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### Case Presentation: Part 1

*Mr. K is an 82-year-old man with a history of hypertension, diet-controlled diabetes, low back pain, hyperlipidemia, and right carotid endarterectomy who was found to have an enlarging lung mass during an evaluation for syncope. He was diagnosed with stage IIIA squamous cell lung cancer and subsequently underwent chemotherapy and radiation under the guidance of his oncologist.*

*Mr. K is divorced and has a daughter who lives locally as well as two sons who live out of state. He previously worked as a house painter and doing odd jobs. He lives alone and is independent in his activities of daily living. He has housekeeping arranged through his local elder services. He attends religious services weekly. He does not drive but has a friend from his religious community who assists with transportation and shopping. His daughter is his health-care proxy.*

*Recently, he developed increasing symptoms of dyspnea with exertion, cough, and fatigue which have been attributed to his progressive malignancy. As his primary care physician, you wonder: Would it be useful to refer him to palliative care? What about hospice? What is the difference between the two?*

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## Introduction

Older adults in the last decades of life often face serious or life-threatening illness. During this time, they may require not only routine medical care but also support from their physician and other members of the medical team around symptom management and end-of-life decisions. In this chapter, we will review the similarities and differences between hospice and palliative care, including when to consider referring a patient to one of these specialized teams. While hospice offers care to patients in the last 6 months of life, palliative care offers interdisciplinary support for patients at any stage of serious illness. We will also introduce tools for prognostication that can assist the clinician in offering guidance and clinical care appropriate to a patient's life expectancy and goals.

At the end of life, palliative care can provide symptom relief from distressing symptoms or suffering. In dealing with a patient's impending death, clinicians may be faced with the ethical dilemmas of when to withhold or withdraw life-prolonging medications or treatments. This chapter reviews examples of these dilemmas, including controversies regarding requests for hastening death and the ethical aspects of recent legislation around physician aid-in-dying (PAD), recommended approaches for addressing patient symptoms, and ethical aspects of assisting patients in defining their goals of care at the end of life.

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## What Is Palliative Care?

Palliative care provides specialized medical care for people with serious illness. It focuses on providing patients with relief from physical, emotional, and spiritual symptoms associated with a serious illness, whatever the diagnosis may be. Palliative care aims to improve quality of life for both the patient and family. Palliative care providers also focus on assisting the patient and caregiver in understanding illness, identifying personal goals and priorities, and using these goals and values to help direct and inform medical decisions. Palliative care is provided by a team of doctors, nurses and nurse practitioners, social workers, chaplains, and other specialists who work with the patient's primary medical team to provide an additional layer of support. Palliative care complements care provided by other medical providers and can be offered to patients independent of prognosis or treatment goals, including patients seeking life-prolonging or curative therapies. It is appropriate at any age and any stage of a serious illness. Early palliative care involvement for cancer patients has been shown to improve quality of life and mood and, in certain cancer patients, even increase survival compared with standard oncology care [1].

For older adults, palliative care may be provided by primary care providers or may involve referral to experts in palliative medicine or geriatrics who can lead or guide complex discussions about goals of care and advanced symptom management. Palliative care can be delivered in the outpatient or inpatient setting as well as in the home or long-term care facilities. Palliative care should be considered in the following situations for older adults:

- Presence of physical, emotional, or spiritual symptom distress
- Increasing frailty and functional dependency
- Symptomatic heart failure, COPD, cancer, dementia, or other serious illness
- Medical plan does not seem to match patient's personal goals

#### **Case Presentation Continued**

*Mr. K returns a few weeks later with increasing symptom burden due to his progressive malignancy; it is appropriate at this point to involve both oncology and palliative care in the treatment plan. Further disease-modifying therapies such as chemotherapy or radiation should be discussed, as well as symptom-oriented treatments which will address his dyspnea, fatigue, and cough.*

*After meeting with his oncologist, Mr. K elects not to have further chemotherapy. In his discussions with her, he feels that the benefits of prolonging his life do not outweigh the burden of treatment. He meets with the interdisciplinary palliative care team, and, over time, they address his physical symptoms as well as support and safety at home, functional status, fears and goals for the future, and priorities. When should hospice care be considered for Mr. K?*

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## **What Is Hospice Care?**

Unlike palliative care, which is appropriate at any point in serious illness, hospice is primarily aimed at end-of-life care. Hospice can be a confusing term as it can be used to refer to a philosophy of care, a care team, a location of care, and a Medicare insurance benefit. The Medicare hospice benefit, which was made permanent in 1986, provides the basis for most insurance agency definitions of hospice care. This benefit, which allows patients with Medicare A the ability to choose the hospice benefit as an alternative to acute care hospitalization, is available to patients who have an estimated life expectancy of 6 months or less as documented by two physicians. At the time it was established, the goal was to allow patients and families access to support at home to enable a comfortable death outside of the hospital. In order to qualify as a hospice agency, Medicare stipulates that hospices must have the following components:

- Medical director
- Nurse
- Social worker
- Chaplain
- Home health aide
- Volunteer program
- Bereavement program
- Access to a nurse by phone 24/7

- Nursing home visits ranging from daily to every 2 weeks depending on need
- Medications for comfort and those related to the hospice diagnosis
- Durable medical equipment including hospital bed, wheelchair, suction, oxygen, and commode

Each hospice agency is independently licensed and can provide different levels of service within these guidelines. While the majority of hospice care is provided in the home, hospice can be provided wherever the patient lives including assisted living and long-term care facilities. Some acute care hospitals have contracts to provide short-stay inpatient hospice care in the hospital for acute symptom management. Additionally, many states have freestanding hospice facilities, which may be short or long stay, and may utilize insurance or private pay for room and board.

Although the hospice philosophy tends to prioritize comfort and quality of life over medical procedures and prolongation of life, there has been a shift toward including “open-access hospice.” This approach allows for invasive treatments such as IV medications, artificial nutrition and hydration, palliative radiation and chemotherapy, and short-term ventilator support and other modalities that may provide relief of symptoms associated with a life-limiting disease. Although these treatments may prolong life, they are used primarily to palliate symptoms and, when provided by hospice, are always used in the setting of a terminal illness.

Hospice care most often involves a visiting nurse. The differences between hospice benefits versus visiting nurse services are described in Table 4.1.

**Table 4.1** Key Differences Between Visiting Nurse Services and Home Hospice

Visiting nurse	Hospice
Homebound status	Encouraged to “go out”
Focus on rehab or skilled need	Does not require a skilled need
No medication coverage	Medications covered
Standard qualifications for oxygen	No O <sub>2</sub> level to meet oxygen requirement
Co-pays for home DME <sup>a</sup>	DME covered and delivered
Episodic payment	Per diem payment

<sup>a</sup>DME durable medical equipment

### Case Presentation Continued

*You mention the option of hospice care to Mr. K to assist with symptom management and support. He says he’s “not ready.” You ask him to elaborate. Mr. K tells you that his cousin’s wife died with home hospice. “Once the hospice nurse went in, he died in about a month. That will be ok when I’m ready, but I’m not ready yet.” You know that Mr. K qualifies for home hospice care based on a prognosis of less than 6 months and that there is no requirement for a*

*high symptom burden, debility, homebound status, or imminent death. In fact, he can remain active, continue to see his primary care clinician in clinic, and continue to receive most medications while on hospice. You reassure him that hospice assists in living well in the time left and is not only useful at the very end of life. Additionally, you are able to share with him the following benefits of hospice care.*

Hospice has been shown to improve quality of life for both patients and their caregivers in the following ways [2–6]:

- Improved pain assessment and management
- Improved bereavement outcomes
- Overall improved patient and family satisfaction
- Less physical and emotional distress
- Improved quality of life
- Lower risk of post-traumatic stress disorder and prolonged grief disorder among caregivers
- Better caregiver self-reported health
- Lower mortality rates
- Lower cost

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## Prognosticating for Older Adults

The science and art of prognosticating for older adults continues to grow. Numerous prognosticating tools take into consideration a variety of factors including a patient’s underlying disease and comorbidities, functional status, and site of care (inpatient vs community or nursing home) [7]. Specific prognostication tools, such as the Palliative Performance Scale, can be used to help make determinations about hospice eligibility. For older adults, prognostication can be particularly challenging since they may have multiple comorbidities or functional limitations that could affect their prognosis.

An online resource to help clinicians make prognostication determinations and navigate the literature around prognosis is available at [eprognosis.org](http://eprognosis.org) [8]. This website provides prognostication calculators and tools, as well as instructional guidance around discussing prognosis with patients. In addition to the use of more sophisticated prognostic tools, a “no” answer to the relatively simple “surprise” question of “Would I be surprised if my patient died in the next year?” has been shown to identify patients with limited prognosis who may benefit from palliative care involvement or may qualify for hospice care [9].

### Clinical Pearls: Palliative Care Versus Hospice

Palliative care focuses on providing patients with relief from physical, emotional, and spiritual symptoms associated with a serious illness, regardless of the specific diagnosis. It can be provided at any point in the disease. It is usually provided by specialists and can occur in the hospital, clinic, or at home.

Hospice is care provided by a team during the last 6 months of life which emphasizes symptom management, support for caregivers, quality of life, and bereavement. In the United States, it is most often provided in the home with a team of visiting clinicians. However, it can also be provided in a hospice house, hospital, or wherever the patient lives (i.e., nursing home, assisted living facility, etc.).

Hospice can be provided to patients who are not homebound and focus on improving quality of life, not on hastening death. Two physicians must certify that the patient most likely has a prognosis of 6 months or less.

The “surprise” question, “Would I be surprised if my patient died in the next year?” has been validated as a tool to identify patients who may benefit from palliative care or qualify for hospice.

Patients and families who receive hospice care report improved quality of life and fewer bereavement symptoms than those who do not receive this service.

### Case Presentation: Part 2

*Mr. K returns to see you in clinic 6 weeks later. He is receiving low-dose morphine for dyspnea and cough. He finds now that he is having trouble walking from the door to the mailbox at the end of the driveway due to progressive fatigue. He is spending more time in the house and spends most of the day in the chair watching TV or reading. He often drifts off to sleep. He is eating less. Hospice nurses are coming to the home to assist with his care.*

*You decide to perform a home visit. During this visit, Mr. K shares with you that he feels ready to die. He states that he is not depressed, but that he feels that he is just waiting for death, and he cannot do things he used to enjoy like walk to religious services or concentrate on a book. He knows that his functional status will not improve as the natural course of the disease is for him to become more dependent. He asks you if you can “end it with a pill.” How should you respond?*

## Requests for Hastened Death

Requests for hastened death are not uncommon in the palliative care and hospice population [10, 11]. An approach to a request for hastened death has been described in the palliative care literature [12, 13]. First, the clinician must respond in a non-judgmental manner and with respectful curiosity and compassion. The goal is to ask open-ended questions so as to determine the source of the patient’s request and, at

the same time, to validate and acknowledge the patient's statement. Possible responses could include, "It sounds like this might be important to you. Can we talk more about what you are thinking?" The clinician should confirm a shared understanding. For example, when a patient says he wants to "end it," he could be referring to his life, his treatment, or this clinical encounter. You might say, "What exactly do you mean when you say, 'Can you end it with a pill?'" Once it is confirmed that the patient is talking about hastening death, you must then determine whether the patient is asking you to act on a plan for physician aid-in-dying (PAD), whether he wants to open a dialogue about suffering, or if the desire is to plan more theoretically for the future. It is equally important to discuss the motivation behind this request. Frequent reasons for asking for hastened death include [14–16]:

- Uncontrolled pain or other symptoms
- Concern of being a burden
- Loss of sense of self
- Loss of control
- Fear of the future

Many requests for hastened death are made by patients seeking ways to control the dying process. In these situations, the request for hastening death may reflect a fear of the future and/or a source of unaddressed suffering. It is crucial to partner with the patient to determine whether a trial of treatment may improve quality of life and alleviate suffering. However, in some instances, the patient may continue to request hastened death despite adequate symptom management and spiritual and psychological support. In this situation, the clinician must balance patient autonomy with non-maleficence, the principle of avoiding harm. The ideal approach uses open-ended questions to understand sources of potential suffering. The clinician should express his commitment to the patient and to assisting with alleviating suffering, even if PAD cannot be provided.

#### **Case Presentation Continued**

*You ask Mr. K what he means by "end it all with a pill." He tells you that he is always short of breath, even at rest. He has no pain. He is worried about burdening his daughter. She is caring for him full time, and he wants to die so that she can get back to her work and family. He feels badly that he continues to live and yet cannot contribute in a meaningful way to the society or his daughter. He used to at least help with the grandchildren but cannot even do that anymore. You ask if it would be acceptable to try a higher dose of opioids for dyspnea, arrange for a meeting with his daughter to discuss these issues, and have the social worker visit to help identify additional resources for support. You confirm with him that he can bring up his feelings about death at any time and that you are willing to continue this discussion. You also offer to have the chaplain visit him to explore the spiritual issues further. You confirm with him*

*that he was not expecting you to provide a prescription for medication to end his life. Rather, he wanted to be able to express how he feels badly being a burden and feels that his life is not meaningful at this point. He agrees to continue the discussion.*

*How would you approach the situation differently if Mr. K had instead said that he was hoping you would give him a prescription to end his life?*

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## Physician-Assisted Dying

Several terms are used to refer to a physician's role in assisting a patient in ending their own life. The most commonly used term is physician-assisted suicide (PAS). PAS is defined by the American Medical Association as occurring "when a physician [or other health-care provider] knowingly facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide)" [17]. Physician-assisted dying is not synonymous with euthanasia. Euthanasia occurs when a third party administers medication or acts directly to end the patient's life. Euthanasia is illegal in every state in the United States.

The term "physician aid-in-dying" is used to describe the practice authorized under the Washington, Oregon, California, and Vermont "Death with Dignity" Acts and is meant to reflect the requirement that patients receiving PAD must have a life expectancy of 6 months or less. The American Academy of Hospice and Palliative Medicine (AAHPM) prefers the term physician-assisted dying (PAD), as it is a more accurate description and is less emotionally charged than physician-assisted suicide. PAD is defined by the AAHPM as a physician providing, at the patient's request, a prescription for a lethal medication that the patient can self-administer by ingestion, with the explicit intention of ending life [18]. Although historically PAD has not been included in the domain of standard medical practice, it is now legally sanctioned in four states. PAD was first legalized in Oregon in 1997 and subsequently in Washington, Vermont, and California. Currently, approximately one-sixth of the US population resides in a state where PAD is legally permitted.

Both the American Academy of Hospice and Palliative Medicine (AAHPM) and the American Geriatric Society (AGS) have published statements on physician-assisted dying [19]. The most recent guideline from AGS, published in 1995, strongly favors aggressive palliation including withholding or withdrawing medical interventions and treating symptoms even if there is an unintended effect of hastening death. The guideline advises that clinicians thoroughly explore the source of the patient's suffering and address all possible avenues to alleviate suffering including the option of palliative sedation (discussed below) and the option to forgo artificial nutrition and hydration. Finally, AGS position statement emphasizes the importance of protection against coercion. At the time of this writing, the AGS statement on PAD is currently



undergoing review. The AAHPM statement strongly recommends that medical practitioners approach the request systematically to address all possible causes of fear and suffering and to ensure that quality palliative care is provided. The guidelines state, “The most essential response to the request for PAD in the practice of palliative care is to attempt to clearly understand the request, to intensify palliative care treatments with the intent to relieve suffering, and to search with the patient for mutually acceptable approaches without violating any party’s fundamental values.”

For those who practice in a state where PAD is not legal, the approach to a patient’s request for assistance with ending their life will include active communication, symptom management, and partnering together to determine a mutually agreed upon care plan. In states where PAD is legal, each clinician must decide his or her own position and determine what they find ethically justifiable. A clear consensus is not available from the various professional societies as they disagree on the ethics of PAD. The best practice would support open discussion and respectful, compassionate validation of viewpoints expressed by patients and colleagues. If a provider in a state where PAD is legal is not personally comfortable with this practice, referral to another provider for evaluation around PAD can be offered, but the original physician-patient relationship should not be terminated but should continue to focus on symptom management and emotional support.

In states where PAD is not legal, if the request for PAD persists despite systematic evaluation and optimal palliative care intervention, clinicians and patients may discuss discontinuation of potentially life-prolonging treatments such as steroids, insulin, oxygen, dialysis, or medically assisted hydration or nutrition. In situations with intractable pain or other distressing symptoms persist despite palliative care interventions, palliative sedation may be considered even to the point where the patient is rendered unconscious.

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## Discontinuation of Treatments at the End of Life

Patients and clinicians must weigh the benefits and burdens of treatments at the end of life. De-prescribing medications whose time frame to benefit exceeds the expected prognosis may provide some improvement in quality of life [20]. Medications to consider in this category may include statins, aspirin, and diabetes medications. Discontinuing antibiotics and other potentially life-prolonging medications also requires a consideration of the patient or surrogate decision-maker’s individual goals, as well as likelihood of benefit compared to burden and risk of, for example, *Clostridium difficile* or other medication-related complications [21].

Other considerations for discontinuation of treatments at the end of life include terminal extubation and withdrawing life-prolonging treatments such as hemodialysis. In these situations, shared decision-making must be used to weight burdens and benefits of the treatment as it pertains to the patient’s goals of care, either currently or as expressed previously to a surrogate decision-maker or in an advanced directive. Withdrawing life-sustaining treatments is considered ethically and legally equivalent

to withholding it [22]. When the decision is made to withdrawal of life-sustaining treatments, symptom relief, usually with opioids, and support for the family and patient should always be considered as part of the plan of care.

Patients with automatic implantable cardioverter-defibrillators (AICD), permanent pacemakers (PPM), or other advanced cardiac treatments may wish to consider deactivating these devices at the end of life in order to allow for death to occur or to avoid prolonging the dying process in the setting of underlying life-limiting illness such as advanced heart failure or cancer [23]. The goal in any discussion regarding withdrawing treatments at the end of life should be to elicit the patient's goals and preferences and explore how the treatment in consideration may or may not help the patient reach their goal—of comfort, of life prolongation, or of maximizing function [24].

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## Palliative Sedation

Palliative sedation is a clinical procedure aimed at relieving refractory symptoms in patients with advanced illness. Most clinical guidelines reserve the option of palliative sedation for patients who are actively dying and who are suffering from refractory symptoms that have failed all other treatments. Symptoms most commonly addressed by palliative sedation include dyspnea, restlessness, pain, and delirium. In most cases, a sedative is administered continuously to lower consciousness and provide relief from symptoms. The primary intention of palliative sedation is to promote comfort, not to hasten death [25]. There is no current available evidence to suggest that palliative sedation to unconsciousness hastens death; in fact, studies have shown the opposite [26]. Despite this evidence, palliative sedation raises ethical concerns when it lowers consciousness to the degree that the patient cannot interact with others, loses the ability to change his or her mind, and is unable to eat or drink.

Several medical societies have published position statements on palliative sedation including the American Academy of Hospice and Palliative Medicine (AAHPM), the American College of Physicians, Hospice and Palliative Nurses Association, American Medical Association, European Association for Palliative Care, National Hospice and Palliative Care Organization, and the National Comprehensive Cancer Network [27]. Although these guidelines differ in some aspects, they agree that palliative sedation is a valid medical procedure to palliate refractory symptoms at the end of life. The AAHPM guidelines specify that, “as with any medical procedure, palliative sedation must satisfy the criteria of having a specific clinical indication, a target outcome and a benefit/risk ratio that is acceptable to both the clinician and patient. Palliative sedation should only be considered after all available expertise to manage the target symptom has been accessed” [28].

There are two main approaches to the ethical dilemma presented above. The goal in this case is to relieve suffering and avoid maleficence, doing harm to a patient.

**Case Presentation Continued**

*Mr. K's functional status has declined further. His daughter has moved into the home to assist with personal care. He can no longer leave his bed and receives sponge baths. He has continuous oxygen at the bedside but, despite this, he appears to be working hard to breathe and seems to be in distress. The hospice nurses call to let you know that they believe he is actively dying and will die in days to a week. They ask for an order for liquid morphine 2.5 mg every hour as needed for dyspnea. His daughter calls you concerned that, given his age and respiratory issues, this dose of morphine could hasten his death.*

In hospice and palliative care, clinicians must be aware that the ethical principle of maleficence includes [29]:

- Failing to provide adequate symptom relief
- Insisting that patients confront the reality of their dying
- Failing to offer potentially helpful interventions
- Failing to stop treatments when the burden exceeds the benefit

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**The Rule of Double Effect**

The rule of the double effect has often been used to provide moral justification for treatments at the end of life that may hasten death. This doctrine was developed by Roman Catholic moral theologians in the Middle Ages and is still used in both Catholic and secular bioethics [30]. The doctrine focuses on the intention of the prescribing clinician, rather than the effect of the medication, and validates the use of treatments which are intended to relieve suffering or restore health even if the intervention has potential adverse effects including shortening life. The four elements of the doctrine are:

1. The good effect has to be intended (e.g., relieving pain or dyspnea).
2. The bad effect can be foreseen but not intended (e.g., could possibly shorten life).
3. The bad effect cannot be the means to the good effect (e.g., cannot shorten life in order to relieve pain).
4. The symptom must be severe enough to warrant the risks; this is known as proportionality.

Under the principle of double effect, if the clinician's intent is to relieve dyspnea, prescribing additional opioids is morally and legally acceptable even when the drugs may theoretically shorten the patient's life. The principle of double effect has come

under criticism due to the fact that it is rooted in one religious tradition; it assumes that death should never be intentionally hastened; it hinges in the clinician's intent, which cannot be validated; and it cannot be applied to all ethical decisions at the end of life. Furthermore, in clinical practice, the risk of harm is often overestimated. For example, the stated justification for the use of opioids at the end of life is often that the benefit of symptom relief outweighs the risk of hastening death when death is near. However, in most cases, there is a minimal risk of hastening death, and patients often live longer when medicated with opioids at correct doses at the end of life. Nevertheless, the basic tenants of the principle of double effect—to prioritize relief of suffering over a potential yet unguaranteed harm which is proportionally less likely—are grounded in the ethical principles of beneficence and non-maleficence and remain a helpful construct. Although useful, the principle of double effect may not be necessary when a shared decision-making process is utilized. The shared decision-making process, which is described below, focuses on the patient's goals rather than the clinician's intent and includes the ethical principle of autonomy in addition to beneficence and non-maleficence.

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## Shared Decision-Making Process

In this model, the clinician facilitates communication among the involved parties and uses ethical principles to make a shared decision which incorporates medical knowledge, culture, and values, and weighs possible risks and benefits. Often, perceived disagreements about treatment or goals are due to misinformation or lack of clinical knowledge about the treatments. For example, some clinicians and patients believe that using opioids for dyspnea and pain will often hasten death and therefore wish to reserve opioid use for the active dying stage or avoid them completely. In fact, carefully titrated opioids are not likely to hasten death and may actually lengthen life when provided in a pharmacologically appropriate manner. Similarly, both clinicians and patients may believe that choosing to forgo further chemotherapy may allow for improved quality of life (benefit) with the burden of hastening death. However, studies have shown that for patients considering fourth-line chemotherapy, avoiding chemotherapy may improve both quality of life and survival [31].

The process of shared decision-making requires that both parties fully understand the risks and benefits of the treatments discussed. The impact of these burdens on patients and families is influenced by many factors including prognosis, chance of cure, and impact on others. Thus, when having these discussions, it is important to have a clear understanding of prognosis and to elicit all of the patient's concerns which may extend beyond health-care issues to family, finances, faith, and legacy.

### Case Presentation Continued

*In the case of Mr. K, an appropriate response to his daughter's concerns regarding prescribing opioids for dyspnea would include the following information:*

1. *The opioids, if dosed appropriately, are very unlikely to cause respiratory distress.*
2. *The benefit of the opioids in alleviating shortness of breath, particularly in the setting when there is no cure available, may outweigh any potential risk of hastening death.*

*As part of this conversation, it would be appropriate to engage Mr. K and his daughter in a discussion to clarify his goals for care at this time in his illness, reaffirm his priorities, and confirm which risks he is willing to take for which benefits.*

*After a discussion regarding the above, Mr. K's last days are spent with his family at his bedside. The hospice team teaches them to administer liquid morphine to ease symptoms of dyspnea as well as other medications to ease terminal delirium. Mr. K's breathing becomes more irregular and he eventually becomes apneic and dies. The hospice team provides bereavement care and psychosocial support to the family. His family calls you, grateful for the care you and the oncology, palliative, and hospice teams provided to enable him to die comfortably at home. They share memories from his life and appreciation for his care and his peaceful death.*

## **Conclusion**

End-of-life and serious illness situations present ethical challenges for clinicians caring for older adults. By partnering with the patient and family to elicit goals of care, as well as availing themselves of resources such as prognostic indices to help determine reasonable approaches, clinicians can help match treatments given—or withheld or withdrawn—to the patient/family's goals of care as death approaches. Clinicians should be familiar with indications to involve palliative care, including helping with symptoms or suffering in any serious illness situation, as well as those for hospice. Clinicians should be aware of the potential ethical challenges of end-of-life decision-making as it pertains to requests for hastening death. This has become much more of a regular occurrence and will most likely become even more common in the future, as legislation about physician aid-in-dying has been approved in several US states and is under consideration in many others. A focus on symptom relief and shared decision-making is critical to navigating the ethical issues around this issue, and the other challenges related to death and dying, in the older adult population.

## **Clinical Pearls**

*Physician aid-in-dying (physician-assisted suicide) occurs when a physician provides, at the patient's request, a prescription for a lethal medication that the patient can self-administer by ingestion with the explicit intention of ending life. PAD is legal in four US states as of this writing.*

*Euthanasia* occurs when a third party administers medication or acts directly to end the patient's life. Euthanasia is illegal in every state.

*Palliative sedation* is a clinical procedure aimed at relieving refractory symptoms in patients with advanced illness. A sedative is administered continuously to lower consciousness and provide relief from symptoms. The primary intention of palliative sedation is to promote comfort, not to hasten death.

*Withdrawal or withholding of treatments* at the end of life should use a shared decision-making process around the patient's goals and preferences, balancing benefits and harms.

*The rule of double effect* refers to treatments intended to relieve suffering or restore health that may have an unintended consequence such as shortening life.

*Shared decision-making* involves exploring goals of care and weighing risks and benefits of treatments under consideration.

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## Additional Recommended Reading

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