## Palliative sedation

We wish to correct the inaccuracies in the *CMAJ* article by Tibbetts[1] on Quebec's end-of-life bill. Tibbetts writes … "hospitals in Quebec and the rest of Canada often offer palliative sedation to ease suffering. In extreme cases, doctors use 'terminal sedation,' in which patients are medicated into unconsciousness and deprived of artificial nutrition to expedite imminent death." Where the author obtained this information is unclear, but the two paragraphs that follow contain quotes from a health law ethics professor and a retired palliative care physician — both of whom claim there are no "rules" and imply that this process is happening frequently.

The Canadian Society of Palliative Care Physicians formed a task force to review and develop a framework for the use of palliative sedation.[2] This framework outlines the indications, decision-making, drugs and monitoring to be used in palliative sedation.

Tibbett's[1] assertation also implies that palliative sedation hastens death by dehydrating patients who are too sedated to eat or drink. In a recent systematic review of 11 retrospective and prospective studies involving 1807 patients, with 621 patients receiving sedation, no substantial difference between sedated and nonsedated patients was found.[3] A recent prospective study found that palliative sedation was a definable clinical intervention that had no effect on survival.[4] Both studies noted the most frequent reason for palliative sedation was delirium.

The debate about physician-assisted death is too important of an issue to be hampered by inaccuracies and misrepresentation.

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I am disappointed in Tibbett's[1] reporting in *CMAJ* on terminal sedation, Bill 52 and the euthanasia debate. The following statement appears in the article: "As it stands, hospitals in Quebec and the rest of Canada often offer palliative sedation to ease suffering. In extreme cases, doctors use 'terminal sedation,' in which patients are medicated into unconsciousness and deprived of artificial nutrition to expedite imminent death."[1]

The term "terminal sedation" has fallen out of favour because it misrepresents the intent of the intervention. Palliative sedation, although not commonly used, is a medically respected and recognized intervention for patients with intractable symptoms, where the only option is to provide sedation to relieve suffering. Palliative sedation is normally offered only once a palliative care team has deemed symptoms to be intractable (e.g., meaning all reasonable and available avenues to relieve the patient's suffering have been tried, explored and offered), and just not difficult to manage.

Palliative sedation can be light or deep, and the intent is to relieve the patient of intractable suffering, not to end the patient's life. Patients are not "deprived" of artificial nutrition to expedite imminent death. If artificial nutrition is not a part of the care plan for the patient, it is not forced. In almost every case of palliative sedation, the patient is often near death, and to offer artificial nutrition is often futile and potentially harmful because it could cause additional symptoms.

While providing palliative care to patients, physicians often have to overcome myths and "untruths" (i.e., morphine hastens death, methadone is for patients with addictions, and patients are forced into palliative care to save the health care system money).

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## Clopidogrel and proton pump inhibitors

In their comprehensive review of antithrombotic agents following acute coronary syndromes, Matteau and Bhatt[1] discuss the drug interaction between proton pump inhibitors and clopidogrel. They note that the COGENT trial, led by Bhatt, found no increased risk of major cardiovascular events at six months in patients receiving omeprazole with clopidogrel.[2]

The COGENT trial employed a proprietary product containing omeprazole and clopidogrel (CGT-2168) purposefully formulated to circumvent any drug interaction by releasing the two drugs separately.[3,4] It offers no information about the safety of omeprazole and clopidogrel in patients who take clinically available products together.

A large and growing body of evidence suggests that omeprazole and pantoprazole exert differential effects on the antiplatelet effect of clopidogrel.[5,6] Although the clinical significance of the interaction remains the subject of debate, there is no compelling reason to use omeprazole rather than pantoprazole in this setting.

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