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Regarding Palliative Sedation

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Letter to the Editor **17-00044**

Regarding Palliative Sedation

To the Editor:

The call by Morita et al. for consistency in research about palliative sedation (PS) is timely.[1] Widely used definitions of PS refer to the use of sedative drugs *in dying patients* to induce a state of decreased or absent awareness (unconsciousness) so as to relieve intolerable suffering from refractory symptoms.[2,3] For many clinicians, this will conjure up an image of a severely distressed patient *in the last hours or days of life* who is rendered unconscious as a result of the symptomatic need for repeated doses of sedatives.

However, it is clear from the extensive literature that the clinical application of PS is not universally identical, and that this is the source of much ambiguity and consequential confusion. Thus, as noted by Morita et al., a palliative care unit in the U.S. can report that 23% of 186 patients who received PS were discharged alive.[4] This would be impossible in Belgium and The Netherlands (where euthanasia is legal) because rapid inducement of continuous deep sedation (CDS) appears to be the norm,[5] partly because of pressure from relatives to hasten death,[6] and where it is commonly understood that “if the patient is still here tomorrow, then we will double the dose” regardless of need.[7] Indeed, CDS in these countries is sometimes organized like euthanasia, with a family farewell before the patient is rendered permanently unconscious.[6] In contrast, in the U.K., clinical practice tends to reflect the guidelines of the European Association for Palliative Care,[3] with the emphasis on titrating doses proportionately against symptoms, maintaining consciousness if at all possible.

The lack of consistency is further exemplified in a Cochrane systematic review of PS,[8] in which two of 14 studies were of patients who at *some point in the last week of life* received a sedative (any dose or above a certain threshold); and a third study (limited to the last two days