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Editorial

Palliative sedation: The end of heated debate?

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After more than 15 years of engagement in research on palliative sedation, we dare to pose that it is among the most challenging topics in end-of-life care. The first publications on palliative sedation appeared in this journal as early as 20 years ago. Chater et al.[1] stressed the need for proper terminology and proposed to abandon the term "terminal sedation." While palliative sedation has remained the most commonly used term ever since, it has also become clear that simply using a common term does not guarantee the use of a common concept, leave alone common practices. The international qualitative UNBIASED study has shown that "palliative sedation" may refer to different practices of sedation.[2] For instance, UK clinicians reported a continuum of practice from the provision of low doses of sedatives to control terminal restlessness to rarely encountered deep sedation, while Belgian clinicians predominantly discussed the use of deep sedation.

The indications for palliative sedation have received frequent study. Fainsinger et al.[3] demonstrated in one of the first international studies (conducted in Israel, South Africa, and Spain) that delirium was the most common problem requiring sedation, while sedation for existential distress was more controversial. Several studies have subsequently consistently demonstrated—across countries and within different patient populations—that palliative sedation is an important practice in end-of-life care. The UNBIASED study demonstrated that clinicians in the United Kingdom, Belgium, and the Netherlands have different rationales for their use of palliative sedation, for instance with regard to the acceptability of losing consciousness in the last days of life, the involvement of patients and representatives in the decision-making, and the extent to which the hastening of death is an acceptable outcome of sedation.[2] This is echoed in the linked Flemish qualitative study where palliative care clinicians sometimes had difficulties in distinguishing sedation from the ending of life, as in euthanasia, especially when the sedating medication was increased disproportionally or when they had used sedation for patients with a longer life expectancy.[4] In addition, Morita et al.[5] have described that many nurses involved in palliative sedation felt serious emotional burden related to sedation, potentially pointing to the moral intuition of nurses that palliative sedation is sometimes difficult to distinguish from euthanasia. Schildmann et al.[6] demonstrated considerable variation in the content and quality of palliative sedation guidelines. To facilitate the development of high-quality palliative sedation guidelines worldwide, the European Association for Palliative Care (EAPC) developed a 10-point framework.[7] Key recommendations of this framework are that palliative sedation is potentially indicated for patients with intolerable distress resulting from refractory symptoms, and who have an expected prognosis of hours or days at most.

The long list of publications on palliative sedation in this journal demonstrates that research in the past decades has come a long way in describing and comparing its practice. However, several questions remain. How can we explain its rather high frequency in some countries? Also, in an era of increased emphasis on shared decision-making, how can patients or their representatives be adequately involved in the decision-making process? How should we deal with patients who suffer unbearably from refractory symptoms, but have a life expectancy of more than 1–2 weeks? Future work should critically evaluate whether palliative sedation guidelines still reflect and support current clinical and societal views on a good death. It should also focus on education about palliative sedation in medical and nursing curricula and informing the general public about what palliative sedation is and when it can be used. Such education would facilitate informed debates about the circumstances in which palliative sedation can be an acceptable procedure to support a good death.

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