Original Article

Intentional Sedation to Unconsciousness at the End of Life: Findings From a National Physician Survey

Michael S. Putman, BA, John D. Yoon, MD, Kenneth A. Rasinski, PhD, and Farr A. Curlin, MD

Pritzker School of Medicine (M.S.P.); Section of Hospital Medicine (J.D.Y.) and Section of General Internal Medicine (K.A.R., F.A.C.), Department of Medicine; and MacLean Center for Clinical Medical Ethics (J.D.Y., F.A.C.), The University of Chicago, Chicago, Illinois, USA

Abstract

Context. The terms "palliative sedation" and "terminal sedation" have been used to refer to both proportionate palliative sedation, in which unconsciousness is a foreseen but unintended side effect, and palliative sedation to unconsciousness, in which physicians aim to make their patients unconscious until death. It has not been clear to what extent palliative sedation to unconsciousness is accepted and practiced by U.S. physicians.

Objectives. To investigate U.S. physician acceptance and practice of palliative sedation to unconsciousness and to identify predictors of that practice.

Methods. In 2010, a survey was mailed to 2016 practicing U.S. physicians. Criterion measures included self-reported practice of palliative sedation to unconsciousness until death and physician endorsement of such sedation for a hypothetical patient with existential suffering at the end of life.

Results. Of the 1880 eligible physicians, 1156 responded to the survey (62%). One in ten (141/1156) physicians had sedated a patient in the previous 12 months with the specific intention of making the patient unconscious until death, and two of three physicians opposed sedation to unconsciousness for existential suffering, both in principle (68%, $n = 773$) and in the case of a hypothetical dying patient (72%, $n = 831$). Eighty-five percent ($n = 973$) of physicians agreed that unconsciousness is an acceptable side effect of palliative sedation but should not be directly intended.

Conclusion. Although there is widespread support among U.S. physicians for proportionate palliative sedation, intentionally sedating dying patients to unconsciousness until death is neither the norm in clinical practice nor broadly supported for the treatment of primarily existential suffering. J Pain Symptom Manage 2013;46:326–334.

Address correspondence to: Farr A. Curlin, MD, Department of Medicine, University of Chicago, 5841 South Maryland Avenue, MC 5000, Chicago, IL 60637, USA. E-mail: fcurlin@bsd.uchicago.edu

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Introduction

Although U.S. physicians do not widely endorse physician-assisted suicide or euthanasia,[1–4] "palliative sedation therapy" has been advanced by medical ethicists,[4–7] medical professional organizations,[2,8–10] and the U.S. Supreme Court[11,12] as an ethically acceptable means of relieving suffering at the end of life. When physicians titrate sedating medications to relieve refractory symptoms, unconsciousness is commonly a foreseen but *unintended* side effect.[6,10] Such practice is widely supported. A debate has emerged, however, regarding whether it is ethically permissible to sedate dying patients in such a way as to intentionally make the patient unconscious until the patient dies. Quill et al.[6] distinguish the former practice, which they call "proportionate palliative sedation" (PPS) from the latter practice, which they call "palliative sedation to unconsciousness" (PSU). Although Quill et al.[6] support both practices, PSU has been opposed by Jansen and Sulmasy as "sedation toward death"[13–15] and by others as "slow euthanasia."[16,17] Particularly contentious is the use of PSU to treat existential suffering.[2,5,6,13,18,19]

Despite extensive past research on both physician-assisted suicide and euthanasia[20–26] and a vigorous debate about PSU,[6,7,13–15] to date there have been no national studies of U.S. physicians' opinions and practices related to such sedation. In Europe, 22%–45% of physicians reported ever having administered drugs to "keep the patient in deep sedation until death."[27] A similar study in Britain found that almost one in five physicians who recently had a patient die had provided the patient with "continuous deep sedation until death," and two in five reported making the decision with "an expectation or some degree of intent to hasten the end of life."[28] Although the intention to hasten death via palliative sedation has been frequently observed,[29,30] epidemiological studies have yet to find a link between palliative sedation and the hastening of death.[31,32] One study on 677 Connecticut internists found that 78% considered terminal sedation to be ethically appropriate for intractable pain despite aggressive analgesia.[33] In a national survey of U.S. physicians from all specialties, 18% reported religious or other moral objections to "sedation to unconsciousness in dying patients."[3] Yet, studies conducted in the U.S. have neither investigated physician practices nor distinguished carefully between PPS and PSU.

To address this gap in knowledge, we surveyed a large, nationally representative sample of practicing U.S. physicians to investigate their self-reported practices of PSU, their appraisal of the appropriateness of PSU in a clinical vignette, and their opinions regarding hastening death in end-of-life care. In these items, we used specific language to describe the act of intentionally sedating a patient to unconsciousness until death. Because previous studies have found practice type and religious characteristics to be associated with controversial end-of-life practices,[27,33–35] we included measures of both in our analysis.

Methods

Survey

In 2010, we mailed a self-administered confidential questionnaire to a stratified random sample of 2016 practicing U.S. physicians aged 65 years or younger.[36] The sample was generated from the American Medical Association Physician Masterfile, a database intended to include all practicing U.S. physicians. We first selected 1164 physicians from those with a primary specialty of internal medicine, family medicine or general practice, and cardiology or nephrology. We then included an oversample ($n = 716$) of physicians working in specialties that care for disproportionate numbers of patients at the end of life (hospice and palliative care, geriatrics, oncology specialties, and pulmonary/critical care) and asked them to estimate how many of their patients had died during the previous 12 months. We used validated lists of South Asian, Arabic, and Jewish ethnic surnames[37–39] to increase the number of Hindu, Muslim, and Jewish physicians in the study. Physicians received up to three