



# Palliative sedation— still a complex clinical issue!

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It is my anecdotal impression that, in reviewing the recent contents of palliative care journals, it is hard not to find an article on palliative sedation. In view of increasing interest in that topic and some of the surrounding controversy, the presentation in this issue of *Current Oncology* of a quality improvement report by McKinnon *et al.*<sup>1</sup> on the use and documentation of the practice in their palliative care setting is timely and arguably a wake-up call to other programs. Those authors identified a number of documentation deficits and the need to implement guidelines that standardize charting and staff education.

To highlight the trends of published articles on palliative sedation, Papavasiliou *et al.*<sup>2</sup> produced a bibliometric analysis of the literature between 1945 and 2011. Until the early 1990s, after two frequently-cited publications appeared in the *Journal of Palliative Care*<sup>3,4</sup>, there was very little to find. Subsequently, research productivity rapidly increased and a debate on terms and definitions started that will likely continue for some time. The bibliometric analysis<sup>2</sup> resulted in an evidence review<sup>5</sup>, which demonstrated that the terminology had become increasingly complex. The review concluded that there is an urgent need “to resolve the conceptual confusion that currently exists in the literature.” That comment by the authors about the possibility that terminology confusion is, in the end, a reflection of confusion in clinical practice resonates very well with the quality improvement report by McKinnon *et al.*<sup>1</sup>.

Ethical perspectives on palliative sedation have added to the complexity, and it can sometimes be an intellectual challenge to follow the ethics specialists as they debate conflicting viewpoints<sup>6-8</sup>. Ten Have and Welie<sup>7</sup> recently published a review on the ethics debate about the difference between palliative sedation and euthanasia. The dominant view is that these practices are morally distinct, but an alternative perspective contends that moral experience and practice variation can make the distinction questionable<sup>7,8</sup>. The need to use targeted education to help clinicians

understand the significance of the ethical concept of intent is seen as a key issue.

A systematic review by Maltoni *et al.*<sup>9</sup> identified eleven articles that highlighted refractory delirium as the most frequent indication for sedation and could find no evidence that appropriate use of palliative sedation had a detrimental effect on survival. Benzodiazepines were the most common medications used to achieve palliative sedation. A source of some concern was that seven of the studies included psychological or existential distress as one of the main reasons for using palliative sedation. Maltoni and colleagues described those indications as “particularly delicate and controversial.” Indeed, a recent survey of U.S. physicians that examined the acceptance and practice of palliative sedation found that 68% of respondents opposed using palliative sedation for existential suffering<sup>10</sup>. A position statement from the U.S. National Hospice and Palliative Care Organization on palliative sedation acknowledged significant disagreement among palliative care specialists about the issue and, because of a lack of consensus, could not make a firm recommendation other than to urge caution and multiple discussions with the patient, the family, and the team<sup>11</sup>.

The National Hospice and Palliative Care Organization recommended a written institutional policy to address issues of criteria, procedure, ongoing staff education (especially about ethical distinctions between sedation and assisted suicide or euthanasia), and careful monitoring and data collection of palliative sedation practice. In 2006, our program developed a palliative sedation clinical practice guideline<sup>12</sup> with an addendum on “psycho-existential distress” which states that “based on our experience and currently available evidence, we do not recommend palliative sedation as a means to alleviate psycho-existential distress as the only refractory symptom in the end of life.” We can claim to have partially met the National Hospice and Palliative Care Organization recommendations with our monitoring and data collection dating back to a review of palliative care practice in 2010<sup>13</sup> and a publication in 2000<sup>14</sup>.

The publication by McKinnon *et al.*<sup>1</sup> and their conclusions are to be commended. Many palliative care programs (including my own) should consider emulating their quality improvement initiative.

# CONFLICT OF INTEREST DISCLOSURES

The author has no financial conflict of interests to disclose.

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