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Palliative Sedation: Further Evidence Needs to Be Accompanied by Ethical Guidance to Ensure Professional Practice at the End of Life

To the Editor: Maltoni et al[1] present important evidence on survival and further clinical outcomes of palliative sedation (PS). At the same time, the authors raise controversial ethical issues concerning the professional handling of this end-of-life practice. We would like to focus on two aspects of PS that are relevant to ethical decision making at the end of life.

First of all, Maltoni et al,[1] like many authors before them, stress the ethical distinction between PS and so-called slow euthanasia. According to this distinction, the intention of physicians in PS is to reduce suffering but not to shorten life, whereas in euthanasia (ie, ending a patient's life on request) there is an intention to hasten death. However, the relevance of this distinction for the purpose of evaluating professional practice at the end of life is questionable. First, physicians' intention is an impractical criterion to distinguish end-of-life practices. This is because from the outside, it is impossible to judge the intention of a physician. Although it is true that dose and mode of titration may provide some information about a physician's intention, these parameters have been shown to be too vague and not reliable in discriminating physicians' actions at the end of life. Second, the findings of empirical research indicate that physicians intend the shortening of life in a broad spectrum of end-of-life practices.[2] This is even true for palliative care in which, according to our survey among physician members of the German Association of Palliative Care, 27.3% of 780 respondents indicated that they had performed practices such as symptom alleviation and limitation of treatment with the intention to shorten life.[3] Against such a background, we argue that there is a need for joint empirical-ethical analysis to provide sound distinctions regarding end-of-life practices.

Our second comment refers to the scientific foundation of professional decision making in PS. As acknowledged by Maltoni et al[1] and emphasized in the accompanying editorial by Bruera,[4] there is a scarcity of high-quality clinical research on the provision and impact of PS. Although we support the authors' call for more evidence to inform clinical practice, we argue that even the best evidence will not be sufficient to guide professional practice with regard to PS. The reason for this is that PS, like other end-of-life practices, involves important value judgments that need to be dealt with by applied ethical analysis. This is not only true for controversial decisions about PS in the case of psychological distress, as discussed by Maltoni et al and Bruera, but also with regard to other clinical/ethical issues, such as appropriate information for patients (or their representatives), involvement of patients or their representatives in decision making, and the role of the multiprofessional team in these decisions. The findings of our systematic review of guidelines on PS indicate that there is not only considerable variation with regard to recommendations on ethical issues, but also a lack of ethical arguments to substantiate the respective recommendations.[5]

In summary, the review by Maltoni et al[1] provides an excellent example of empirical research, which is needed for the professional practice of PS. At the same time, empirical data alone will not be sufficient to guide health care professionals in difficult situations involving end-of-life care. There is a need for joint empirical/ethical health research that can provide a sound foundation for improved evidence- and ethics-based decision making at the end of life.

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST
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