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VIEWPOINT

Geriatric palliative care: clinical imperatives, ethical challenges and public health opportunities

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Summary

Population ageing is accelerating globally, creating complex clinical, ethical and organisational challenges for health systems. Older adults frequently experience multimorbidity, frailty and cognitive impairment, leading to unpredictable illness trajectories and high palliative care needs. Geriatric palliative care (GPC) has emerged as an integrative approach uniting geriatric, palliative and rehabilitative principles to address these multidimensional needs. Recent European recommendations emphasise needs-based assessment, interdisciplinary collaboration, caregiver support, culturally sensitive communication and integration across care settings. In Switzerland, persistent barriers – including fragmented care pathways, limited workforce training, variable access in nursing homes, low uptake of advance care planning and inequities affecting socioeconomically and culturally diverse populations – underscore the urgency of implementing coordinated GPC models. Strengthening home- and nursing home-based palliative care, embedding GPC competencies in undergraduate and postgraduate curricula, establishing shared-care frameworks and aligning national strategies with international ageing agendas represent key priorities. Investment in GPC is essential to ensure equitable, person-centred and sustainable care for a rapidly growing population of frail older adults.

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The demographic transition towards an ageing population presents significant clinical, ethical and societal challenges. Older adults frequently experience multimorbidity, frailty, cognitive decline and social vulnerability [1]. While their end-of-life trajectories are less predictable, the demand for timely, high-quality palliative care remains critical. A recent White Paper from the European Association of Palliative Care (EAPC) emphasised the need for an integrative model. This model should unite geriatric, palliative and rehabilitative approaches across the entire course of frailty [2]. In Switzerland, Voumard et al. previously identified the persistent challenge of integrating palliative care into geriatric medicine. This process is hindered by prognostic uncertainty and fragmented care pathways [3].

The ongoing ageing of populations will require health systems to develop care models that are not only clinically effective but also equitable, sustainable and responsive to cultural and existential needs. Achieving this will necessitate the creation of collaborative frameworks that integrate geriatric and palliative expertise, supporting older adults through a continuum of care that adapts to evolving needs and trajectories, rather than concentrating solely on late-stage interventions. In recent years, several countries have initiated academic and clinical innovations to strengthen the connection between geriatric and palliative care. While some have established interdisciplinary centres or collaborative programmes, the establishment of dedicated academic positions or chairs focused on integration remains uncommon. These pioneering initiatives underscore the increasing recognition of the need for a holistic and coordinated approach to the complex needs of ageing populations. Broadening the adoption of such models could substantially improve the quality and continuity of care for older adults with serious illnesses. Moreover, integrating these collaborative frameworks with health systems could lead to measurable system gains, such as reduced hospital days and decreased caregiver burnout, presenting a compelling case for policymakers about the ethical and cost-effective nature of integration.

Multiple definitions of "geriatric palliative care" (GPC) converge on its role as the intersection of geriatrics and palliative medicine, intended to address the complex, multidimensional needs of older adults [2, 3].

Rather than relying solely on prognosis, GPC should be grounded in systematic needs assessment and shared care planning, tailored to each patient's resources, preferences and values, or, when capacity is lost, to those of their designated representative [2, 4].

This approach recognises that many older adults experience prolonged vulnerability and functional decline, rendering prognosis-driven models inadequate [1].

The recent EAPC White Paper advanced this perspective by advocating for an integrative approach to palliative, geriatric and rehabilitative care for frailty. It identified eleven conceptual domains – including person-centred care, proactive planning, shared decision-making, caregiver support, interdisciplinary collaboration, training, cultural sensitivity, community integration and ethical frameworks – that collectively offer a comprehensive roadmap for the future of GPC [2].

To operationalise these concepts, validated screening and trigger tools must be developed for use across care settings and integrated with electronic health records, ensuring timely identification of needs and systematic referral to appropriate palliative care services.

Prognostic uncertainty remains a central challenge in geriatric populations, as multimorbidity, frailty and recurrent acute events contribute to unpredictable illness trajectories [1].

Traditional palliative care models, often based on cancer-type prognostic curves, do not adequately address the fluctuating and prolonged decline characteristic of frailty and dementia [1, 2].

This underscores the necessity of needs-based triggers, such as functional decline, recurrent hospitalisations, caregiver burden or indicators of distress, to facilitate timely integration of palliative care. To move from concept to practice, clinicians might consider a set of indicators such as observed functional decline beyond baseline levels, two or more hospitalisations within six months, and significant caregiver burden reported. Implementing these indicators as actionable triggers requires prioritising their validation, integrating them into electronic health records, and aligning them with reimbursement frameworks to encourage systematic adoption in clinical practice. In line with this approach, the recent EAPC White Paper advocated for a transition from fragmented criteria to a structured framework of needs-based triggers, integrated across clinical, ethical, organisational and public health domains [2].

Older frail adults carry a high burden of symptoms and multidimensional needs. Pain, delirium, depression, loneliness and loss of meaning are highly prevalent, yet often underrecognised [1].

Beyond clinical management, future priorities should include systematic screening of psychosocial and existential suffering. This type of suffering is closely tied to requests for assisted suicide in this population. Research and practice must converge on models that integrate symptom control with meaning-making. These models should support both patients and their caregivers.

Care settings play a critical role in geriatric palliative care. Nursing homes have become the primary sites of residence and death for older adults in Switzerland and other developed countries, yet access to specialist palliative care remains inconsistent [1, 5].

Integrating palliative care models into long-term care facilities has been shown to improve outcomes and reduce unnecessary hospital transfers; however, the absence of national minimum standards persists [6–8].

Key priorities include defining essential palliative competencies for nursing home staff, securing funding for training, and establishing sustainable collaboration models with specialist teams. Incorporating GPC standards into nursing home accreditation processes will be vital to ensure consistent practice across regions. Many frail older adults express a preference to die at home, yet this wish is frequently unmet [9, 10].

Fulfilling this preference necessitates a robust home-care system capable of managing complex needs without compromising quality. Essential measures include investment in home palliative care networks, development of hospital-at-home services, integration of telehealth and expansion of mobile interdisciplinary teams [2, 11].

Further research into the cost-effectiveness and quality outcomes of home versus hospital death will inform resource allocation. In the absence of these structures, equitable choice regarding place of death will remain an unachieved goal.

Equity represents a critical dimension of geriatric palliative care. Migrant populations, socially disadvantaged groups and individuals with low health literacy encounter substantial barriers to accessing palliative care [12, 13].

GPC must proactively address these disparities. Strategies should include culturally sensitive tools, targeted outreach and multilingual communication to ensure effective engagement. Public health campaigns co-developed with affected communities can help reduce inequities. Their impact requires systematic evaluation [13].

Without targeted interventions, population ageing may exacerbate existing inequalities in end-of-life care.

The workforce component is equally urgent. Developing a new generation of clinicians skilled in both geriatrics and palliative care requires significant investment of time and resources [14].

Physicians, nurses and allied health professionals are all integral to delivering geriatric palliative care. Systematic reviews reveal that interprofessional palliative care education remains fragmented and inadequately evaluated. These issues expose critical gaps in training and preparedness [14].

Establishing dual training pathways, interprofessional curricula and financial incentives will be essential for building sustainable capacity. Undergraduate medical and nursing education should also incorporate geriatric palliative care concepts early in the curriculum [15].

Early exposure to multimorbidity, frailty, end-of-life trajectories and Advanced Care Planning (ACP) in older adults can dispel misconceptions, reduce stigma and foster inter-specialty collaboration from the outset [14].

Evidence from Switzerland and other European countries indicates that palliative care is underrepresented in undergraduate curricula. As a result, young clinicians are insufficiently prepared for the complexities of caring for frail older patients [14, 16].

Strengthening education at this foundational level is crucial to ensure that future healthcare professionals are equipped to meet the complex needs of ageing populations. To facilitate workforce development, a five-year training timeline could be mapped, starting with foundational knowledge in undergraduate education. This would progress to specialised geriatric and palliative care courses, transition into interdisciplinary clinical rotations, and culminate in dual fellowship opportunities. Visualising this progression can transform the current gap into a tangible pathway for growth and capacity building.

ACP is a pivotal component of geriatric palliative care [2]; despite established legal frameworks, the uptake of ACP remains low among older adults in Switzerland. Many individuals are aware of advance directives. However, few have completed them. Completion rates are particularly low in French- and Italian-speaking regions [17–19].

Effective ACP requires tools that are simple, accessible and culturally sensitive. These tools should be usable by a wide range of professionals across hospital, nursing home and home-care settings, all within a shared decision-making model [20–22].

Expanding dementia-sensitive ACP models tailored to individuals with cognitive decline –beyond pilot projects – and integrating them into reimbursement frameworks will be essential for achieving broader and sustainable implementation [21, 23].

The distinction between geriatrics and palliative care is fluid, and effective synergism is essential [11]. Geriatricians and palliative care specialists both possess expertise in ethical decision-making; geriatricians offer in-depth knowledge of multimorbidity, frailty and long-term trajectories, while palliative care specialists excel in symptom management and end-of-life care. GPC should be delivered through a network model, with general palliative needs addressed within geriatrics and complex cases co-managed with specialist teams [24]. To ensure sustainability and quality, it is crucial to establish formal shared-care models and competency frameworks that clearly delineate roles [14].

Consider creating a concise matrix to operationalise this fluid boundary, outlining “who does what when” across care settings. This could include, for example, identifying specific situations in which palliative care specialists take the lead, such as in the management of complex symptoms, while geriatricians might handle the overarching management of chronic conditions. Providing a sample rubric can help accelerate local adoption and facilitate the integration of these shared-care practices. The EAPC White Paper further emphasised the importance of rehabilitation, advocating for an integrated approach that not only addresses symptoms and frailty but also prioritises the preservation of functional capacity and autonomy as core care objectives [2].

With population ageing, the challenges of long-term care financing and caregiver support emphasise the urgency of prioritising GPC. Integrating GPC into national health strategies, in alignment with the WHO's "Decade of Healthy Ageing" and Age-Friendly Health Systems, will be essential [25].

Each initiative should be explicitly tied to the pillars of this global agenda, which include fostering age-friendly communities, combating ageism and supporting integrated care models for older adults. By aligning GPC strategies with these international commitments, we can ensure that older adults are not marginalised in policy or funding decisions. Developing robust population-level indicators of GPC quality further supports this alignment. The recent White Paper offers a comprehensive European framework, positioning the integration of geriatrics, palliative care and rehabilitation as the gold standard for addressing the complexities of ageing and frailty [2].

Geriatric palliative care has evolved from a niche field to a necessity at the intersection of two rapidly expanding disciplines. The future of GPC depends on three key imperatives: consolidating academic recognition through dedicated chairs, research initiatives and curricula; embedding GPC within public health strategies to promote equity for vulnerable populations; and advancing clinical practice by enhancing home and nursing home care, integrating ACP and addressing ethically sensitive issues such as assisted suicide and dementia.

Inaction risks leaving a rapidly expanding segment of the population underserved, vulnerable to preventable suffering and excluded from advancements in care. Investment in GPC is not only a clinical and ethical obligation but also a reflection of the health system's capacity to provide older adults with dignity, equity and scientific rigour.

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