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Attitudes Regarding Palliative Sedation and Death Hastening Among Swiss Physicians: A Contextually Sensitive Approach

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In Switzerland, where assisted suicide but not euthanasia is permitted, the authors sought to understand how physicians integrate palliative sedation in their practice and how they reflect on existential suffering and death hastening. They interviewed 31 physicians from different care settings. Five major attitudes emerged. Among specialized palliative care physicians, convinced, cautious and doubtful attitudes were evident. Within unspecialized settings, palliative sedation was more likely to be considered as death hastening: clinicians either avoid it with an inexperienced attitude or practice it with an ambiguous attitude, raising the issue of unskilled and abusive uses of sedatives at the end of life.

INTRODUCTION

The modern hospice movement seeks to relieve the suffering of severely ill persons, while simultaneously offering holistic care in answer to human suffering when facing one’s impending death. One of the hospice movement’s major aims in the 1960s was to reduce fears linked to the use of morphine. The use of morphine by the clock (i.e., in a continuous and regular manner) became accepted in the practice of palliative care together with the promotion of its use by the ladder (i.e., a set of guidelines for administering analgesics established by the World Health Organization) in the 1990s (Meldrum, 2005). However, in the last 15 years, it became clear that some patients at the end-of-life exhibit symptoms (e.g., pain, dyspnea, delirium) refractory to opioids or other medications. Therefore, new practices such as palliative sedation (with the use of the sedative drug midazolam)—aimed at relieving particularly difficult symptoms—emerged in palliative care practice in the early 1990s.

By relieving distress in a terminally ill person in the last hours or days of a patient’s life by means of a continuous intravenous or subcutaneous infusion of a sedative drug, palliative sedation, in some ways, challenges the principle of “natural death” elaborated by founders of palliative care. It questions the limits between life and death and is considered by some as a further step in the aim of modern medicine to die without pain and with human care (Seymour, Janssens, & Broeckaert, 2007). From the beginning, palliative sedation was debated. Some physicians stating they had to sedate more than 50% of patients at the end of life (Ventafridda, Ripamonti, De Conno, & Tamburini, 1990), whereas others strongly disagreed and affirmed it to be a rare practice (Fainsinger, Miller, & Bruera, 1990; Lichter & Hunt, 1990). The practice of palliative sedation...
raised important ethical issues and was even described as slow euthanasia (Billings & Block, 1996). What is still striking in the literature is that palliative sedation is ill-defined as to its indications and methods (Blondeau, Roy, Dumont, Godin, & Martineau, 2005; Manzini, 2011) and that many subtypes of sedations exist from mild, superficial, temporary sedation to terminal, continuous, and deep sedation until death. Studies carried out throughout Europe indicate the use of deep palliative sedation in 2.5% of all deaths in Denmark, 4.8% in Switzerland, and 8.5% in Italy (Miccinesi et al., 2006). In the context of palliative care units (PCUs) and hospices, the prevalence of sedation varies greatly with a range from 3% (Kohara, Ueoka, Takeyama, Murakami, & Morita, 2005) to 51% (Claessens, Menten, Schotsmans, & Broeckaert, 2008).

Palliative Sedation, Death Hastening, and Existential Suffering

Palliative sedation is defined as an exceptional but necessary practice in palliative medicine, in which the intention, the procedure, and the outcome are to be distinguished from euthanasia (De Graeff & Dean, 2007; Materstvedt et al., 2003). Hastening death is an undesired secondary effect, according to the ethical principle of double-effect (Manzini, 2011; Verkerk, van Wijlick, Legemaate, & de Graeff, 2007), and is an exceedingly rare occurrence (Maltoni et al., 2009; Maltoni et al., 2012). The ethical principles of proportionality (the fact that the perceived benefits must outweigh the potential harms) and respect of autonomy (patients must express explicit requests), but also the principle of beneficence (Morita, Tei, & Inoue, 2003) are regularly cited to justify the use of palliative sedation in patients with refractory symptoms (Cherny & Portenoy, 1994).

In recent years, the debate became more focused on palliative sedation for existential suffering. Indeed, palliative sedation is said to be more frequently administered in answer to moral suffering than physical pain (Morita, Tei, & Inoue, 2003). Existential suffering can be expressed as feelings of meaninglessness, of being a burden on others, death anxiety, wish to control the time of death and lack of social support (Morita, 2004). The debate in end-of-life care is whether it is ethical to sedate a patient with such existential distress at the end of life.

Some authors consider palliative sedation as an acceptable but exceptional intervention for existential distress refractory to psychosocial interventions (Morita, 2004). However, studies in the Netherlands, where euthanasia is legal, suggest similarities between the two actions. For example, in one out of ten patients receiving palliative sedation, its use was preceded by a request for euthanasia or assisted suicide (Miccinesi et al., 2006). Also, patients receiving palliative sedation or dying with euthanasia have comparable diseases; 86% of those dying by euthanasia suffer from cancer, which is also the most frequent diagnosis in patients receiving palliative care (Materstvedt et al., 2003). Another study showed a decrease of euthanasia in the Netherlands coincident with an increase of palliative sedation suggesting that the latter is being used as an alternative to euthanasia (Sheldon, 2007).

Attitudes and Practices Facing Palliative Sedation in Different Countries

Few empirical studies have been conducted about attitudes and practices of clinicians (e.g., physicians and nurses) toward palliative sedation specifically addressing existential suffering and the question of hastening death. Seymour and colleagues (2007) showed that palliative sedation in Belgium and the Netherlands is often seen as an equivalent action or a third way to euthanasia, whereas in countries where it is strictly prohibited such as the United Kingdom, euthanasia or assisted suicide are not discussed by clinicians and academic researchers in the context of palliative sedation for existential suffering. In a quantitative and qualitative study in Québec (Blondeau, Dumont, Roy, & Martineau, 2009; Blondeau et al., 2005), physicians’ and pharmacists’ justifications for palliative sedation in case of existential suffering didn’t openly refer to euthanasia or assisted suicide.

A survey of members of the German Association for Palliative Medicine about end-of-life medical practices, showed that 90% of respondents were opposed to legalizing euthanasia and 75% were against legalizing assisted suicide, whereas 94% were in favor of palliative sedation (Muller-Busch, Oduncu, Woskanjan, & Klaschik, 2004). Among members of the Swiss Association for Palliative Care, a similar study (Bittel, Neuenschwander, & Stiefel, 2002) demonstrated a more nuanced stance: A slight majority (56%) oppose assisted suicide and 69% oppose euthanasia. A minority of physicians (8%) and nurses (4%) reported having practiced assisted suicide, whereas 3% of physicians and 3% of nurses practiced active euthanasia during their career. Forty percent of physicians and nurses would be willing to help a patient commit suicide, whereas 44% would accept a patient’s wish for active euthanasia if it were allowed by law. Missing in this Swiss study are the professionals’ opinions about palliative sedation. No such study has been carried out to date in Switzerland.

The Swiss context is particularly interesting regarding end-of-life policies. Assisted suicide is practiced in this country because of a law stating that assisting a suicide for non-egoistic motives is not punishable. The law doesn’t explicitly mention physician-assisted suicide, whereas euthanasia is strictly prohibited. In the Netherlands and Belgium, both practices are lawful (Seymour et al., 2007). Switzerland is closer to the State of Oregon in the United States, where only physician-assisted suicide is authorized (Bosshard, Fischer, & Bär, 2002).
Most palliative clinicians in Switzerland are members of the Swiss Association for Palliative Care. Experts from the Association established Swiss consensus guidelines about palliative sedation in 2005, following international recommendations such as those of De Graeff and Dean (2007). Palliative sedation is considered by Swiss palliative care experts as a necessary practice when facing intractable symptoms, and is to be used with caution in case of existential suffering, as it may entail a risk of a slippery slope toward the use of palliative sedation to hasten death (Strasser, 2005).

This vigilance must be understood in the Swiss context where assisted suicide is permitted. Facing the absence of an explicit law regulating assisted suicide, the Swiss Academy of Medical Sciences (SAMW) as well as Swiss Association for Palliative Care do not consider assisted suicide as part of medical practice. Regarding euthanasia, a distinction is made between active euthanasia (killing upon request) which is prohibited by law, (active) indirect euthanasia (i.e., unintentional death hastening through measures aimed at symptom control, such as morphine), and passive euthanasia (i.e., withholding or withdrawing life-sustaining treatments such as mechanical ventilation or artificial nutrition/hydration). Indirect and passive euthanasia are admitted by the Swiss Academy of Medical Sciences and by the legal system. In recent years, some Swiss academic hospitals (Lausanne, Geneva, and Zürich) allow assisted suicide associations to respond to hospitalized patients asking to end their life if strict criteria are respected (Pereira, Laurent, Cantin, Petremand, & Currat, 2008).

Contextually Sensitive Social Research

This research is part of a broader quantitative and qualitative study (Beauverd et al., 2013) based on Blondeau et al.’s research (2005, 2009) in Canada. In the qualitative part of the study, which is presented here, our aim was to understand how physicians integrate palliative sedation in their practice especially when facing existential suffering. Our approach is influenced by the Theory of Structuration from sociologist Anthony Giddens (1984) in that it considers institutional rules and resources, as well as individual positions and values, both influencing practices. This theory acknowledges contextual variation, that is, the dynamic relationship between the context and the individuals within it. It emphasizes structural constraints as well as individual choices and reflexivity. Individuals observe, test, and reflect upon their own conduct and those of others, which gradually shapes social practices. The interplay between individual and social factors is displayed differently at various times in particular settings. Context is therefore crucial. Giddens’ work offers some important guiding principles, which have been used in diverse researches in health care (Duncan, Jones, & Moon, 1996; Fulop et al., 2005; Lehoux, Sicotte, Denis, Berg, & Lacroix, 2002).

We used Giddens’ (1984) theory to analyze physicians’ views and practices about palliative sedation. How do physicians adapt their work routines and use (or avoid) innovations such as palliative sedation? How do they reflect on palliative sedation with respect to existential suffering and hastening death? Considering that professional decisions are influenced by social factors, we searched for similarities and differences of practices in various settings of care considered as more or less specialized in palliative care. Then, based on our data, we categorized the main attitudes regarding palliative sedation, existential suffering, and death hastening.

METHODS

Physicians affiliated with the Swiss Association for Palliative Care, working in the French part of Switzerland, were approached to take part in this study. In addition, the authors made use of their networks of contacts to add, in a purposive sampling approach, respondents from the acute care setting of academic hospitals, because it is an essential end-of-life setting to include in the study. The research was approved by the Ethics’ committee for clinical research of the University of Lausanne.

A total of 201 physicians were contacted for the study. Of the 74 physicians who volunteered to participate in the previous quantitative phase of the study based on a clinical vignette (Beauverd et al., 2013), 51 respondents also accepted to participate in this qualitative phase based on a semistructured interview about palliative sedation. Although quantitative and qualitative data were analyzed separately, we used data previously gathered in the quantitative phase (open question in clinical vignette) to help us formulate the interview questions. Two researchers in humanities and medical anthropology using qualitative methods, with a thorough knowledge of the palliative care field, contacted the physicians to organize an interview, which was conducted face-to-face within the respondents’ work environment. Although 20 interviews were initially planned, respondents were more numerous than expected. Of the 51 persons who volunteered, 35 respondents were selected by purposive sampling to provide a diversified and well-proportioned group in each setting of care with respect to age, gender and years of practice. Data saturation was checked and achieved after 31 interviews (see Table 1).

Interview questions sought to capture contextual as well as individual aspects (Giddens, 1984) shaping the practice of palliative sedation. The dimensions explored were

- clinical aspects of the practice (choice of drug and guidelines in the setting);
- practice (or non-practice) of palliative sedation in case of existential suffering;


• dominant ethical values regarding palliative sedation and care around this practice;
• consensus with colleagues within the setting of care; and
• attitudes toward the perceived risk of hastening death through sedation.

Interviews ranged from 1 hour to an hour and a half. Contents of all 31 interviews were audiotaped and fully transcribed. The research team conducted a preliminary analysis by discussing data and identifying emerging themes in an ongoing process during data collection. Once all interviews were complete, a computer-assisted analysis was carried out. Interviews were coded separately by three researchers using the software Atlas.ti. Key themes appearing throughout the interviews were identified, compared and discussed before coding was cross-checked by the two medical anthropologists of the team. Interviews were analyzed in groups organized by settings of care before being compared with interviews from other contexts of care. Following an iterative process, flexibility and constant comparison method (Barney & Strauss, 1967), coding was expanded to include new categories such as the distinction or comparison of palliative sedation with assisted suicide and/or euthanasia. Finally, a transverse analysis based on thematic software extractions was used to identify relationships, interconnections, hierarchy, as well as distributions of themes and attitudes throughout settings of care.

Participants were grouped by practice setting—either general or specialized palliative care, with general care consisting of general practice and hospital-based acute care; specialized palliative care settings included “first-line” care in a PCU or “second-line” consultancy services (either in inpatient acute care or home-based). The rehabilitation setting was considered intermediate as described below.

The characteristics of each group were as follows:

• The general practitioners (GPs) receive patients at their office or visit them at home. This setting of care can be considered as unspecialized in palliative care because GPs see a general population of patients. End-of-life care is part of the spectrum of care although it comprises only a small proportion of the care provided by GPs.

• The acute care settings’ group is composed of physicians from different medical disciplines (oncology, internal medicine, emergency medicine) within academic hospitals. Palliative care in those contexts is an emerging, as yet not fully recognized, medical practice. End-of-life care represents a portion of the care offered in such settings, which generally remain unspecialized in palliative care.

• Rehabilitation centers in Western Switzerland often have a special mission for gerontology and/or palliative care. Some had a specialized inpatient PCU in development at the time of the interview. Expertise in such settings is in the process of extending to specialized palliative care.

• Inpatient palliative care consult teams offer second-line palliative care consultations and advice to unspecialized acute care settings of academic hospitals. The entire focus is palliative care.

• Home palliative care consult teams offer second-line palliative care consultations and advice for patients at home and in unspecialized settings such as nursing homes. The entire focus is palliative care.

• (PCUs are specialized palliative care inpatient services inside a regional hospital or are organized as independent units, such as hospices. The entire focus is palliative care.

RESULTS

The physicians’ attitudes toward the practice of palliative sedation tended to correlate with the care settings, distinguished according to their degree of specialization in palliative care, and, for the generalists, the availability of specialized palliative care in their institution. Years in practice, experience in palliative care, and gender also influenced physicians’ attitudes. These aspects of individual trajectories were taken into account in the following context sensitive analysis, in accordance with the assumption by Giddens (1984) that both organizational and subjective attitudes influence practice. First, we describe tendencies in each context of care before labelling five dominant attitudes throughout the selected care settings.
Trends in Various Contexts of Care

In terms of medication selection and use of guidelines, GPs and acute care physicians were furthest from current standard palliative care recommendations regarding sedation. Indeed, physicians in those settings used other drugs than midazolam and a majority of physicians in both groups did not use protocols or guidelines concerning palliative sedation. However, important differences were seen between these two groups. The GPs interviewed rarely offered palliative sedation to their patients despite positive attitudes toward palliative care in general. However, acute care physicians tended to practice sedation, and when they did, adapted its use to their needs. With regard to palliative care, GPs represent a rather inexperienced and selective group with rare practice, whereas acute care physicians, who are also rather inexperienced, practice palliative sedation with different medication choices and in specific situations.

Rehabilitation centers’ physicians can be considered as an intermediate group evolving to become specialists in palliative care, with some interesting differences. These physicians, most of whom had previous experience in palliative care, followed guidelines on palliative sedation, used the recommended drug and were more supportive of palliative sedation to relieve existential suffering, which was not the case in specialized palliative care contexts where physicians were globally more reluctant to use palliative sedation for existential suffering.

When asked if palliative sedation shortened life, clear differences appeared between the unspecialized physicians and physicians working in specialized palliative care settings. On the one hand, most GPs, acute care, and rehabilitation centers’ physicians saw the shortening of life by sedation as inevitable. On the other hand, a majority of physicians in palliative care spoke rather of the risk of shortening life in some situations that could be avoided with good clinical skills. Among physicians who said that palliative sedation shortens life, those interviewed in acute care settings made the least difference between sedation, assisted suicide, and euthanasia. Although GPs and physicians in rehabilitation centers often thought that palliative sedation shortens life, most of them said that palliative sedation wasn’t the equivalent of euthanasia. Specific characteristics with regard to professional context, the moral values attached to sedation and the position with regard to existential suffering and death hastening were identified in each care setting and are henceforth presented in more detail.

GPs: Relational Care Rather Than Palliative Sedation

Professional context and moral values. GPs mainly work as independent physicians and were generally opposed to palliative sedation, which was considered as a default choice and a “heavy price to pay.” Most GPs pointed out the risks of a slippery slope with palliative sedation, which could be performed as an easy solution for caregivers “to keep patients quiet” and was a major reason for not practicing it. Moreover, the patients’ home was often considered as a difficult place to perform palliative sedation as compared to hospitals and specialized PCUs for technical and monitoring reasons. A majority of GPs said they never carried out palliative sedation, whereas some of them had used it in selected cases during their career. Communicating with the patients seemed more valuable, with relational care representing an important alternative to palliative sedation especially in case of existential suffering. Giving “a taste for life,” “to live one’s life to the maximum until the end” were predominant arguments for GPs, who often have a long-term relationship with their patients.

Existential suffering and death hastening. Without being opposed or clearly disagreeing about sedating a patient in case of existential suffering, most GPs said they would not use deep sedation in those cases. This reluctance could also be due to the fact that they regarded palliative sedation as hastening death. However, most GPs interviewed did distinguish palliative sedation from euthanasia and assisted suicide, while also refusing to practice assisted suicide.

Acute Care Settings: Lack of Time and Unplanned Sedations

Professional context and moral values. Palliative sedation in this context is often described in situations of precipitation due to time-pressure. Whereas some physicians in the selected acute care settings said they often used palliative sedation, others never used it. Although time and organizational constraints were strong in such institutions, physicians could choose not to use sedatives at the end of life because it was not considered as a recommended practice. In most Swiss hospitals, palliative sedation is not yet part of routinely available treatments in end-of-life care. On this matter, some physicians stated important disagreements with senior physicians whose role was to maintain the hospital’s rules and practices. These senior physicians were perceived to view palliative sedation of unproven value in end-of-life care. Sedation at the end of life is thus either avoided or used only in emergency and unplanned situations; it is adapted to the constraints of the institution and is not always clearly differentiated from assisted suicide and euthanasia.

Existential suffering and death hastening. Physicians in this setting would offer sedation for existential suffering, whereas, some viewed assisted suicide as more appropriate than palliative sedation in those cases. For example, a female oncologist said she would prefer to start an assisted suicide procedure to respond to existential suffering rather than using palliative sedation. A majority of physicians in this group considered palliative sedation as hastening death and some...
favored euthanasia or assisted suicide without saying they would do it themselves. One doctor said he was in favor of legalizing euthanasia in Switzerland. Another female doctor affirmed that death was “almost wished” and “a gift of freedom” in cases of intractable suffering. Without stating that she would perform euthanasia, she would “rather relieve the person as quickly as possible at the end of life.”

Rehabilitation Centers: Respect for Autonomy and Assisted Suicide Demands

Professional context and moral values. In the rehabilitation centers, respondents often compared their setting favorably with respect to other hospital units where prolonged futile care was frequent. A majority of physicians in this group considered it their mission to raise awareness of palliative care among their colleagues. In their opinion, palliative care, including palliative sedation, was a way of respecting the patient’s needs to let go and prepare for death. The respect of the patient’s wish and autonomy was highlighted more predominantly in this setting than in other places of care.

Existential suffering and death hastening. Physicians in this group had rather unclear and ambiguous positions, although generally more favorable than GPs regarding the use of palliative sedation for existential suffering. Most of them said that palliative sedation hastens death, which was considered as a “risk of the doctor’s job.” They agreed and understood the patients’ wish for assisted suicide, while being clearly opposed to euthanasia. The value of autonomy brought physicians in rehabilitation centers to be opposed to euthanasia but rather open to assisted suicide “if it is the patient’s will.” For example, a young female doctor said “But on the idea that someone wants to commit suicide, unlike others—I don’t know catholic people for example who don’t understand because God has to decide—it doesn’t raise issues for me. None … I understand.”

Inpatient Palliative Care Consult Teams: Precautions Regarding Palliative Sedation in Acute Settings

Professional context and moral values. Within this setting, practices are strongly affected by the relationship with unspecialized hospital teams consulting the inpatient palliative care consultant team. Palliative care principles must be explained and justified to acute care practitioners who do not always understand the nature of palliative sedation. The particular role of the second-line team is mentioned by all physicians interviewed as difficult at times because of the need to “keep communicating and raising reflection among teams even when we don’t agree with them.” Some physicians mentioned the lack of training in palliative care in the hospital and that some palliative sedations could be avoided or better anticipated if the palliative care consult team was called in earlier. For those physicians, the patient and family’s wishes were of the highest importance and were often presented as core values to the acute care team. In those discourses, the difficulty of being part of a minority medical discipline in the hospital could be sensed. Palliative care professionals have to adapt to institutional norms and routines and have limited flexibility to implement palliative care practices.

Existential suffering and death hastening. Physicians in this group were clearly in favor of palliative sedation but generally opposed to its use in case of existential suffering. Two female senior doctors with a long experience in palliative care said they were very cautious with sedation in general but that “they joined the cause” of palliative sedation because it had become more and more accepted in palliative care practice. Most of the physicians in this group considered it was important to distinguish palliative sedation from assisted suicide or euthanasia because first-line teams and families could “easily confuse the two gestures.”

Home Palliative Care Consult Teams: Questioning of Palliative Sedation as Distinct From Euthanasia

Professional context and moral values. Within this group, most physicians also worked or had worked in PCUs. They put a rather strong emphasis on situations where palliative sedation was not the ideal solution, because it did not bring the expected comfort to patients and could be particularly hard on the families. They saw the difficulty for inexperienced caregivers to grasp the difference and not to conflate it with euthanasia.

Existential suffering and death hastening. Similar to inpatient palliative care consultant teams, this group of physicians tended to oppose the use of palliative sedation for existential distress. The consensus needed to be shared between caregiver/patient/family and it was less the patient’s autonomy (as in rehabilitation centers) than shared decisions that were of major importance. In this group, life shortening with palliative sedation was considered more as a risk than in inpatient consultant teams. Most of the home palliative care consulting physicians said it did shorten life although some added that the result was not as important as the intention. One doctor said, “for me the intention is crucial. I mean, I never sedated a patient with the aim to kill someone, but rather relieve the person to die, is it a sedation? It’s difficult to answer.” One male doctor said that it can be considered as active indirect euthanasia:

All the ambiguity is to know are we in euthanasia or not? In my opinion, we are clearly in it… we always practice it in palliative care, we can never exclude it and that’s what we used to call indirect active euthanasia, which means our
action or the drug used may contribute to accelerating death, but the intention is not to kill.

The positions of physicians in home palliative care consult teams on the distinction between palliative sedation and euthanasia were rather questioning and doubtful. Similar to inpatient palliative care consult teams, some said with a pragmatic stance that euthanasia simply existed in hospitals. Others stated that palliative sedation was a better alternative because it respects the natural time of dying. However, the positions in home palliative care consult teams did not always distinguish palliative sedation and euthanasia and it wasn’t always clear whether the physician would or would not agree to perform palliative sedation to hasten death.

**PCUs: Special Risks with Long-Term Sedation**

*Professional context and moral values.* In PCUs, physicians all had long experience in palliative care settings. Palliative sedation is more common and guided by institutional protocols. Physicians are not confronted with inexperienced caregivers on a daily basis such as in palliative care consult teams. They are first-line caregivers in contexts fully dedicated to palliative care, where palliative sedation is an anticipated medical intervention part of the routines.

*Existential suffering and death hastening.* Similar to palliative care consult teams, PCU physicians were clearly in favor of palliative sedation but generally rather opposed to its use in case of existential suffering, unless temporary sedation was used after existential issues had been explored with the patient and family. Physicians in this group tended to say that palliative sedation did not necessarily shorten life, but some raised the issue of a risky practice if hydration or feeding are interrupted. PCU physicians spoke of the importance for palliative sedation not to go on for too long, otherwise ethical issues linked to hydration withdrawal would surface. A male doctor with a long experience in palliative care spoke of palliative sedation as a “semi-euthanasic act.” Long palliative sedations were also seen as very burdensome for professionals, especially nurses. Another clear concern of physicians in this group was for the patient’s relatives. Indeed, respondents seemed strongly reluctant about assisted suicide, because of the perceived psychological effects on relatives. Palliative sedation was seen as more a humane solution for families because the clinicians remain responsible for care until death. Moreover, the fact that palliative sedation interrupts communication was seen as difficult for the families (whereas in the rehabilitation centers the interruption of communication was seen as a patient-centered issue). Regarding euthanasia, a few physicians were rather open to it and wondered if it should be legalized, because they believed that they participated in death hastening when practicing some palliative sedations.

### Major Attitudes Regarding Palliative Sedation Across Care Settings

Putting in perspective findings across the care settings, five different attitudes, linked to rules and dominant values regarding the care offered, as well as to more subjective attributes (degree of specialization in palliative care, years of practice, gender), were identified and labeled: an inexperienced attitude, a cautious attitude, a convinced attitude, a doubtful attitude and an ambiguous attitude regarding palliative sedation (see Table 2).

The inexperienced attitude concerns physicians who are mainly in the GP group, who have the choice to integrate palliative sedation in their practice or not. There is more flexibility than in other contexts of care and relational care was valued more than sedation. Within acute care settings where organizational constraints are strong and specialization in palliative care is weak, an inexperienced attitude was also identified.

In palliative care consult teams, both a cautious and a convinced attitude were identified. The cautious attitude was seen in physicians who consider themselves as being from an older generation, having a long experience in specialized palliative care and justifying their strong reluctance toward midazolam and palliative sedation in general. This group of senior physicians, often women, has accepted the idea of palliative sedation but are very cautious with its use and, in all situations, formally reject palliative sedation for existential suffering. These physicians have adopted the new practice but not in all its uses.

The convinced attitude mainly concerns younger physicians with some years of experience in specialized

### Table 2

**Categories of Attitude Characteristics**

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inexperienced</td>
<td>• Lack of knowledge about medication and procedure</td>
</tr>
<tr>
<td></td>
<td>• Rare use of PS and never in case of existential suffering</td>
</tr>
<tr>
<td></td>
<td>• Distinction between PS, assisted suicide, and euthanasia</td>
</tr>
<tr>
<td>Cautious</td>
<td>• Knowledge and experience of medication and procedure</td>
</tr>
<tr>
<td></td>
<td>• Rare use of PS and never in case of existential suffering</td>
</tr>
<tr>
<td></td>
<td>• Distinction between PS, assisted suicide, and euthanasia</td>
</tr>
<tr>
<td>Convinced</td>
<td>• Knowledge and experience of medication and procedure</td>
</tr>
<tr>
<td></td>
<td>• Conviction that PS in case of existential suffering in rare situations is acceptable</td>
</tr>
<tr>
<td></td>
<td>• Strong distinction between PS, assisted suicide, and euthanasia</td>
</tr>
<tr>
<td>Doubtful</td>
<td>• Knowledge and experience of medication and procedure</td>
</tr>
<tr>
<td></td>
<td>• In favor of PS in case of existential suffering in rare situations</td>
</tr>
<tr>
<td></td>
<td>• Doubt that PS is clearly distinguished from assisted suicide and euthanasia</td>
</tr>
<tr>
<td>Ambiguous</td>
<td>• PS practiced without following protocols</td>
</tr>
<tr>
<td></td>
<td>• In favor of PS in case of existential suffering</td>
</tr>
<tr>
<td></td>
<td>• PS is an equivalent action to assisted suicide and euthanasia</td>
</tr>
</tbody>
</table>

*Note:* PS = palliative sedation.
palliative care. They are confident in the clinical and ethical utility of palliative sedation in general. They are reluctant to use it for existential suffering, but can conceive it in exceptional situations. Clear distinction is made between palliative sedation and euthanasia or assisted suicide, mainly because of the intention not to kill. These physicians put strong emphasis on clinical skills and knowledge in palliative care in order to practice sedation appropriately, allowing them to conceive it as a safe practice.

In PCUs, a doubtful attitude is predominant and concerns physicians who have a long experience in palliative care, but who reflect and wonder whether, in some cases, palliative sedation is not a sort of indirect euthanasia because of the risk of death hastening. Their arguments are the same as physicians with a convinced attitude, and they use sedation rather often, but their daily practice in palliative care settings has brought them to doubt the clear separation between sedation and euthanasia.

Finally, some ambiguous attitudes were found among physicians who are rather open to palliative sedation as well as euthanasia or assisted suicide. They agree to sedate patients whether for physical or existential suffering and often compare sedation to euthanasia while being rather elusive and unclear about their position. Those attitudes are mostly found among physicians in acute care. When those physicians use palliative sedation, it seems there is little reflection and distinction between sedation, euthanasia and assisted suicide. In rehabilitation centers, ambiguous attitudes could also be noticed although physicians here were more overtly open to assisted suicide than euthanasia.

**DISCUSSION**

The more physicians are specialized in palliative care and are in favor of palliative care professionalization, the more they distinguish palliative sedation and the use of morphine at the end of life from euthanasia (Peretti-Watel, Bendiane, & Moatti, 2005). These findings are confirmed in this study where most physicians trained in palliative care and who have experience in specialized contexts show a convinced attitude that palliative sedation does not shorten life and is not the same as euthanasia. Interestingly, the more they distinguish palliative sedation from euthanasia or assisted suicide, the more they are opposed to sedate patients in cases of existential suffering.

Important differences were seen between specialized physicians who have first-line tasks and care for the patients globally (such as physicians in PCUs), and those that are second-line consultants. Those who have experience in a PCU and do not have to promote palliative care in an unspecialized care setting tend not to distinguish palliative sedation from euthanasia as clearly as physicians who work in palliative care consult teams. In PCUs (and home palliative care consult teams, where most physicians have experience in PCUs), death hastening is considered a risk and it is often questioned on the ground that palliative sedation might be considered as indirect euthanasia. PCU physicians are more doubtful as to whether palliative sedation can be clearly distinguished from euthanasia, than second-line palliative care physicians, who make the clearest distinction between palliative sedation and euthanasia. However, second-line physicians in acute care settings are also those who have little opportunity to provide alternatives to palliative sedation because they are often called in too late and feel forced into situations where the suffering is acute and there is no time for alternatives.

Also, differences were observed between older palliative care specialists and younger physicians. The older generation was more cautious and reluctant to use sedation in general, whereas younger physicians generally considered palliative sedation an acceptable practice. The fact that senior female palliative care specialists more often had a cautious attitude could hint toward gendered roles in medicine, where women physicians are known to value relational aspects more than men, often choosing more relational medical disciplines such as pediatrics, geriatrics, and palliative medicine (Jaisson, 2002). The more cautious attitude also typically reflects a tendency in modern medicine to separate soma from psyche (Le Breton, 2008). Physicians remain more comfortable caring for physical symptoms; whereas psychological and spiritual issues are deemed as more a personal responsibility of the patient.

Delimitation between euthanasia and palliative sedation relies on the physician’s attitude and intention, although some studies showed that intention cannot always clearly be separated from an unconscious wish to shorten the life of someone who is dying in great suffering (Fondras & Rameix, 2010). According to the sociologist Seale (2003), physicians in palliative care have strong means to relieve suffering, but those instruments of technical control can be used to accelerate death as well. Following Giddens (1990), although actors are becoming increasingly more self-aware and reflexive in our modern societies, they are never totally conscious of their intentions and actions and can’t always offer justification for them. Three levels of consciousness are distinguished: discursive consciousness (narrative reconstructions which can be verbally explained), practical consciousness (everyday knowledge on which action is based which does not need to be formulated verbally), and existential security (to which actors do not have access), which remains an unconscious motivation. This process creates a tension that explains the extent to which some actors will or will not experiment new activities (Lehoux et al., 2002). In the case of palliative sedation, strong unconscious motives due to the need for existential security must be considered as potential influencing factors.

In the Swiss context where assisted suicide and euthanasia are discussed as clearly different actions, our results suggest that euthanasia—in extreme cases where the limit
between life and death is tenuous—is more conceivable to some palliative care physicians than assisted suicide. Although unintentional death hastening and withdrawal of treatments are accepted in medical practice, they tend to generate reluctance and doubts about the use of palliative sedation. Nonetheless, they are considered as different from assisted suicide, which is regarded as a violent action for families and clinicians. On the other hand, in rehabilitation centers, there is a tendency to a more conciliatory attitude toward assisted suicide than euthanasia, even if most physicians were opposed to practicing it. This attitude appears to be linked to the focus on patient autonomy, rather than larger consensus taking into account clinicians and families’ opinions. It suggests that the more the patient is seen as a free individual and less as part of a network of relatives and caregivers, the more physicians can accept the patient’s wish to end his or her life. Indeed, in more specialized groups, the fact of taking into account not only the patient, but also the relatives and caregivers seemed to be a major factor in the professionals’ decision to reject assisted suicide. Finally, in acute care settings, palliative sedation, assisted suicide and euthanasia were often considered as basically equal actions. Thus, these practices could be confounded, which raises the issue of unskilled and possible abusive use of sedatives due to organizational constraints such as time pressure, poor recognition of palliative care as a medical discipline and generally a lack of reflection on such practices. The acute care setting appears to be a particularly important area of palliative care practice, whether first or second line. Earlier recognition and referral to palliative care teams would allow better clarification and support to front line physicians and avoid ambiguous and potentially harmful uses of palliative sedation.

In conclusion, palliative sedation plays an increasing role in the management of intractable symptoms affecting a small proportion of patients at the end of life. Important ethical concerns persist, especially regarding its use for existential suffering. Most Swiss physicians interviewed in this study related concerns about death hastening, assisted suicide, and euthanasia. Our results suggest that physicians are likely to behave differently according to their clinical context. Variations in practice, rules, and values should be taken into account when discussing guidelines and the subject of palliative sedation in general, not only by comparing different national contexts but also by considering different attitudes among professional groups and settings.

This study, based on a contextually sensitive approach, identified differences between physicians in specialized palliative care and unspecialized settings, and also showed some differences within these care settings. Among specialized palliative care physicians, differences between convinced, cautious, and doubtful attitudes were evident, the latter mainly being due to concerns about longer duration palliative sedations. Within unspecialized settings, palliative sedation is more likely to be considered as death hastening, with differences between clinicians avoiding palliative sedation with an inexperienced attitude and those practicing it with an ambiguous attitude. The importance of values regarding care, years of practice, gender, and the concept of the patient as an autonomous actor or, on the other hand, as part of a social and care network, also influence the physicians’ attitudes toward palliative sedation, existential suffering, and death hastening. Moreover, organizational constraints (such as time pressure, lack of recognition of palliative care) can lead physicians to use palliative sedation as an alternative to euthanasia, especially in acute care settings. We therefore feel that it is important to continue reflecting on this practice by acknowledging subjective and contextual characteristics, especially in countries where assisted suicide and euthanasia are legalized.

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