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Letter to the Editor

Palliative Sedation and End of Life: Lights and Shadows

Dear Editor:

We read with great interest the article of Rietjens et al¹ about continuous deep sedation in Netherlands. The authors compared the rate of deep sedation at the end of life in 2005, 2010, and 2015, and they found a considerable increase of this practice throughout the years, especially for older and cancer patients. Palliative sedation (PS) often represents a fundamental tool in long-term care medicine for physicians attending to terminally ill patients, when no other treatments can relieve their suffering. End-of-life periodically steps into the limelight because of all its ethical, religious, and legal implications. The right to decide on one's own life often comes into conflict with states' laws.^{2,3} In this respect, Netherlands is one of the most advanced nations in terms of cutting-edge legislation about end-of-life, but not all countries have shown such sensitivity toward these issues over the years. We would like to highlight some outstanding questions regarding PS and the gap between its purposes and its application in clinical practice.

PS is usually used to decrease the consciousness of patients affected by untreatable symptoms in the last hours or few days of their life.⁴

Some misconceptions contributed to its limited diffusion along with the lack of knowledge even among practitioners. First, PS is not only used in case of refractory pain but also to manage delirium and dyspnea and all the other symptoms commonly encountered in end-of-life patients, including existential suffering.⁵ Second, PS is often confused with euthanasia or assisted suicide; in contrast, many studies have shown that sedated patients live longer than non-sedated ones.⁶ Pain, in fact, activates the stress response and worsens cardiorespiratory conditions.⁷

PS seems to represent a good compromise between a patient's right to a dignified death and religious beliefs, but its definition and field of application raise some ethical concerns. The Italian National Committee for Bioethics indicated 4 conditions to start PS: an untreatable disease, an imminent death, presence of refractory symptoms or acute terminal event, and informed consent.⁸ Imminent death is defined as occurring in hours or a few days; this lapse of time is ambiguous and many definitions by international societies extend this temporal limit to 2 weeks. We strongly believe that the paramount importance of PS lies in the fact that it can really give back dignity to the patient, making him free from unbearable symptoms, but these symptoms can often last much longer than "hours or few days."

The necessity of informed consent raises some concerns about patients affected by delirium and other psychiatric disorders occurring during the last moments of terminal disease. In addition, 1 fundamental characteristic of informed consent is the possibility to be withdrawn at any time, but, once deep PS sets in, the patient has no further chance of changing his or her mind.^{9,10}

In conclusion, PS is a key weapon in the management of end-of-life patients but its practice and knowledge are not adequately widespread among physicians. Even if it has the potential role to reconcile the inalienable right to die without suffering and religious issues, many ethical questions remain unanswered, such as patients with long-lasting refractory symptoms and those with unbearable physical and psychological symptoms who are not at the end-of-life; this raises the question of if their living can be still called "life" and what life really is.

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