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Authors
Smith, Alexander K
Micco, Guy

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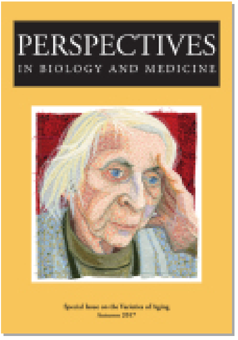

Alexander K. Smith, Guy Micco

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SERVING THE VERY SICK, VERY FRAIL, AND VERY OLD

geriatrics, palliative care, and clinical ethics

ALEXANDER K. SMITH* AND GUY MICCO†

ABSTRACT How can we provide the best care for growing numbers of very frail, very sick, or very old people? The disciplines of geriatrics, palliative care, and clinical ethics each have a good deal to offer to improve care for elders, yet each field is saddled with heavy historical baggage. Using a case as a springboard, we address specific strengths and shortcomings of each field, and what these disciplines can learn from each other. Geriatrics is currently largely focused on prevention of disability, cognitive impairment, and death; it should reorganize around a palliative approach to providing care for elders living with multiple chronic conditions, disability, and dementia. Palliative care, while paying some attention to the spectrum of advanced illness, concentrates primarily on cancer; it should expand its central purpose to include providing supportive care to elders with serious illness and their caregivers. Ethics committee members and consultants principally stress individual autonomy; they need to expand their approach and develop longitudinal relationships with patients and family members, routinely incorporating them in deliberations and the crafting of recommendations. However, improving these three disciplines will only go so far toward improving the care of very frail, very sick, or very old people. What is most needed is longitudinal care provided by interdisciplinary primary care teams steeped in the core principles of all three disciplines.

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*Division of Geriatrics, University of California–San Francisco, and Geriatrics, Palliative, and Extended Care, Veterans Affairs Medical Center, San Francisco.

†Joint Medical Program, School of Public Health, University of California–Berkeley.

Correspondence: Alexander Smith, 4150 Clement Street, 181G, San Francisco, CA 94941.

E-mail: alexander.smith@ucsf.edu.

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How can we provide the best care for the growing population of older adults, many of whom are either very frail or very sick? The traditional medical model of care is focused on treatment of single diseases. This can work well for pneumonia, cancer, or diabetes in younger patients. It does not, however, work as well for frail older adults who have accumulated multiple chronic conditions and disabilities. These elders often depend on family or paid caregivers to provide assistance with taking medications, transportation, and other activities of daily living, such as dressing and bathing. A practitioner in the traditional medical model might prescribe medications that make sense in isolation but have harmful interactions with other medications or ill effects, such as increasing the risk for falls. In addition, working within the traditional medical model might lead to treatments that require burdensome transitions for older adults and their caregivers, such as repeated tests or hospitalizations. This model tends to be least effective when frail elders are very sick or near the end of life.

We begin our perspective with the clinical case of Mrs. A, a frail elderly woman who develops a severe illness. We use this story as a springboard to present alternatives drawn from geriatrics and palliative care to the traditional single disease-focused medical model. In settings where patient, family, and health-care practitioner values conflict, clinical medical ethics be a helpful addition to the care of patients. These disciplines—geriatrics, palliative care, and clinical ethics—have much to contribute to the care of patients like Mrs. A. Following the case of Mrs. A, we will outline how these disciplines overlap, discuss how each developed historically, and consider how they might have provided better care for our patient. However, only a small amount of care for the frail, very sick, or very old is provided by specialists in geriatrics, palliative care, or clinical ethics: the majority of care is provided by primary care practitioners. Therefore, we emphasis throughout the need for interdisciplinary primary care teams that offer longitudinal care for patients across settings and that are steeped in core geriatric, palliative care, and ethical principles.

CASE STUDY: MRS. A

Mrs. A is a 95-year-old woman with mild cognitive impairment, heart failure, diabetes, osteoarthritis, and reliance on others for meal preparation and management of finances. Several years ago, she and her husband moved from their home of 50 years to an elder care community that is focused on "healthy aging." After her husband died two years ago, she had to move from the independent living area to the assisted living part of this community because, without his help, she could not sufficiently care for herself. One night, the assisted living staff becomes concerned about her rapid breathing rate and level of distress and, since there is no indication that she wouldn't want to be taken to the hospital in case of emergency, they call 911. She is brought to the emergency department of her local hospital where her condition is found to be critical: she is confused, moaning and grimacing, and her body temperature and blood pressure are low. She is diagnosed with a severe pneumonia.

Mrs. A has a Physician's Orders for Life-Sustaining Treatment form, or POLST, a set of orders that is legally binding in many states and that can travel with patients from home to hospital and remain valid. The Elder Care Community staff provided the POLST for residents to complete on their own. Mrs. A completed the form, and her primary care physician signed it at a subsequent office visit. Her POLST states that resuscitation should not be attempted in the event that she has a cardiopulmonary arrest, that she should be transferred to a hospital only if comfort needs cannot be met in the current location, and that she wishes to avoid feeding tubes.

After Mrs A's husband died, her health care proxy or surrogate—her decision-maker in the case she should become unable to make her own medical decisions—became her daughter, who lives on the other side of the country. When the emergency department reaches her by phone, she states that she was unaware of her mother's POLST form and that she wants all possible measures taken to prolong her mother's life. She will fly out as soon as possible.

The emergency department grants the daughter's request, and Mrs. A is admitted to the intensive care unit. A breathing tube is inserted into her throat, and she is placed on mechanical ventilator support. She is sedated to alleviate discomfort from this tube. A large bore catheter is inserted into her neck to deliver fluids directly into her major blood vessels, and a separate catheter is inserted into an artery in her wrist to measure blood pressure. A nasogastric tube is placed from her nose to her stomach to deliver fluid and nutrition.

The patient's daughter arrives two days later. She asks that "everything" continue to be done to maintain her mother's life. The ICU team considers this "futile" and abusive treatment and calls for a palliative care consult, asking for help to convince Mrs. A's daughter to "get on board" and "let her mother go." The palliative care team tries subtly to convince her that she is not respecting her mother's wishes as described in the POLST, and that hospice would be more appropriate. After two visits, Mrs. A's daughter tells the ICU team that "the palliative care team thinks they know more about my mother from a form than I know about my mother from a lifetime of knowing her." She asks that the palliative care team no longer be involved in her mother's care.

The patient remains ventilated and sedated and requires intravenous blood pressure boosting medications. Fluid and nutrition continues to be given through a nasogastric tube. Her ICU physicians and nurses request an ethics committee meeting, again stating the situation is "futile." The nurses say they feel that they are "torturing" Mrs. A against her wishes. The physicians agree and additionally see her treatment as a waste of resources. The ethics committee meets with the ICU team, without the daughter present, and determines that the patient's daughter, as the assigned health-care proxy, has, in effect, asked that the POLST be changed. They note that *futility* has no universally agreed-upon meaning, and that the likelihood of clinical improvement in Mrs. A's condition is non-zero. The ICU attending physician complains that the ethics committee is just "rubber stamping" the daughter's wishes.

OVERLAPPING AREAS OF EXPERTISE

Geriatrics, palliative care, and clinical ethics are distinct fields both conceptually and in practice. Geriatrics is focused on care of older adults (gerontology is a closely related field in the science of aging). Palliative care is concerned with the care of seriously ill persons of any age. Clinical medical ethics deals with ethical issues that arise in health care. As illustrated in Figure 1, each field has areas of expertise to which it can claim near-exclusivity and areas of overlap with another field or fields. With few exceptions, care of well elders is the domain of geriatrics, pain and other symptom management is the purview of palliative care, and confidentiality of medical information is a clinical ethics issue. All three fields overlap in several areas—for example, in the case of aid-in-dying for older adults with serious, "terminal" illness.

Geriatrics

Geriatrics, and the related field of gerontology, shoulder some of the responsibility for shaping the care of people like Mrs. A. Consider Mrs. A's elder living community, focused on "healthy aging." The roots of the healthy aging movement can be traced to three related paradigm shifts within geriatrics and gerontology: the successful aging movement, the compression of morbidity hypothesis, and the rise of biomedical gerontology. While it is beyond the scope of this paper to review these in detail, a summary will help place the case of Mrs. A in the context of these movements.

In 1987, Jack Rowe and Robert Kahn published a paper in *Science* titled "Human Aging: Usual and Successful." Rowe and Kahn posited a distinction between "usual aging," in which extrinsic factors such as poor diet, lack of exercise, and smoking lead to detrimental modifications of the aging process, and "successful aging," in which, through modification of diet, exercise, and behaviors, people manage to live to advanced age without the functional losses commonly associated with aging.

Researchers in this area have made several critical contributions to the science of geriatrics and gerontology. The observation, for example, that substantial differences in function of older adults had been ignored, with poor function merely attributed to "normal" aging, has led to needed critical examination of the sources of heterogeneity. The argument that exercise, diet, and health behaviors such as smoking have the potential to profoundly influence the aging process, albeit

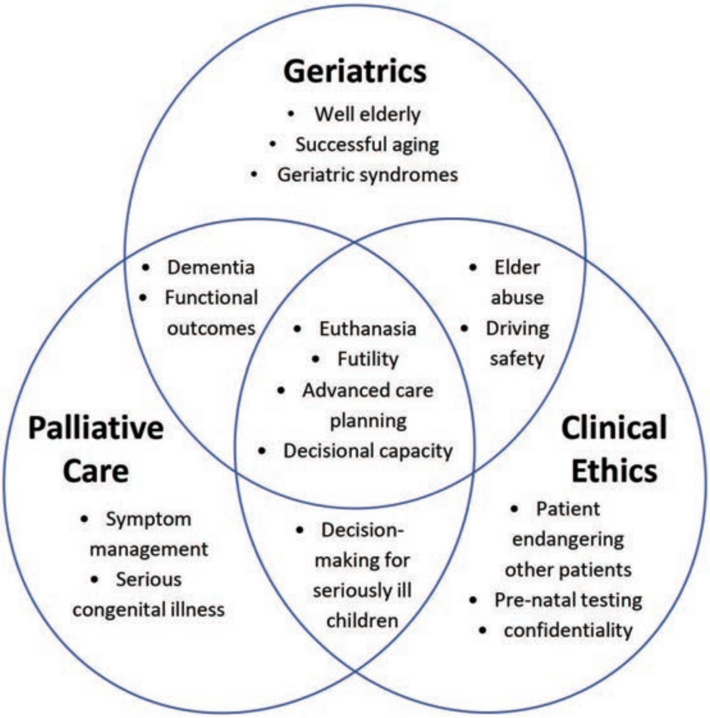

Figure 1

Geriatrics, palliative care, and clinical ethics.

presented with little evidence, has led to a dramatic shift within the scientific community and the lay public. Conduct an internet search for the terms "successful aging" or "healthy aging," and you will find images of supposedly older adults (really in their late 50s) skydiving and playing volleyball on the beach. Commercial ventures such as Successful Aging Expos are organized around products designed to prevent disability, with scant to no scientific evidence (Succesful Aging Expo 2017).

The successful aging movement was built on the compression of morbidity hypothesis, first articulated by Jack Fries (1980), which argues that thanks to advances in public health and medicine, morbidity is being compressed into an ever-smaller period of time toward the end of the natural lifespan. This claim is supported by evidence that human mortality curves have become increasingly rectangular over time (see Figure 2).

The field of biomedical gerontology takes the ideal of compression of morbidity a step further: the goal is not only to prevent, or at least delay, the onset of age-related diseases, but also to extend life. There does seem a biological limit to the lifespan of living beings; for some animals this time is much shorter than for

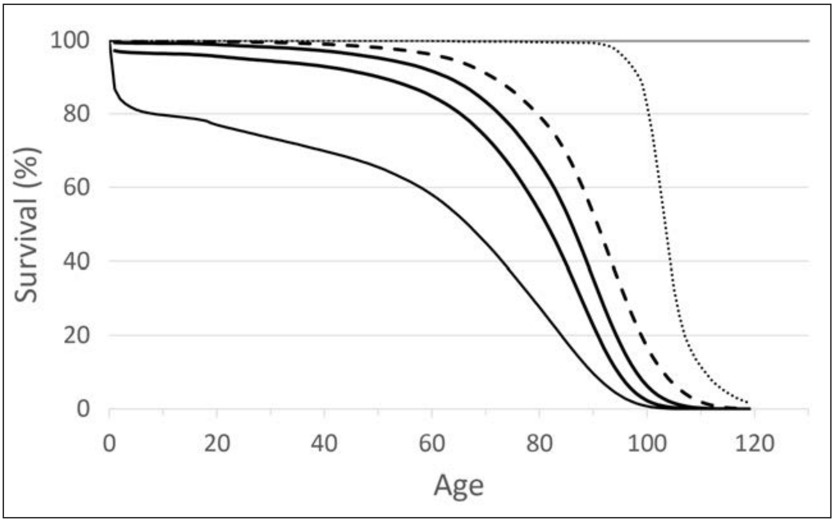

FIGURE 2

Rectangularization of survival curve and the promise of biomedical gerontology

SOURCE: BELL AND MILLER 2005.

humans, for a few it is longer. So, might our lifespan in some part be due to our genetic and metabolic programming? One piece of evidence in support of this is the existence of what appear to be "longevity genes." In 1993, Cynthia Kenyon and colleagues discovered that through a single-gene mutation, they could double the lifespan of the roundworm *Caenorhabditis elegans*. This work has been extended to the fruit fly and mouse (Clancy et al. 2001; Flurkey et al. 2001). By extension, humans may not necessarily have an immutably fixed length of life. This discovery sparked a revolution in aging science that now includes as a goal the extension of the human lifespan beyond the limits posited by Fries (Fontana, Partridge, and Longo 2010).

The problems with the successful aging movement, the compression of morbidity hypothesis, and the rise of biomedical gerontology are fourfold. First, they divert resources away from supporting older adults, such as Mrs. A, who have "failed" at aging, and who are living with progressive disability, cognitive impairment, or multiple chronic conditions—in other words, most patients in geriatrics clinics, assisted living facilities, and nursing homes. Second, they overstate the potential for exercise, diet, and other salubrious behaviors to modify the course of disability and cognitive decline in advanced age. While health behaviors are important, they are dwarfed by other factors, such as the severity of a patient's disease, the cumulative burden of multiple chronic conditions, and socioeconomic status (Chen et al. 2012; Holstein and Minkler 2003; Moon et al. 2014). Third, they stigmatize those elders who do not, for whatever reasons, age successfully. Attributing healthy and successful aging to lifestyle and behavior choices sends the implicit message to older adults living with disability and functional decline that if they had only tried harder, or been more virtuous, they would have been "successful" (Holstein and Minkler 2003). Finally, if the promise of biomedical gerontology—and it is currently only that, a promise—comes to fruition, our world will be faced with new practical and ethical challenges for which we are ill prepared. Are we ready for a society of individuals living to 130 or 150 or longer? Who will have access to these blockbuster treatments? In an already overpopulated world, where will these people live? How will we feed them? Whom will they displace? Who will decide?

Thus, the excessive focus on successful aging and prevention of disability has diverted resources and distracted geriatrics from its core mission: improving care for frail, very sick, or very old people, such as Mrs. A (Gillick 2007). How could geriatrics have played a stronger role in improving Mrs. A's care? Unfortunately, the reality is that no geriatrician was available in her area to assist with care, and even under the most optimistic scenarios, this is unlikely to change. There has been a steady erosion in the number of board-certified geriatricians and enrollment in geriatrics fellowship training programs over time (Langston 2012; Wasserman 2015). Partly as a result, the vast majority of elder care in the outpatient setting is not provided by geriatricians, but by primary care clinicians.

Geriatricians, though few in number, can play a key role in training multidisciplinary primary care teams in the core geriatric principles essential to the highest-quality longitudinal care of older adults. These principles include, among other things, a focus on maintaining physical function, recognizing cognitive decline, and assessing and managing falls, incontinence, polypharmacy, and delirium. Older adults generally want to remain in their homes as long as possible. Interdisciplinary primary care teams should ideally meet patients such as Mrs. A in their homes, rather than in clinics. In-home assessments are vital to devising practical means of promoting independence and safety. The provision of a meals-on-wheels program, a grab bar in the hallway, or a shower chair, and the removal of stray wires and throw rugs are all low-tech, inexpensive means that can literally save lives. A primary care team might have referred Mrs. A to an adult day program two years ago, after the death of her husband, which might have been able to provide sufficient support for her to remain in the independent living part of her care community. The interdisciplinary nature of the team is key, as the complex medical and psychosocial issues faced by people like Mrs. A require a team approach. Social workers, for example, are skilled at recognizing signs of elder financial abuse or neglect; they or psychologists may pick up on early signs of depression. Nurses have skills and training that physicians lack in management of wounds and dressing changes. In addition, an interdisciplinary care team with robust training in geriatrics, palliative care, and clinical ethics may have done a better job in helping Mrs. A and her daughter with completing the POLST form.

POLST forms were originally developed in nursing homes (Oregon POLST 2017). Their use has since expanded far beyond the original purpose—for very sick, frail, or very old people—to include people at younger ages with any terminal condition and, controversially, healthy people without a known limited life expectancy. Mrs. A apparently had the capacity to make complex decisions at the time she completed the POLST form. Although she had mild cognitive impairment, often a precursor to dementia, most patients with this problem can engage in clinical decision-making such as advance-care planning. In practice, as in this case, POLST forms are often given to patients to be completed independently, then signed later by the physician. This approach violates the spirit of the POLST, which is meant to be completed by a physician, after holding one or more conversations about "goals of care" and advance-care planning with patients or their health-care proxies. Ideally, a physician on an interdisciplinary team should have brought together the patient and daughter, by phone or videoconference, if not in person, to discuss Mrs. A's underlying goals of care and complete the POLST form in accordance with those goals. Ideally, the physician, Mrs. A, and her daughter would have come to an agreement on goals, translated the goals into specific orders, addressed any of the daughter's concerns, and arrived at a consensus about what should happen clinically if Mrs. A became critically ill.

Palliative Care

The origins of palliative care can be traced back to the modern hospice movement, founded by Dr. Cicely Saunders in the 1960s for the care of dying patients (Clark 2007). Saunders insisted on an interdisciplinary approach to treating the physical, psychological, social, and spiritual sources of suffering of the dying, which she called "total pain." In 1974, Dr. Balfour Mount, a Canadian surgical oncologist, coined the term "palliative medicine" to mean a hospice-like approach to care for hospitalized patients, and to avoid the negative connotations that the word *hospice* had accrued (Clark 2007). After a slow start, during the past 10 years palliative care has grown explosively in U.S. hospitals. Over 90% of large hospitals now have a palliative care program (Dumanovsky et al. 2016). While the increasing popularity of palliative care may reflect its effectiveness in alleviating distressing symptoms near the end of life, its remarkable growth may have been driven by evidence that palliative care consults are associated with shorter lengths of stays and cost savings for hospitals (Morrison et al. 2008).

While the origin of palliative care in the hospice movement provided a strong theoretical starting point and framework, it also saddled palliative care with heavy baggage. Hospice is associated with dying and death, as most hospice care is delivered to imminently dying patients. To be eligible for hospice benefits in the United States, two physicians must certify that a patient will die within six months, if his or her disease runs its "normal" course. Despite intensive efforts to increase lengths of stay in hospice prior to death, these are actually decreasing, down to 17.4 days in 2014 from 18.5 days in 2013 (NHPCO 2015). Most non-palliative medicine physicians associate palliative care with hospice and, by extension, wait to request a palliative care consultation until their patients are near death. Palliative care has struggled to redefine itself as care for persons living with serious illness, ideally initiated at the time of diagnosis, regardless of their proximity to death. Although the strongest evidence for palliative medicine, a trial that demonstrated increased quality and length of life when palliative care consultation was initiated in the outpatient setting early in the course of illness, palliative care services are provided principally in the hospital late in life (Cunningham et al. 2016; Temel et al. 2010). Separating palliative care from care for the dying has been an ongoing struggle, complicated by a deep ambivalence within the field about divorcing palliative care from hospice (Smith 2011).

Most early palliative care programs, such as the pioneering program at the Memorial Sloan Kettering Cancer Center, were created for patients with cancer (Clark 2007). But the demographics of serious illness have shifted dramatically, and the field of palliative medicine has struggled to grow with the changing times (Gillick 2005). The aging of the baby boomers has led to a growing need for palliative care among elders living with heart and lung disease, dementia, and the accumulation of multiple chronic conditions and disabilities. The functional trajectories, symptoms, and palliative needs of these elders differ dramatically from those of younger patients with cancer. The nascent field of geriatric palliative care is still finding its footing (Goldstein and Morrison 2005). New knowledge and skills need to be learned, as treatments such as morphine and nebulizers that are effective in advanced cancer give way to interventions such as functional assessment and grab bars that are effective in the care of elders with complex medical and psychosocial problems.

As noted above, the best overall approach with Mrs. A would have started before the hospital, with an interdisciplinary primary care team steeped in the principles of geriatrics, palliative care, and clinical ethics. This team would have developed a longitudinal relationship with Mrs. A and her daughter, engaged in advance-care planning discussions together, and optimized Mrs. A's quality of life in her home. However, for those many very sick, frail, or very old patients who are admitted to the hospital, there is room for improvement in hospital-based palliative care consults as well.

A fundamental issue in hospital-based palliative care is the problem of "two hats." In the hospital, palliative care teams generally operate as consultants. As with any consult service, they are asked to evaluate and treat patients with a specific purpose in mind. For other consult services, such as infectious disease, recommendations about workup and treatment are generally made with little conflict with patient or family values. However, in the case of Mrs. A, and as is frequently the case in our experience, the palliative care team is asked to consult specifically because the medical team and the family's values and preferences are in direct conflict. Who, then, is the "client" for the palliative care team? Is it the ICU clinician who requested the consult? Is it Mrs. A? Her daughter? In palliative care, the unit of care is supposed to be the patient and family (Ferrell et al. 2007; Get Palliative Care 2015). Yet the palliative care team members must feel some obligation to respond to the needs of persons requesting a consult, or they will be at risk of not being consulted in the future. How should they act when the consultation request is seemingly in direct conflict with the values of the patient or surrogate?

A mature palliative care team should have an established relationship with the consulting physicians in the hospital, including the ICU team. The palliative care team would have taught consulting physicians that requests along the lines of "get the family on board" or "get the DNR" are not appropriate. Rather, consults should be framed as a request for assistance in navigating goals of care discussions. In this case, the palliative care team might have managed the expectations of the consulting physicians, saying for example, "I can see how this situation is upsetting. You may feel like you're torturing Mrs. A, but Mrs. A's daughter feels like you're trying to save her life. Our job is to work with you and her to establish proper goals of care for Mrs. A."

Though establishing good relationships with the consulting physicians is important, the primary obligation of the palliative care consult team is to the patient and family, in this case Mrs. A and her daughter. Though they serve in a consultative role in the hospital, palliative care clinicians should view themselves as primarily beholden to the patients, not the physicians placing the consults. The alternative risks role confusion and conflict. In our case, the consulting palliative care team seemed more responsive to the requests of the consulting physicians than the needs and concerns of Mrs. A and her daughter. Rather than confronting Mrs. A's daughter with the POLST form, the palliative care team should have started by getting to know Mrs. A's daughter, empathizing with her strong emotions and stressful situation, and forming a relationship with her. A good relationship is the foundation for working through difficult decisions in palliative care. Starting a palliative care consult without first building a relationship leads to misunderstanding, defensiveness, and in some cases, being fired (Smith et al. 2007).

All professions have a culture, and physicians and other health-care professionals who go into palliative care often do so with a set of firm convictions about what constitutes a "good" or a "bad" death (Steinhauser et al. 2000a, 2000b). For them, a good death occurs at home with the support of hospice surrounded by a supportive family. A bad death occurs in the hospital, or worse, in the ICU, hooked up to a ventilator, punctuated by what are seen as violent attempts at cardiopulmonary resuscitation. These notions of "good" and "bad" are not unsubstantiated. The families of people who die in the ICU are at higher risk for post-traumatic stress disorder and depression (Kross et al. 2011). Family satisfaction with the care of people who die at home with hospice is higher than satisfaction with death in the hospital (Teno et al. 2004). Thus, it is not surprising to see in a recent commentary by Dr. Robert Truog that "many physicians hold a covert belief that sometimes the doctor really does know best, and that actions based on the values and preference of the patient can lead to objectively disastrous consequences for everyone involved . . . doctors and nurses also see themselves as having moral agency in these situations, and feel an independent responsibility to avoid actions that may be harmful to others" (Truog 2017, 587).

These firmly held, yet perhaps barely conscious, beliefs can impede optimal care when they dominate a clinician's actions. In the case of Mrs. A, the palliative care team confronted Mrs. A's daughter with her mother's signed POLST form that indicated a preference to avoid the sort of bad death in the ICU she was headed toward. A better approach would have started with building a relationship, as noted above—eliciting fears and concerns, providing emotional support, and ultimately sharing concerns in meetings with family members. This is where a member of the care team, often a nurse or a chaplain, can voice the apprehension that, despite their best efforts, Mrs. A likely will soon die and that further treatment is just prolonging her dying. Plainspoken testaments like this from members of the care team who spend considerable time at the bedside often carry tremendous weight in family meetings; they certainly carry more weight than lengthy descriptions of physiologic changes, laboratory values, and ventilator settings, the usual content of ICU family meetings. The ICU physicians could share their concerns about how a continued aggressive ICU course will end for Mrs. A: undergoing attempted cardiopulmonary resuscitation with virtually no hope of success. A negotiated way forward can often be reached that balances respect for Mrs. A's daughter, as the patient's proper surrogate, and the medical team's understanding of good medical care, both aligned with Mrs. A's known prior desires and current best interests (Smith, Lo, and Sudore 2013).

Clinical Ethics

Clinical ethics committees were first created in the late 1970s in response to advances in technology, specifically hemodialysis for patients with advanced kidney disease and ventilators for patients with respiratory failure. These advances forced physicians, hospitals, and society at large to grapple with a pressing set of questions: how should scarce life-saving resources be allocated? How should we act when reasonable people hold different values, such as the value of life or the value of control over what happens to one's body?

The very first hospital ethics committee was advocated by the New Jersey Supreme Court ruling in the landmark 1976 Quinlan case, as a kind of physician-dominated prognosis committee. Subsequently, several landmark cases prompted acceleration calls for clinical ethics committees, including the Supreme Court ruling in the case of Nancy Cruzan, a young Missouri woman in a persistent vegetative state with a feeding tube. Based on existing Missouri state law, the Supreme Court ruled against Cruzan's parents' request to remove the tube, but affirmed a right to refuse life-sustaining treatments. The Court allowed each state to set evidentiary standards for refusal. By 1993, on the heels of the Cruzan case, the national association for the accreditation of hospitals required all hospitals to have mechanisms (such as a committee) to deal with ethical issues. As a result, ethics committees grew explosively between 1980, when they were present in 1% of U.S. hospitals, to the end of the 1990s, when they were present in 100% of hospitals with over 400 beds (Fox, Myers, and Pearlman 2007).

Early in its history, the American ethics committee relied on pure "principlism," a focus on four guiding principles: autonomy, beneficence, non-maleficence, and justice (Beauchamp and Childress, 2002). The first of these principles, autonomy, has taken precedence over the others as American medicine has increasingly moved away from its paternalistic past. As a partial corrective to this, these committees have evolved over time to consider other ways of reflecting on an ethical issue. They have learned from feminist ethics the importance of relationships and caring, and from virtue ethics the value of the characterological disposition of medical practitioners to do good for their patients. Perhaps most helpfully, the mature ethics committee understands the crucial lesson of narrative ethics: that, though there are many points of view in telling a clinical story and all should be heard and considered, still the patient's voice should be paramount (Jones 1999). Despite these relatively new developments in medical ethics, the default position is often an over-reliance on individual patient autonomy, as in the case of Mrs. A.

Through the 1980s and '90s, ethics committees became more open to allowing patients and their families (or surrogates) into their meetings. Despite this more open practice, only about half of all ethics committees actually allow family members to be present, and only one-third invite patients to attend (Fox, Myers, and Pearlman 2007). If the committee convened to discuss Mrs. A's situation had been a "mature" committee, it would have required hearing from her daughter in some fashion—preferably in person at a meeting with ICU staff—so as to understand her point of view and allow her to hear the perspective of others. Yet, even relatively mature ethics committees that seek to gather information from patients or family members sometimes ask them to leave before they engage in deliberations to develop recommendations. Unfortunately, meetings behind closed doors can lead patients and their caregivers to assume the worst motivations for the committee's recommendations: "They're doing this to save money," or "It's because we're black." Further, there is a tendency in these meetings to engage in a form of "groupthink" (Lo 1987). Welcoming contrasting perspectives to the deliberation phase of consultation, including those of the patient's health-care team members, consulting clinicians, patients, and caregivers, even outside community members, improves transparency, inclusivity, and confidence that diverse perspectives have been considered.

In our case, how could this have gone better? As in many clinical ethics consultation services, the goals, values, and preferences of the patient and caregiver were not directly represented. Instead, they were filtered through the perspectives of the consulting physicians or nurses. This loss is critical. Talking directly with the patient's daughter would have allowed for a back-and-forth discussion, with greater understanding and respect for her concerns, perspectives, and experiences. Direct communication allows for fuller consideration, perhaps a reframing, of the ethical issues at stake, taking these from a theoretical to the personal level. For example, it would have been useful to hear about Mrs. A's daughter's wishes for her mother, and *her* understanding of what her mother's values and preferences might have been under these circumstances. Most importantly, meeting in person allows for relationship building. In palliative care, and to some extent in geriatrics, there is a deep appreciation that a good relationship is an essential prerequisite for having tough conversations about life and death.

Autonomy isn't the only principle to consider here. Mrs. A's daughter and the ethics committee should weigh Mrs. A's best interests by considering the risks, burdens, and benefits of ongoing and proposed treatments (Smith, Lo, and Sudore 2013). This would necessitate a clear understanding of the likely outcomes of aggressive ICU-level treatment on Mrs. A's life and functional outcome. In addition, Mrs. A's daughter ideally should come to understand the moral distress of her mother's physicians and nurses, who feel they are torturing their patient.

One last consideration, often unspoken, is the question of cost and resource allocation. In our experience, physicians are not infrequently overheard saying, in effect, "If they had to pay for this, they wouldn't be forcing us to provide 'futile' treatments." This attitude is very difficult to counter, and we believe it best not to broach it in the context of a clinical ethics committee meeting. Rather, this question should be directly addressed by the ethics committee (or its consultants) through ethics education sessions with the medical staff.

CONCLUSION

Geriatrics, clinical ethics, and palliative care are distinct disciplines that address the needs of seriously ill older adults, a large and growing segment of the American population. As we have described, each discipline has strengths and each has shortcomings with the potential for improvement. We conclude here by discussing how they can learn from each other and work together to improve the care of patients like Mrs. A.

While there has been a slowly evolving course correction toward greater involvement of patients and families in clinical ethics consultations, a more complete move in this direction is overdue. Some clinical ethics consult services view palliative care consultations as an existential threat. This is because clinicians may give up on ethics consultants as too readily endorsing a surrogate's demands; palliative care is then called in to set matters straight. To rectify this, ethics consultants should work with palliative care providers and geriatricians to develop skills in establishing relationships with patients and family members, attending to their emotional responses, and involving them centrally in deliberation and decision-making.

The public is bombarded with the notion that frailty and disability are not inevitable, and the most popular medical personalities (such as Dr. Oz) assail us with the message that healthy living will lead to a long life free of disability to the end. Swept up by the fears of baby boomers, claims about successful aging, faith in the compression of morbidity, and the promise of biomedical gerontology, geriatrics has bought into the idea that frailty and disability are not inevitable, and that we can "cure" aging. In fact, in most cases, we can delay the onset of disability, or slow its progression, but we cannot prevent it altogether; for those who live long enough, disability is generally inevitable, at least for some period, before death (Smith et al. 2013).

Geriatrics should balance the important search for methods of preventing disability and dementia with a palliative focus. Most geriatric care is intended to improve quality of life through promoting adaptation, avoiding the harms of over-testing and over-treatment, and through the support of caregivers. These are core elements of palliative care. The field of geriatrics, the related field of gerontology, and health-care systems that provide care for older adults need to refocus on this geriatric-palliative care approach. Palliative care, concerned for so long with the care of people with cancer, with dying patients, and with the transition to hospice, should, in addition, attend to the needs of older adults with multiple and complex chronic conditions, disability, and dementia. Palliative care clinicians and geriatricians should work collaboratively to create new models of elder care in hospitals, nursing homes, and in home-based care programs. While there is a convergence of these disciplines in these areas, and recent growth in combined geriatrics and palliative care fellowship training programs, both are still necessary given the broad areas of distinction of each discipline (see Figure 1).

Given the kind of interdisciplinary care we are suggesting, Mrs. A might never have reached the ICU. She and her daughter, with the primary health-care team's help, might have agreed on the goal of comfort, rather than opting for potentially life-saving ICU care. Alternatively, Mrs. A might have decided on limited ICU treatment, on a trial basis, for an acute illness such as the pneumonia she developed. In either case, treatment plans based on the patient's agreed-upon goals of care could have been formulated. This strategy would have the potential of preventing painful conflicts in stressful end-of-life scenarios such as played out in the case of Mrs. A.

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