeetingnotes.substack.com/p/limits-and-goals-in-medicine>; Farr A. Curlin and Christopher Tollefsen, *The Way of Medicine: Ethics and the Healing Profession* (University of Notre Dame Press, 2021); Aaron Rothstein, "The Purpose of Medicine," *The New Atlantis*, June 23, 2015, <https://www.thenewatlantis.com/practicing-medicine/the-purpose-of-medicine>.
28. Ira Byock, *Dying Well: The Prospect for Growth at the End of Life* (Riverhead Books, 1997).
29. Christoph Gabl, Angelika Feichtner, and Dietmar Weixler, "Sedation Indicated? Rethinking Existential Suffering: A Narrative Review," *Annals of Palliative Medicine* 13, no. 2 (2024): 397–414, <https://doi.org/10.21037/apm-23-474>.
30. Tadeusz Pacholczyk, "Making Sense of Bioethics, Column 171: Palliative Sedation While Approaching Death," *The National Catholic Bioethics Center*, September 30, 2019, <https://www.ncbcenter.org/making-sense-of-bioethics-cms/column-171-palliative-sedation-while-approaching-death>.
31. Pacholczyk, "Palliative Sedation While Approaching Death."
32. *Ethical and Religious Directives for Catholic Health Care Services*, 7th ed. (United States Conference of Catholic Bishops, 2025), 28, <https://www.usccb.org/resources/ethical-and-religious-directives-catholic-health-care-services-seventh-edition>.



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