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Geriatricians' Perspectives on Continuous Deep Sedation Maintained Until Death in Patients Over 75 Years Old: A Qualitative Study

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Abstract

Purpose

Since 2016, continuous deep sedation until death (CDSUD) has been a legal right in France for certain patients at the end of life. However, CDSUD remains poorly studied in geriatric practice, and its role in geriatric care and clinical use remains unclear. This study therefore aimed to explore geriatricians' perspectives on CDSUD in patients over 75 years old, an issue of particular relevance given the recent enactment of legislation authorizing medical assistance in dying in France.

Methods

We conducted a multicenter qualitative study involving 13 geriatricians working in acute care, rehabilitation units, and nursing homes across different regions of France. Semi-structured interviews were performed using a previously developed interview guide. Data were analyzed using inductive thematic analysis within a constructivist and empirical ethics framework.

Results

CDSUD was described as rarely used in geriatric practice and considered appropriate for a specific profile of patient : patients with cancer and presenting symptoms such as refractory dyspnea or extreme agitation. Major barriers for geriatricians included the high prevalence of patients' cognitive impairment and the rarity of explicit patient requests. Prognostic uncertainty in multimorbid and frail older patients also complicated the identification of a short-term life-threatening prognosis, as required by law. Participants reported frequent use of proportional sedation, sometimes confusing this practice with CDSUD.

Conclusion

CDSUD remains poorly understood and rarely practiced by geriatricians, suggesting that the current CDSUD law may not be suited for geriatric care. Improved training, earlier advance care planning, and stronger collaboration with palliative care teams may help better integrate CDSUD into geriatric practice.

Key summary points

Study aim : To explore geriatricians' perspectives on the use of continuous deep sedation until death (CDSUD) in patients aged 75 years and older.

Findings : CDSUD remains poorly understood and rarely practiced among geriatricians. Major barriers included poor knowledge of the law by the geriatricians, high prevalence of cognitive impairment among

patients and prognostic uncertainty, especially in multimorbid patients.

Message : The current law regarding CDSUD may not be suited to geriatric practice. Improved training, earlier advance care planning, and stronger collaboration with palliative care teams may help better integrate CDSUD into geriatric care.

Introduction

In 2016, France enacted the Claeys-Leonetti law [1], which grants terminally ill patients with a short-term life-threatening prognosis access to continuous deep sedation until death (CDSUD) in two situations : following a decision to withdraw life-sustaining treatment or in the presence of refractory suffering. CDSUD may either be requested by patients themselves or, if the patient is unconscious, can be initiated by the medical team after a collegial procedure. CDSUD should be distinguished from proportional sedation, which is intended to alleviate symptoms and may be transient, intermittent, and potentially reversible [2]. In contrast, CDSUD aims to suspend the patient's consciousness until death. However, despite this legal framework, data on how CDSUD has been implemented in clinical practice over the past decade in France remains scarce. The use of CDSUD has become an integrated part of end-of-life care in many countries, before it was formally legalized in France [3]. In Europe, the prevalence of deaths involving CDSUD has increased significantly in the past years, particularly in Belgium, Denmark, and the Netherlands (from 3–12% in the early 2000s to 12–18% by 2019) [4]. Several factors may explain this increase. First, the indications for CDSUD have broadened, extending beyond physical symptoms to include psycho-existential distress. Furthermore, awareness of CDSUD practice has increased among patients and their families, while physicians have gained greater familiarity and expertise in its implementation [4].

Variations in CDSUD practices between countries may at least partly be explained by differences in national clinical practice guidelines. For instance, some guidelines do not recommend the systematic withdrawal of artificial nutrition and hydration during CDSUD, and some even advocate for maintaining minimal hydration [5]. These differences are reflected in clinical practice, with artificial nutrition and/or hydration being maintained in approximately 65% of CDSUD cases in Italy, compared with fewer than 40% in Belgium. [6]. Furthermore, substantial variation in CDSUD practices exists across patient populations. In end-of-life care, CDSUD is less frequently used in patients over 75 years old, regardless of diagnosis, than in younger patients with cancer (7% vs. 13%, respectively) [6].

In France, data regarding the implementation of CDSUD remains scarce. In 2020, a multicenter quantitative study examined thirty-six CDSUD cases across fourteen French hospitals during a one week [7] period. In most cases, CDSUD was proposed by the referring medical team and initiated following withdrawal of life-sustaining treatment. By contrast, only six patients explicitly requested CDSUD themselves. The authors highlighted significant variability within clinical contexts, the medication regimens that were used, and the discontinuation of artificial hydration or nutrition, underscoring the need to explore physicians' intentions and practices further.

Bretonnière *et al*. [8] conducted a qualitative study involving hospital and community physicians, including those practicing in nursing homes and home care, one year after the law's enactment in 2017. They found that CDSUD was rarely used, owing not only to limited access to midazolam in community settings, but also to physicians' perceptions of CDSUD as a moral grey area and concerns about legal protection. Some physicians conflated CDSUD with euthanasia, which either deterred its use or, conversely, facilitated it when euthanasia was perceived as appropriate but legally unavailable. CDSUD was also sometimes confused with proportional palliative sedation, with physicians describing cases of proportional sedation when asked about CDSUD. In home care, these conceptual and ethical challenges were compounded by logistical difficulties in accessing sedatives and balancing symptom relief with the preservation of relational care [9]. For palliative physicians, CDSUD was seen either as a medical prescription to relieve clinical suffering or as a response to a patient fearing death.

While several studies have explored the role of CDSUD in intensive care [10] and palliative care settings [11, 12], none have specifically addressed its use in geriatric patients. The population of older adults, especially those aged over 75 years, is heterogeneous and presents unique clinical, ethical, and decision-making challenges due to multimorbidity (including neurocognitive disorders) and frailty. In this context, decision-making capacity may be impaired, while goals of care can vary considerably among individuals. In this context, understanding how geriatricians perceive and implement CDSUD is of particular importance.

Thus, the aim of this study was to explore geriatricians' perspectives on the use of continuous deep sedation until death in patients aged 75 years and older, in order to better identify the specific challenges, barriers, and facilitating factors associated with its implementation in geriatric practice.

Methods

Study design

This qualitative study employed inductive thematic analysis [13] and was conducted within a constructivist epistemological framework, drawing on an empirical ethics approach. We chose this design to explore geriatricians' perspectives on the use of CDSUD with geriatric patients, to better understand the facilitators and barriers to its implementation. We used thematic analysis, following Braun and Clarke [14], to identify recurrent patterns of meaning, without presupposing theory development. In accordance with a constructivist orientation [15], we generated themes analytically through the interaction between participants' accounts, the research context, and the researchers' interpretative work. An empirical ethics perspective allowed us to examine how ethical reasoning is enacted in everyday clinical decision-making in geriatric care, without imposing a prescriptive normative framework. We used the Standards for Reporting Qualitative Research (SRQR) to report this study [16].

Sampling and participant recruitment

We recruited participants to ensure a diversity of profiles among geriatricians working in acute geriatric units, rehabilitation and long-term care units, mobile geriatric teams, and nursing homes. We sought variation in gender, age, experience, and institutional settings (university or non-university hospitals). Recruitment occurred progressively throughout data collection and analysis, with initial contact established through email invitations and followed by snowball sampling for simplicity [17]. To enhance sample heterogeneity, participants were recruited in different regions of France (Île-de-France, Nantes, Sables-d'Olonne, Lyon, Nancy)

Data collection

All interviews were conducted by ML, a second-year resident in geriatric medicine. Additional background information was collected, including age, gender, practice location, and additional training in ethics or palliative care. For practitioners working in hospitals, we asked whether the hospital was a university hospital.

During the interviews, we asked geriatricians to describe a situation in their clinical experience involving CDSUD. Interview prompts and follow-up questions aimed to understand the specific characteristics of older adults that might influence both the decision-making process regarding CDSUD, as well as its application. If participants did not have a personal experience of CDSUD to share, they were invited to reflect upon a clinical situation in which CDSUD might have been considered. Interviews were conducted using a semi-structured interview guide, constructed by ML and LM, a geriatrician and PhD candidate experienced with qualitative research methods, and pre-tested before finalizing the interview version (Table 1). The interview guide was modified throughout the interviews and analysis, in accordance with the principles of inductive thematic analysis. ML conducted all interviews (March 2023–June 2024), either in person or via videoconference. Interviews were audio-recorded with participant consent. All interviews were audio-recorded, transcribed in verbatim, and pseudonymized for subsequent analysis. During the final four interviews, no substantial new insights into CDSUD emerged, leading ML and LM to conclude that data saturation had been reached.

Table 1 Semi-structured interview guide

Data analysis

Data were analyzed following the principles of inductive thematic analysis [14] to identify key themes and then explore relationships between them. Within this approach, we first examined qualitative data iteratively, relying on an in-depth reading of the transcripts in order to identify relevant segments. We used an inductive coding approach, deriving codes directly from empirical data rather than applying a predefined coding framework. Codes were iteratively compared, refined, and organized into themes and subthemes that reflected recurring patterns of meaning across the dataset. The analysis was conducted manually using a constant comparative approach across interviews, allowing us to identify similarities and variations in geriatricians' accounts. Consistent with our constructivist epistemological framework

and empirical ethics approach, we paid particular attention to how participants articulated professional and ethical justifications, and to how these were embedded in specific clinical practices and organizational contexts. Themes were conceptualized as analytically generated and co-constructed through the interaction between participants' accounts, the research context, and the researchers' interpretative work. Analytical rigor was strengthened through a multi-level triangulation process. Findings were discussed at key stages of the analysis with LM, a geriatrician with experience in qualitative research, as well as with peers, both geriatric residents and practitioners and other residents ongoing training in palliative care. ML maintained a reflexive research journal during the study to document analytical decisions and methodological reflections.

Ethical considerations

This study was classified as non-interventional research (non-RIPH, *recherche n'impliquant pas la personne humaine, research not involving human subjects*) under French law and was approved by the ethics committee of Gérond'If (acceptation number 72023). Transcripts were pseudo-anonymized, and audio recordings were deleted after transcription. The study was registered with the Data Protection Officer of the Assistance Publique - Hôpitaux de Paris. All participants provided written informed consent for this research.

Reflexivity

A reflexive approach was adopted throughout the study to acknowledge the potential influence of the researcher's background and position on data collection and interpretation [18]. ML's position as a second-year resident in geriatric medicine facilitated access to potential participants through professional networks and enabled fluidity during interviews by allowing the use of a shared clinical language [19]. This insider position also contributed to participants' confidence in discussing complex clinical situations and professional practices [19]. However, some participants may have been concerned about possible judgments about their clinical practice and might have sought professional validation during the interviews. Conversely, the interviewer's status as a junior physician with limited clinical experience may have reduced perceptions of hierarchy. Participants, many of whom have had longer professional experience, may have felt more at ease in a "teaching" position and discuss the situation without fear of criticism [20, 21]. Furthermore, the interviewer's familiarity with geriatric practice may have led certain issues to appear self-evident, requiring a conscious effort to encourage participants to elaborate on experiences and assumptions that might otherwise have remained implicit [22]. Throughout the study, the interviewer aimed to maintain a non-judgmental stance and encouraged participants to provide detailed explanations. Reflexivity was supported by maintaining a research journal [23], and by regularly discussing emerging interpretations with LM, to challenge assumptions and strengthen the credibility of the analysis.

Results

Thirteen geriatricians participated in this study. Interviews lasted a mean of 32 minutes (14–55). Six of the geriatricians worked in acute geriatric care units, one in a post-acute care and rehabilitation unit, three in long-term care units, two in mobile geriatric teams, and one in a nursing home. The healthcare settings in which they practiced also varied. While the majority worked in university hospitals, four geriatricians worked in non-university general hospitals, one in a private nursing home, and one in a non-profit healthcare institution. The physicians' mean age was 37 years (range 31–45 years), and 69% (n = 9) were women. Only 13% of the physicians (n = 3) had additional training in ethics or palliative care. Physician characteristics are presented in Table 2.

Our study found three main themes: (i) the legal framework for CDSUD was perceived as ill-suited to geriatric patients; (ii) CDSUD remains an exceptional practice for geriatricians; (iii) uncertainty surrounding the decision-making process. The themes and associated sub-themes are presented in Fig. 1.

Table 2 Participant characteristics

CDSUD rarely fits the realities of geriatric medicine

The indications of CDSUD in daily geriatric care

CDSUD remains rarely used in geriatrics for several reasons. Geriatricians' reluctance to implement CDSUD appears to stem from limited knowledge of the legal framework and a lack of practical experience. They also report uncertainty about the intention underlying its use, questioning whether it could inadvertently hasten patients' deaths while also fearing that others might perceive them as acting with that intention.

Geriatricians report limited knowledge of the legal framework for CDSUD

Several participants explicitly stated their incomplete knowledge of the law (both personally and in their peer circle) and of its practical implications. This constituted a barrier to implementing CDSUD.

"It hasn't really become part of my practice yet, but more because of lack of knowledge than because of fear or reluctance." (Interviewee 5)

"The law is very poorly known among physicians, even among geriatricians, both in terms of its framework and its application." (Interviewee 7)

In addition, our interviews underscore persistent confusion between palliative proportionate sedation and CDSUD. Nine out of thirteen geriatricians described clinical situations they considered examples of CDSUD, which upon closer examination, corresponded to palliative care contexts in which progressive symptom control with opioids and benzodiazepines was initiated, sometimes subsequently leading to

deep and continuous sedation until death. In these cases, the primary intention was symptom relief rather than the explicit induction of deep unconsciousness maintained until death. This semantic and conceptual ambiguity reflects a limited familiarity with the specific legal and ethical framework of CDSUD.

"*They sleep well, but they still have periods of wakefulness. They can gently squeeze your hand without being fully sedated.*" (Interviewee 3, describing a situation considered a CDSUD situation).

Limited experience of CDSUD

The fact that only a small number of patients receive CDSUD at the end of life contributes to limited familiarity with the practice, generating apprehension among some geriatricians. They report feeling uncomfortable with CDSUD due to a lack of experience. Notably, most participants do not mention seeking additional training to facilitate its integration into their practice. To address this difficulty, however, two geriatricians reported using or even developing specific protocols tailored to geriatric patients and adapted to the availability of medications within their institutions.

"I'm not very comfortable with it [CDSUD], and I don't think my colleagues are either, because it's not something we do […] You're always more comfortable with something you do every day." (Interviewee 10)

"They [geriatric colleagues] don't do it regularly, so they didn't dare increase the doses […] so after that I created a protocol." (Interviewee 11)

Furthermore, some geriatricians considered CDSUD to fall outside the scope of geriatric medicine, viewing it instead as a practice reserved for palliative care specialists. Two geriatricians went even further, stating that end-of-life care and palliative management are not part of the role of physicians working in acute geriatric units. Practicing acute geriatrics implies a commitment to "active" medicine aimed at curing patients, with supportive care considered only as a last resort once curative treatments have failed.

"It's as if they were saying: 'Coronary angiography is for cardiologists, and CDSUD is for palliative care physicians.'" (Field note, May 2023)

"To me, it [CDSUD] feels more like a procedure that should be overseen by palliative care." (Interviewee 10)

"I think geriatricians working in acute care chose it not to do palliative care." (Interviewee 12)

"We are in acute geriatrics, and we provide active care." (Interviewee 5)

The risk of hastening death

Another limiting factor in proposing or implementing CDSUD seems to be fear of being accused of euthanasia, which was not legal in France at the time of the interviews. Geriatricians reported that such suspicions sometimes arise from patients' families, nursing staff, and sometimes even other physicians. This form of judgment may extend beyond individual cases, potentially calling into question the

practices of an entire team or department. However, the possibility of hastening death is encompassed within the principle of “double effect” as defined in the legal framework governing CDSUD in France. Therefore, it is to some extent inseparable from the practice of CDSUD. The limiting factor described by the participants is not the fear of hastening death itself, which is usually accepted and understood by geriatricians, but the fear of being accused by others of purposefully shortening the patient’s life.

“I was confronted with families talking about euthanasia, saying: ‘You’re killing him, you’re not feeding or hydrating him.’” (Interviewee 3)

“When we discussed it [CDSUD] in acute geriatrics for a patient with metastatic cancer, a nurse told me she felt it was euthanasia.” (Interviewee 1)

“I remember a discussion with a home hospitalization physician who said, ‘Are you performing euthanasia or what?’” (Interviewee 9)

“We’re even starting to get a reputation for practicing euthanasia.” (Interviewee 8)

Some geriatricians accepted this risk when CDSUD was considered clinically justified, particularly when the aim was the alleviation of otherwise unbearable and refractory suffering. One geriatrician, who reported rarely implementing CDSUD, did not consider it to hasten death. In his view, the patient's death is caused solely by the underlying disease, not by sedation itself. Accordingly, when the legal criteria are met, implementing CDSUD is regarded as a legitimate means of improving end-of-life care. From this perspective, the possibility of a "double effect" is considered to have little practical relevance.

“We emphasize the need to relieve the patient, so from that point on, we may use doses that can gradually lead to death.” (Interviewee 5)

“Maybe it will shorten their life a bit, but they are already dying, so it might as well not be in pain.” (Interviewee 9)

The specificities of considering CDSUD for geriatric patients

Considering CDSUD for patients with cognitive impairment

Most geriatricians we interviewed reported that it is often very difficult—if not impossible—to consider CDSUD for patients with cognitive disorders. This reluctance was largely due to a perceived mismatch between the French legal framework and the clinical realities of geriatrics when cognitive impairment is present. Some participants suggested that CDSUD could be considered if the patient’s preferences had been documented before the onset of cognitive decline, either informally or based on advance directives, in accordance with French law. However, such cases were reported to be extremely rare, and none of the geriatricians had personally initiated CDSUD on the basis of existing advance directives.

"Ideally, before cognitive impairment begins, we would already have advance directives, already have discussed these issues… But that is rarely the case. We are always somewhat constrained." (Interviewee 1)

Another key factor limiting the use of CDSUD in geriatric patients was the rarity of explicit patient requests. According to geriatricians, patients with cognitive impairment rarely request CDSUD themselves, which represents a major obstacle to its implementation. Even when patients expressed a wish to die, either explicitly or implicitly via non-verbal attitudes, these expressions were often interpreted as a manifestation of the patient's cognitive disorder rather than as a genuine, consistent choice.

"A patient requesting continuous deep terminal sedation is extremely rare, mainly due to cognitive impairment." (Interviewee 12)

"Can you really take into account such a comment from someone with cognitive impairment, when it changes from one day to the next?" (Interviewee 2).

Another central concern was the inability of patients with major neurocognitive disorders to provide free and informed consent.

"*It's complicated… I find it much more difficult to propose or perform sedation for patients who are not able to understand what it is*." (Interviewee 8)

For many, this made proposing CDSUD virtually impossible. However, one geriatrician with training in ethics stressed that cognitive impairment does not necessarily imply incapacity to consent and highlighted the need for careful capacity assessment.

"Neurocognitive disorders do not necessarily imply an inability to provide informed consent." (Interviewee 6).

Finally, some geriatricians acknowledged a tendency to accept progressive decline more readily in older patients with multimorbidity than in patients with cancer, which may delay identification of the end-of-life phase.

"We are much more tolerant of decline in an older patient with chronic illnesses than if they had cancer." (Interviewee 12).

Considering CDSUD for multimorbid patients

Although multimorbidity is common in geriatrics, CDSUD was reported to be seldom considered for these patients. Geriatricians perceived CDSUD to be a practice mainly reserved for patients with advanced cancer, where the prognosis is more clearly defined, and the legal criteria are easier to fulfill.

"Clearly, continuous deep sedation until death is only for cancer patients" (Interviewee 11);

"We are dealing with something very clear-cut in the case of a neoplastic disease, and not with multiple chronic conditions." (Interviewee 12)

The main difficulty reported for non-oncological patients was prognostic uncertainty. Fluctuating disease trajectories made it difficult to identify the terminal phase, a key legal requirement for CDSUD, particularly in multimorbid patients with unpredictable clinical courses.

"It is often very difficult to recognize when a person of very advanced age and extreme frailty has entered a palliative phase." (Interviewee 3)

"It makes it all the more difficult to address the end of life in patients with these exacerbations. Because in fact, they've recovered 15 times—why not 16?" (Interviewee 12)

Some geriatricians, however, felt that their expertise in frailty assessment allowed them to more reliably identify the short-term prognosis in these patients:

"As geriatricians, we perhaps have a slightly different perspective on frailty, on its irreversibility […] at a certain point, we know there will be no going back" (Interviewee 5).

The absence of patient requests

Three participants implied that most geriatric patients were unaware of the right to request CDSUD. This lack of awareness was considered as major reason for the rarity of explicit requests. The same participants suggested that future generations, being better informed about end-of-life rights, may be more inclined to initiate such discussions, whereas at present it is often family members who are the ones aware of this option.

"*I think there's mostly a big lack of knowledge of the law and of patients' rights—of citizens' rights, really. "* (Interviewee 10)

"*The geriatric population doesn't know about this type of law—it's more the children, the grandchildren, who know about it*." (Interviewee 11)

"*That population—it'll be different in 10 years, the future generation of older adults […] These patients don't say 'You know I have that right.' It's rare*." (Interviewee 12)

One geriatrician found that initiating CDSUD at the patient's request greatly facilitated decision-making.

"*I find that initiating sedation at the patient's request […] is not complicated*." (Interviewee 4)

Clinical situations considered appropriate for CDSUD by geriatricians

Two clinical situations emerged as the most frequent motives for considering CDSUD: severe respiratory distress and extreme agitation. Refractory pain was rarely cited by the participants as a reason for

considering CDSUD. In all other situations, proportional sedation, particularly for anxiety relief, was considered sufficient to ensure comfort at the end of life, making CDSUD unnecessary.

"*The patient I see as most at risk or in need of CDSUD is the one with respiratory failure… and the terrible agitation of advanced dementia*" (Interviewee 10).

"*We're already providing proportional sedation. That's already [sufficient] end-of-life care*" (Interviewee 2);

"*We very often accompany people with hypnotics and morphine, but never with deep sedation. They're just a little 'stoned'*." (Interviewee 3)

Altogether, geriatricians considered CDSUD appropriate but for a specific profile of patients: patients with cancer, without cognitive impairment, and presenting symptoms such as refractory dyspnea or extreme agitation.

Discussion

This qualitative study explored French geriatricians' perspectives on CDSUD in patients aged over 75, within the legal framework established by the Claeys-Leonetti law. While CDSUD has been recognized as a patient right in France since 2016 under specific conditions, its role in geriatric practice remains uncertain. Our findings show that CDSUD remains rarely proposed and implemented in geriatric care, highlighting the factors that limit its use and suggesting that France's Claeys-Leonetti law may not adequately address the practical, organizational, and ethical challenges encountered in geriatric care. These results align with those of a previous study, which reported lower use of CDSUD and less frequent intensification of symptom-relief treatments for elderly patients [24].

First, our results show that geriatricians interviewed report insufficient knowledge of the law, thus limiting their confidence in proposing CDSUD even in situations where it would be appropriate. Indeed, in our study, geriatricians regularly described clinical scenarios they classified as CDSUD, although these more accurately corresponded to proportionate sedation. However, this conflation is not specific to geriatricians. In 2024, Kremling *et al*. interviewed palliative care specialists from various European countries regarding the identification of situations falling under CDSUD. Their results reveal a low rate of correct identification, mainly due to confusion between the different terminologies of end-of-life sedation practices [25]. This confusion may also be explained by the heterogeneity of definitions in the recommendations concerning end-of-life sedation practices from one country to another [26]. The only element consistently shared across guidelines is that CDSUD involves a reduction in the level of consciousness; however, the intention to abolish consciousness is not always explicitly stated. This lack of clarity may contribute to underuse, cautious attitudes, or inconsistent practices in CDSUD implementation.

Second, we found that one of the major challenges in geriatrics concerns the implementation of CDSUD in patients with cognitive disorders. Cognitive impairment affects nearly one in two patients over the age

of 85 and is highly prevalent in geriatric care [27]. However, the Claeys-Leonetti law includes specific provisions for patients who are unable to express their wishes, notably requiring a collegial discussion before any decision regarding CDSUD is made, as well as taking into account the patient's surrogate's opinion. These collegial decisions are systematically conducted in intensive care units when CDSUD is considered for unconscious patients [10]. Collegial discussions involve a physician external to the department, generally a palliative care physician. By contrast, these collegial discussions seem less widespread in geriatrics and are not explicitly mentioned as decision-making aids for patients with cognitive disorders. This difference may be explained by the high frequency of decisions regarding the intensity of care in geriatrics, which are typically made within the care unit itself without involving an external physician [28]. This approach may also carry over into end-of-life care, particularly in decisions related to CDSUD.

Another major issue concerns assessing suffering in patients with cognitive disorders, whose expressions of pain may be altered. Their difficulty in expressing pain relies on several factors. On the one hand, the neuronal circuits involved in pain processing may be altered by neurodegenerative diseases [29]. On the other hand, at an advanced stage of dementia, verbal communication is severely compromised, which makes self-assessment of pain particularly difficult [30]. Patients with cognitive disorders tend to receive fewer analgesics than others, and reassessment of treatment effectiveness is rarely documented [31]. Numerous hetero-assessment scales exist, some specifically designed to measure pain in older adults. However, these scales are validated only for patients who are completely unable to communicate [32]. Identifying the "refractory" nature of suffering is therefore difficult to assess in patients with advanced cognitive impairment.

Third, one of the major difficulties faced by geriatricians in proposing CDSUD lies in identifying the end-of-life phase in patients whose disease course is long, fluctuating, and unpredictable [33, 34]. Perceiving severe asthenia as part of advanced ageing may lead to greater tolerance of functional decline, potentially delaying recognition of an imminent end-of-life situation. Geriatricians seemed more at ease in discussing end-of-life care with older patients with cancer, whose clinical trajectories may be more predictable [35]. This finding is consistent with previous studies showing that nearly 80% of CDSUD cases involve patients with cancer. [36]. Conversely, in patients with multiple chronic conditions, the illness trajectory is characterized by episodes of decompensation followed by periods of stabilization, making it more difficult to identify an irreversible state. Cardiovascular diseases account for 28% of deaths in those over 75 years of age, and neurological diseases and behavioural disorders account for 13% of deaths [37]. Tumour-related causes rank second after cardiovascular diseases, reversing the trend observed in those under 75 years of age, in whom they rank first [37]. This may partly explain why CDSUD remains uncommon in geriatric practice. Our findings highlight the need for decision-support tools specifically tailored to older patients with multiple chronic conditions, with the aim of improving prognostic assessment. They also underscore the importance of integrating advance care planning into the care of geriatric patients. This approach enables individuals with chronic conditions to define their goals and wishes regarding future treatments and care and discuss these preferences with their families and healthcare professionals.

Fourth, CDSUD implementation varies among medical specialties and the context of end-of-life care. In intensive care units, CDSUD is mainly considered in the context of withdrawing active treatments, particularly mechanical ventilation. In palliative care contexts, CDSUD is primarily considered for the relief of refractory suffering and is therefore used more for symptom control than to accompany the withdrawal of treatment [10, 12]. Although in theory, both types of situations that may fall under one or the other indication for CDSUD (relief of refractory suffering or accompanying the withdrawal of life-sustaining treatments) are encountered daily in geriatrics, CDSUD was considered by the geriatricians in our study to be reserved for refractory suffering. This contrasts with the findings of Mesnage et al., who reported that among the 36 cases of CDSUD identified over one week, 30 were implemented with decisions to withdraw life-sustaining treatments, whereas only two cases were initiated for refractory symptoms. Of these treatment-withdrawal cases, five occurred in geriatric wards [7].

This study has several strengths. To our knowledge, this is the first study specifically exploring geriatricians' perspectives on CDSUD. The use of a qualitative methodology grounded in an empirical ethics approach and using reflexive thematic analysis allowed for an in-depth exploration of physicians' perspectives and practices that would have been otherwise difficult to identify. We sought to maximize variation in participants' characteristics, including age, years of experience, type of practice, and geographical location, in order to capture a broad range of perspectives and enhance the transferability of the findings. Moreover, interviews were conducted with geriatricians practicing in different regions of France, reflecting the French healthcare and legal context regarding CDSUD. The diversity of participants, both in terms of clinical contexts and geographic locations, strengthens the relevance of our findings.

ML maintained a research journal throughout the data collection process to enhance the rigour and trustworthiness of the data collection. In addition, data analysis was conducted through triangulation with LM, a geriatrician and researcher experienced in qualitative research, thereby strengthening the credibility of the findings. However, we must acknowledge several limitations. First, participants may have had a particular interest in palliative and end-of-life care, potentially introducing selection bias. Second, this study reflects on the French legal context and as medical practices are shaped by cultural, organizational, and legislative factors, our findings may not be directly transferable to other countries [38]. Third, to facilitate recruitment across several cities, most interviews were conducted by videoconference. Although this approach enabled the inclusion of geographically diverse participants, it may have limited the depth of interaction and reduced access to certain non-verbal cues compared with face-to-face interviews. Finally, the interviewer's position as a resident in geriatric medicine with a particular interest in palliative care may have influenced both data collection and interpretation. This position may also have encouraged participants to withhold frank discussion of their sedation practices and decision-making for fear of being judged. Conducting interviews with palliative care specialists could help us gain a broader perspective on our research topic.

The diversity of contexts for the application of CDSUD in geriatrics highlights the need for more in-depth training of geriatricians regarding end-of-life care. Indeed, palliative care is not a mandatory component of geriatric residency training in France. Geriatric medicine residents consider themselves insufficiently

trained in palliative care; the only formal opportunity for geriatric residents to receive comprehensive training in palliative care is to complete an additional year of specific training in palliative care via a national cross-specialty training program [39]. This additional year of training, undertaken by only a minority of geriatricians, may not be sufficient to ensure that the palliative care competencies expected within geriatric practice are adequately addressed. Specific palliative care training should provide a clear understanding of the legal framework, incorporate case studies and analyses of clinical situations, and foster open discussion to address misconceptions surrounding CDSUD and facilitate older patients' access to this practice. It should also integrate the concept of advance care planning, enabling patients living with chronic conditions to discuss and articulate their wishes future treatments and goals of care. This issue is of particular relevance in light of the recent adoption of legislation on medical assistance in dying in France [40], and the ongoing development of recommendations regarding the training and competencies required in this field.

Conclusion

This qualitative study highlights that CDSUD remains rarely proposed and implemented in geriatrics and sheds light on the factors contributing to its limited use. Geriatricians described CDSUD as being mainly appropriate for a limited subgroup of older adults, namely those with advanced cancer experiencing refractory symptoms such as dyspnea or severe agitation. They identified several barriers to using CDSUD, including the high prevalence of cognitive impairment, the rarity of explicit patient requests, and the difficulty of establishing a short-term life-threatening prognosis in frail, multimorbid patients, as required by French legislation.

These results emphasized the need for enhanced training in end-of-life law for geriatricians, clearer institutional protocols adapted to geriatric settings, and structured opportunities for anticipatory discussions with older patients before cognitive decline occurs. Strengthening collaboration with palliative care teams and promoting earlier advance care planning may also help align legal rights with clinical realities. Ultimately, clarifying the role of CDSUD in geriatrics requires not only legal knowledge but also a deeper reflection on the specific nature of ageing trajectories and the values guiding end-of-life care for older adults. This may also suggest that France's Claeys-Leonetti law may not be suited to the practical, organisational and ethical questions raised in geriatric care. These findings are particularly relevant in the context of the recent adoption of legislation on medical assistance in dying in France, highlighting the need to further define the training and competencies required in this evolving field.

Declarations

Author contributions: Marie Louarn (ML), LM and JCM contributed to the study design. ML conducted the interviews. ML and LM contributed to data analysis, and all authors contributed to data interpretation. ML drafted the manuscript, and all authors contributed to its revision and approved the final version submitted for publication.

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Financial and competing interests: The authors have no relevant financial or non-financial interests to disclose.

Ethical approval: This study was approved by the ethics committee of Gérond'If (acceptation number 72023) in June 2023.

Informed consent: All study participants gave their oral and written informed consent to participate.

Data and material availability: The datasets generated and analyzed during the current study consist of qualitative interview transcripts containing potentially identifiable and sensitive information. Due to ethical and data protection considerations, these data are not publicly available.

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Tables

Tables 1 and 2 are available in the Supplementary Files section.

Figures

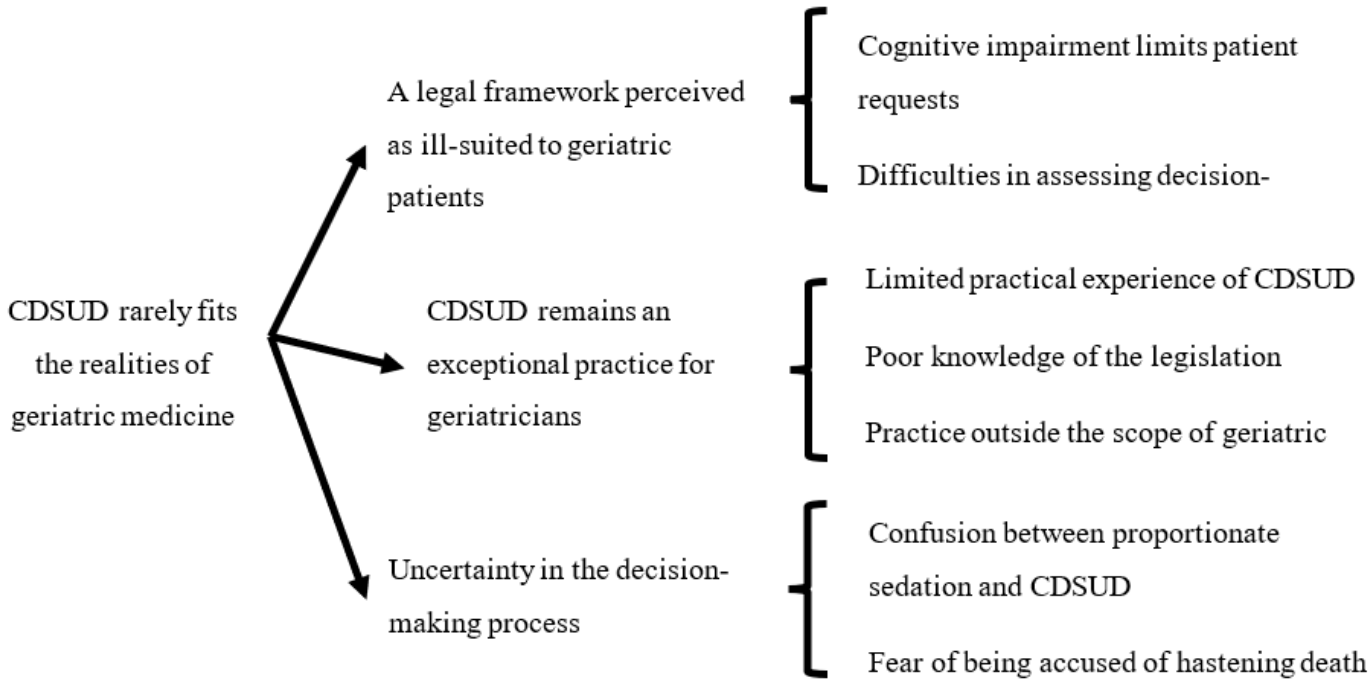


Figure 1

Themes and sub-themes identified

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