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OBM Geriatrics

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Review

Overview of Practical Applications of Healthcare Ethics for Older Adults

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Academic Editor: Giuseppe Ferdinando Colloca

OBM Geriatrics
2025, volume 9, issue 2
doi:10.21926/obm.geriatr.2502314

Received: January 30, 2025
Accepted: May 22, 2025
Published: May 30, 2025

Abstract

Identifying and addressing ethical issues in the care of older adults can be complex and challenging in clinical settings. This article reviews specific ethical principles including autonomy, beneficence, non-maleficence, dignity, and justice, and explores them in the context of interprofessional geriatric care. Situations and related ethical components such as treatment in intensive care units, end-of-life care, dementia care, and aging with advancing technology are included. Case scenarios for each principle or situation are presented, followed by a practical ethical response, and a review of common ethical dilemmas seen in geriatric healthcare settings. Matters related to ethics can arise in these settings and include decision-making capacity, shared-decision making, informed consent, safety, treatment refusals, use of surrogate decision-makers, enhancing autonomy, and advance directives. Collaborative interprofessional discussions can help support clinicians in making ethically sound decisions and delivering person-centered care.

Keywords

Ethics; aging; healthcare ethics; shared-decision making; patient-centered care; older adults; autonomy; capacity; treatment refusal; values-based care

1. Introduction

Healthcare clinicians routinely confront ethical dilemmas throughout their work. Everyday ethics happen often without conscious awareness; challenges occur, hard decisions are made, and issues are managed. Respect for persons, confidentiality, and informed consent are examples of everyday ethics. Everyday ethics can be overlooked due to their regularity in clinical practice (e.g., needing a surrogate for decision making or creating an advance directive) and therefore, under-discussed. Sometimes, however, situations happen when the "best" morally right answer is uncertain, or available options are contentious between patients and clinicians, patients and families, or between members of the medical team. Divergences can become noticeable, and even if not termed an "ethical issue," problems can escalate. Ethical principles and analysis can help clarify ethical issues, facilitate discussion, and help determine the best option for that situation. In healthcare, we are accountable for our respective professional codes, and these codes share common values and principles. For example, respect for dignity and worth of each person, autonomy, beneficence, nonmaleficence, truth telling, dignity and justice are projected principles across disciplines. We are also accountable for our institution's policies and current laws.

Most older adults maintain the ability to make decisions about their lives in accordance with their values and goals and preferences. However, some older adults have compromised decision-making capacity and are vulnerable to abuse and neglect. Ethical frameworks can help protect older adults at risk. Attentiveness to ethics is also helpful for treating older adults with full capacities by promoting respect for values, needs and interests of all stakeholders, mitigating moral distress amongst clinicians, and contributing to a morally mindful environment. Professionals have varied training and experience for managing complex decisions or handling challenging situations. This paper discusses ethical challenges and concepts through common scenarios from an ethical standpoint using common ethical tenets and frameworks to enhance ethical lenses when treating all older adults.

The structure of the paper includes sections with either an ethical principle (e.g., autonomy, beneficence) or circumstance (e.g., treatment in an intensive care unit; aging in the era of technology). Each section begins with the ethical principle or circumstance followed by a brief case example relating that principle or circumstance, then an ethical response (analysis) to the case scenario, and relevant ethical concepts that can be related to the principle or circumstance. Each section ends with a brief comment about that section's ethics related to aging. It is important to note that ethical principles often overlap, and principles and situations are in no order of importance or otherwise. The paper's design is intended for educational purposes and *not* to declare placement of ethical subprinciples/content under specific core principles (e.g., advanced directives (ADs) could arguably fit more properly under autonomy but is placed under dignity because ADs operationalize several ethical constructs). Rather, ethical concepts are place related to the scenario to aid the reader with applying ethical concepts and principles to the example. Ethical challenges are tied to contextual and relational elements that exceed the scope for a summary paper. Lastly, it is not possible to cover every possible detail or response in the ethical analyses. The goal is to introduce key concepts in everyday ethical practise in geriatric settings. Case examples are representative of real cases in healthcare ethics, but completely fictitious and intentionally simplified to stay within the scope of this paper. The reader should be aware that clinician and patient deliberations and

choices are entrenched in a complex system of social relations, expectations, policies, and laws that can significantly affect outcomes of real-life ethical conflicts.

2. Ageism and Healthcare

Aging is a multifaceted process that varies widely among people, influenced by a range of factors such as genetics, lifestyle, and access to healthcare. It is essential to avoid generalizations based solely on a person's age [1]. Ageism – the prejudice against those of different age, commonly towards older adults – is a significant issue in healthcare, often manifesting unconsciously, leading to biased expectations and decisions, and can even lead to unintended micro- or macroaggressions [2]. Ageist beliefs, messages, and interactions have been noted to occur almost daily and the experiences of ageism are associated with negative health outcomes [3]. Older adults residing in long-term care communities may experience even more ageism due to the current culture believing a life living independent is more worthy than a life living in a facility [4].

Internalized ageism can also negatively affect older adults' physical and mental health when they adopt societal stereotypes [3], such as believing they are "too old" to benefit from a given treatment or to advocate for themselves. Within a healthcare environment, expectations of older adults as being "cute" or believing they need help just because of their age are examples of "benevolent ageism" which can also have pernicious effects of undermining older adults' autonomy. Ageism can interact with other factors, such as gender [5] and race [3], further exacerbating healthcare inequalities, and could engender a mistrust in the medical system [6]. Innovative approaches to addressing ageism in healthcare include adopting age-friendly health systems practices [7] as well as fostering intergenerational connection and education which are showing promise in reducing these systemic issues [8].

3. Autonomy and Respect for Persons

Respect for autonomy and persons is a core principle in healthcare ethics and permeates all principles of bioethics [9]. An autonomous person self-governs and employs self-determination [10]. Violations of autonomy should only happen for good reason(s) and with clear justification. For example, physically restraining a person to protect themselves from harming themselves has both reason *and* justification. However, restraining a person because they are not following hospital rules would need further explanations for both the reason and justification.

Clinicians treating older adults experience ethical challenges with balancing autonomy (free choice) and the principles of beneficence and nonmaleficence, which are the duties to provide benefits to the patient while reducing harm [11]. These conflicts are ethically challenging and some decisions can have sizable consequences in a person's life. Some examples of balancing autonomy and beneficence nonmaleficence include determining when it may be time to restrict an aging person from driving, the point in which a person is unsafe to live in their home, and if clinicians should covertly administer medication or involuntarily treat a patient when they have strong objections to the interventions. Some subprinciples core to the principle of autonomy and respect for aging persons include shared-decision making, person-centered care, informed consent, and decision-making capacity.

3.1 Case Example: Principle of Autonomy

Alonso is a 79-year-old man who has a 3 cm bladder mass that is suspicious for malignancy. He is declining to have a procedure to ascertain whether the mass is malignant, stating he wants to treat the mass with supplements he saw on TV to cure his condition. Dr. Stacy is concerned that Alonso is not understanding the seriousness of his condition. Alonso also had a discussion with the urologist, and also declined the procedure with the urologist. Dr. Stacy states that she does not want to pressure Alonso into having a procedure he does not want, but she also does not want to let him think that what he is doing with supplements will help or cure probable cancer.

3.1.1 Ethical Response: Patient Refusal and Persuasion

In general, medical practitioners should engage their patients in a process of shared medical decision making [12]. Ethically and legally, a patient with decision making capacity, or the surrogate if the patient lacks decision making capacity, has the right to refuse any intervention offered even if the decision may result in death [13]. These decisions are supported ethically under the strongly held principle of patient autonomy.

However, just because a patient initially refuses a recommended procedure does not mean that we should stop making the recommendation. The shared medical decision-making process requires that we explore psychosocial factors and remain transparent with patients about our concerns [6, 14]. Perhaps Alonso would provide consent for the team to contact his family or a trusted friend to discuss the recommendation with them, and ideally with his presence. Others may offer a different perspective that may convince the patient about the importance of the procedure, or a perspective that can help clinicians better understand the patient.

It is paramount in these situations to differentiate persuasion from coercion and manipulation [14]. Coercion is a credible and severe threat of harm (not just physical harm) or force to control another. Manipulation is deceiving by lying or misleading, or by withholding or exaggerating information. Persuasion, on the other hand, is not morally objectionable because persuasion permits people to use independent and rational ethical judgment; it is convincing someone by the merit of reason(s) [14]. In encouraging the patient to have the procedure, it is ethical to use persuasion, but never to use coercion or manipulation.

3.1.2 Case Notes: Patient Refusal and Respect for Persons

This scenario, preferring natural remedies over medical interventions, highlights the importance of respecting other people's values. We must not dismiss or undervalue another's fundamental stance that may not align with our personal norms and values. Values come in all forms [15]. Outsiders without the full background may consider supporting a patient's decision to use supplements in place of usual standards for treating cancer as substandard care. This is only because the patient's value of autonomy is stronger than his desire for imposed treatments of any kind, all of which can be concordant with his personal set of values.

In Alonso's case, he clearly had decision-making capacity. He did not obscure the medical facts about the cystoscopy, and he was aware of how his refusal could negatively affect him. Collateral information from his brother confirmed his lifelong choices regarding minimal health procedures due to longstanding personal beliefs, "almost like a religion." Alonso's recourse has been toward

homeopathy or alternative methods. Nevertheless, when the consequences of a patient's refusal are significant, clinicians must ensure the patient is of sound mind and is making a fully informed decision. (NOTE: decision-making capacity and treating over objection are topics discussed in separate sections of this paper).

Ethically, when a patient declines important interventions, we should offer alternatives that they may find more appealing or try to negotiate to find a more mutually acceptable plan. Understanding the patient's reasoning behind their refusal is important. There may be a strong mistrust in the medical situation, demoralization, depression, anxiety, history of trauma, personality disorder, delirium, or other potentially modifiable factor that we may be able to address [6].

3.2 Shared-Decision Making

Shared-decision making is a communication process between clinicians and patients [4]. Shared-decision making, the hallmark of patient-centered care, promotes patient autonomy, as well as clinician autonomy [9]. This process ensures both that the patient's values and preferences will be honored, and that clinicians are able to uphold the standards of their profession. Clinician autonomy allows professionals to make independent decisions based on their expertise and clinical judgment, while adhering to professional standards and protecting the integrity of clinical practice. This consistency with medical standards encourages trust with patients and permits more collaborative care. Clinicians have a crucial role as the medical experts and must present the range of options and clinical ramifications for each option. The patient's role is to bring their values, goals, and preferences to the table for consideration in the decisions. Together, clinicians and patients make decisions based on the best scientific evidence available that aligns with the patient's values, preferences, and goals [8, 12, 16]. Of note, medical clinicians or family members can carry clout affecting genuine patient autonomy. Some older adults may automatically defer to whatever suggestion a medical clinician makes, or what a family member wants [14]. They may do so out of deference to authority [3], their personal choice, individual cultural norms, to not 'make waves', or because they do not fully understand what is being told to them [14]. In these cases, mindful practise of shared decision-making can help actively engage older adults in more meaningful participation when negotiating care that coincides with what *they* truly want for themselves and helps avoid unnecessary or unwanted medical treatments or costs. Goal-concordant care increases confidence and satisfaction with one's medical team [17].

3.3 Person-Centered Care

Carl Rogers [18] formally introduced the concept of patient-centered care in the 1950s, and Neuman and Young brought the model to healthcare in the 1970s [19]. Patient-centered care places the patient at the center of their care as an active co-creator of their treatment plan. Patient-centered care involves medical teams prioritizing the values and preferences of the patient [20] while recognizing that a person's psychosocial factors, beliefs, culture, and attitudes can influence the progression of a medical concern [21]. These factors are essential when developing personalized treatment options [14] and will likely increase patient adherence and satisfaction. Informed consent is a vital component of patient-centered care [22].

3.4 Informed Consent

Unlike a century ago, patients today have legal and ethical authority over their bodies [22], meaning that interventions are only permissible with consent from the patient or an appropriate surrogate.

Informed consent is fundamental in both ethics and law. It is the bedrock of patient-centered care with the explicit purpose to ensure ethical treatment [22]. During emergency situations, informed consent is presumed, and default interventions are to preserve life, unless there is an advance directive present that states otherwise [10]. Most clinical interventions are not an emergency and informed consent must be obtained from either the patient, or the surrogate if the patient lacks decision-making capacity [16] (see separate section on decision making capacity).

Informed consent encompasses three main elements—Information, Competence, and Voluntariness. First, the patient must be given sufficient information about the nature of the procedure (in terms of what a reasonable person would need to know), along with the risks, benefits, and alternatives - including the option to select none [16]. Secondly, the provision of competence means the patient must be capable of understanding, process, and apply all relevant pieces of the information. Thirdly, consent must be a voluntary decision, freely and without coercion or manipulation [14]. All implications of a decision should be comprehended, and consequences should be appreciated in the context of that individual's personal circumstances [20].

3.4.1 Surrogate Decision Making

Ideal surrogates are people who understand the patient's values and preferences and goals and are personally selected by the patient in advance. Terms to describe the person who facilitates decision making with the medical team when a patient is unable can include "surrogate decision maker", "healthcare agent", "healthcare proxy", or "healthcare representative" and these terms are often used interchangeably. Advance care planning is helpful with identifying others to facilitate decision making in the event the patient themselves cannot make healthcare decisions [23]. Unfortunately, many patients without decision making capacity do not have a person pre-selected and clinicians must identify a surrogate [24]. Family members are often chosen to serve as surrogate decision-makers. In America, some states provide a hierarchy of surrogates for the order of selection when one is needed (e.g., court-appointed guardian, next of kin, friend). Institutional policy and local laws can offer direction [25]. Note: Advanced directives are discussed in a separate section in this paper. If a surrogate cannot be located, policies within the healthcare institutions and state laws provide direction and procedures for someone to provide informed consent if needed urgently [26].

3.4.2 Surrogates and Informed Consent

"Surrogates" are people authorized to act on behalf of a patient when a patient is unable to act for themselves. Surrogates receive the same elements of informed consent that a patient would receive, and with the same expectations of receiving the information, competence, and voluntariness. Surrogates use either substituted judgment (substituted consent) or the best interest standard to make decisions for a patient. Substituted judgement should be used, when possible, which means to base decisions on what the patient would want according to the patient's values,

and not what the surrogate, family, or clinicians want [12]. If substituted judgment is unknown, the surrogate would use the best interest standard, which is the decision most favorable in terms of balancing harms and benefits [13]. Informed consent supports patient-centered care and patient autonomy by way of shared-decision making with a surrogate working with the clinician.

3.4.3 Concerns with Informed Consent

To ensure fairness, some factors must be acknowledged when providing informed consent such as the inherent power dynamics, language and health literacy barriers, cultural differences, and time pressures [12, 14, 22]. Unequal power exists between patients and clinicians, with the clinician considered the authority that patients look to for guidance. We must be mindful about the way we present information and treatment choices because the manner in which things are presented are apt to influence patient/surrogate decision making [14]. We must ensure the patients fully understand important components of informed consent, with mindfulness about their health literacy [17], hearing ability, and command of the spoken language – all of which may affect how information is received. A systematic review of the literature found that people's comprehension of core components of informed consent was low [27]. In addition, informed consent is made more difficult when medical decisions are needed quickly which leaves less time for clinicians to explain pertinent details [4], and for patients and family to weigh their options, especially when some cultures make decisions collectively rather than individually [22].

3.4.4 Decision-Making Capacity (DMC)

Technically the term "competence" denotes a legal status and "capacity" is reserved for clinical judgments [26], but these terms are often used interchangeably [16] and will be here. Competence, or the capacity to make medical decisions, is one of the required precepts for a person to provide informed consent (along with receiving information and voluntariness). Questions may arise about whether a patient has decision-making capacity (DMC) when a person makes decisions that may be life altering or goes starkly against medical advice. Nevertheless, these are not reasons to automatically assess DMC; DMC should only be assessed when there is good reason and assessment is warranted [16]. Regardless of age or diagnosis (even dementia or psychiatric illness), patients are always presumed to have DMC until it is verified that they do not [16]. To assess and declare whether a person has DMC, four criteria and conditions must be met. The four key features for DMC are when a patient can: 1) "Understand" the relevant medical information; 2) "Appreciate" how the information applies directly to themselves and their situation; 3) "Demonstrate Reasoning" with the information through a logical process of weighing alternatives pertaining to the patient's particular circumstance and the decision; and 4) "Express a Choice" by verbalizing a preference. If one of the DMC criteria is lacking, the person is considered to lack decision-making capacity, and a surrogate will be needed to make decisions. In addition, decision-making capacity is content specific and can fluctuate [12]. A person may be able to make decisions for simple decisions (e.g., blood draws) but may need a surrogate for help with more complex decisions (e.g., cardiac surgery). Lastly, decision-making capacity can fluctuate due to sickness, delirium, or another temporary incapacitation. Therefore, decision-making capacity should be relevant to the decision at hand and reassessed frequently. Efforts to find the cause of impaired capacity should be identified and remedied as soon as possible [16, 20, 21].

3.5 Aging and the Principle of Autonomy

Autonomy is essential for all adults in any health condition. Unfortunately, healthcare professionals, families, and society often underestimate the capabilities of older adults. Even beyond healthcare settings, many older adults feel that their autonomy is restricted [28]. A large study of older adults living in the community found that individuals who perceived themselves as having reduced autonomy were correlated with factors of having low education, low spirituality, cognitive impairment, anxiety, perceived low social support, and having limitations on activities of daily living [28]. This can be helpful for clinicians to identify and address the needs of some older individuals and ensuring they are empowered to make the most personally meaningful and informed choices [11].

Informed consent is fundamental to uphold the ethical principle of autonomy and allows patients to exercise full self-determination. Both patients and their surrogates have the right to receive information, ask questions about recommended treatments, and make decisions free from external pressures. A genuine partnership with patients and clinicians is necessary for effective shared decision making. The patient's values and goals should be discussed during treatment decision making beyond the intervention that they are consenting. For example, patients deserve a complete explanation of options and having full understanding of the longer-term outcomes of specific treatments, or lack of recovery altogether after that intervention [20, 29, 30].

Age, in and of itself, is not a contributing factor to incapacity. Many older adults live independently well into very late life. When illness, frailty, isolation, or changes in cognition occur, maintaining one's independence can become more challenging [4]. Making decisions about one's healthcare, finances, and where and how to live can also become increasingly complex. Some older adults may fear being a burden on loved ones, others may hope to live out their days in their own homes, alone or with a partner, and some may desire to live with or near family and friends to care for them. It is best to have these discussions with older adults before declines in physical, cognitive, or mental health. Interventions can be put in place to enhance independence and thus support individual's making choices for themselves, whatever those choices may be.

If individuals are found to lack decision making capacity, interventions should always be the 'least restrictive scenario' (e.g., 24-hour long-term care would not be needed if a person could do well with an assisted living environment). Interventions to enhance capacity should also be investigated and put in place to support autonomy [16]. For example, an older adult falling behind on paying bills because they are forgetting to do so may only need a regular visit from a volunteer money manager to keep them on track, rather than someone stepping in to take complete control of their accounts.

4. Beneficence and Justice

The principle of beneficence has strong moral underpinnings and demands that clinicians not only avoid harm and suffering, but should actively promote the well-being of patients – a duty to do good [9].

The principle of justice is grounded in a sense of fairness, including attending to individual rights, relevant laws, and allocation of resources [31]. The COVID pandemic was a stark example of how justice is a critical component of ethics, as older adults as a group were vulnerable to severe effects of the disease, while also being at risk of social isolation and loneliness inherent in social distancing efforts during and after lockdowns. In a time of crisis, when healthcare resources were stressed and

scarce [32], some advocated for reducing protections for older adults in favor of younger people [33]. Intergenerational social strategies that foster solidarity and connection among generations may help to counter these harmful attitudes towards older adults [34].

4.1 Case Example: The Principles of Beneficence and Justice

Mr. Patrick is a 78-year-old man hospitalized for exacerbation of cardiopulmonary disease (COPD) and failure to thrive. He is recently released following ten years of incarceration and is a registered Level 3 Sex offender (considered a high risk of re-offending and a threat to society that requires full disclosure and close monitoring). Cognitive, legal, and financial problems became evident during his hospitalization. Presently he has no medical needs for hospitalization and has no identifiable social supports. He is refusing to leave, finding discharge dispositions willing to accept him unacceptable. Placement in a nursing home is more restriction than he requires. Team wants to know what actions around discharge planning are ethically justifiable and patient centered.

4.1.1 Ethical Response Beneficence and Justice

The tradition of medical paternalism and shift toward patient autonomy has evolved in the past few decades. Respect for patient autonomy is now the cornerstone of medical ethics and often frames many ethical conflicts in clinical care. However, when a patient refuses to leave the hospital despite having no medical needs, a different conflict emerges: a conflict between respect for patient autonomy and justice. Honoring individual autonomy to the exclusion of other values during discharge decision making is unfair to other entities. The principle of justice obligates clinicians, administrators, and healthcare institutions to assess how difficult discharge decisions impact the community served by the entire healthcare system. Justice in healthcare speaks to issues of fair, equitable, appropriate medical treatment in terms of what is due or owed to people and to the distribution of resources determined by defended standards—for example, scarce resources, professional services and time, supplies, bed space, administrative effort, dietary and housekeeping services, and others. Using finite resources on some patients, but not others, is not consistent with ethical notions of justice.

Beneficence obliges clinicians to do good for the patient. Preparing the patient to be healthy for discharge partly fulfills beneficence. Developing a safe discharge plan and work to address underlying barriers to patient discharge also support the principle of beneficence. Mindfulness of bias and retaining a “therapeutic approach” is important. Nonmaleficence is the duty to do no harm. Importantly, concerns for nonmaleficence do not create a duty to permit unending goods and services to a patient. In fact, simply staying in a hospital setting can potentially cause unintended harms (e.g., hospital borne pathogens).

Practical resolutions achieved through discussion and agreement are preferred. Motive indication for the refusal is an important first step. However, the real reason for this patient’s refusal is hard to identify other than he deems the options unappealing. His options are indeed constrained due to his Level 3 sex offender status that prohibits certain locations (e.g., too proximal to a day care), psychiatric needs indication, analysis of competing values of beneficence, nonmaleficence, autonomy and justice is required [35-38]. Typically, these are granted to the individual patient, but they can also be applied to the nursing staff and other stakeholders in the hospital.

In summary, hospitals must meet their obligations to current patients while balancing the needs of incoming patients. Medically there is no reason for this patient to stay. There is no ethical obligation to keep a patient endlessly in the hospital because he demands it. With the principle of justice/fairness we are obligated to discharge patients when they no longer require hospitalizations or else we would need to provide free accommodations for all who wanted it. The authority to engender decisions regarding eviction or forcing someone to leave lies within facility leadership. Assessing any remaining clinical or social needs that the hospital facility can provide for him is ethically indicated under the tenet of beneficence.

4.2 Aging and the Principle of Beneficence and Justice

In considering ethical paths to older people's care, a beneficent approach is one that is person-centered. For example, when receiving treatment for diabetes, clinicians also address diet and exercise and other ways to benefit the patient in addition to prescribing insulin. Whole person care paradigms, such as the Geriatric 4 Ms [36] and the Whole Health model [39] aim to shift from a disease-focused model to one that expands the lens to broader aspects of wellness. Older adults can benefit from preventative care, from complementary and integrative health interventions, and from setting achievable wellness goals. These approaches can also leverage the benefits of an integrated healthcare team, one that aligns a treatment plan to the older adult's own goals for their life to promote positive outcomes.

Discussion of all the injustices in health-care policy is beyond the scope of this review. Distributive justices frequently encountered in healthcare include scarce resources (ranging from organ transplants to medications, tests, and equipment); caring for patients without health insurance; and time allotment per patient (should all patients receive equal time? Or, more complex patients receive more time?). Egregious examples of violating the principle of justice is if a treatment or medication is selected over another due to some benefit of the clinician [15].

5. Non-Maleficence

Non-maleficence is often paired with beneficence and is the moral principle that we "do no harm" (or the least amount of harm) while providing care with the most benefit [9].

5.1 Case Example: Principle of Non-Maleficence

Lauren Smith is an 85-year-old woman recently admitted to the hospital with multiple medical issues that have left her nutritionally compromised. The team believes she needs a nasal gastric (NG) tube to administer nutrition. Lauren is combative and formidably refusing this treatment. The medical team asks if it is ethical to force the NG tube to administer nutrition that can facilitate healing. They believe she does not have decision making capacity for this refusal.

Ethical Response: Treatment Over Objection with a Patient without decision making capacity (DMC).

As stated previously, patients with decision-making capacity (DMC), or their surrogate, have the legal and moral right to decline any treatment, even treatments that would be lifesaving. For patients who lack DMC, there are some situations in which treatment over their objection (lack of assent) could be permissible after careful analysis and with the surrogate's consent.

Rubin and Pager [40, 41] offer a seven-question approach to deliberating through cases when a patient without DMC objects to necessary treatments. The seven questions are:

1. What is the likely severity of harm without intervention?
2. How imminent is harm without intervention?
3. What is the efficacy of the proposed intervention?
4. What are the risks of the intervention?
5. What is the likely emotional effect of a coerced intervention on the patient?
6. What is the patient's reason for refusal?
7. What are the logistics of treating over objection?

In this case, the first step will be to determine whether the patient has the capacity to make the decision to refuse placement of an NG tube and administration of artificial nutrition. DMC is treatment specific and capacity for this identified treatment should be assessed. If she lacks DMC for this decision, engaging with her surrogate decision-maker for consent is required. If the surrogate provides consent, review the seven-question approach to help to clarify whether it is justified to proceed.

The first four questions are largely the domain of the clinical team. Medical teams determine "what can be done" (the options) and ethics determines "what should be done" from the clinical options. Ultimately, the greater the likelihood of, severity of, and imminence of harm without intervention, the greater the requirement to intervene despite the refusal. Using another example, if someone has type I diabetes, not administering insulin leads to both high likelihood and severity of harm and that harm is imminent (within hours to days). Whether or not performing an NG tube placement and giving artificial hydration has a high likelihood and severity of harm should be assessed by the primary team in discussion with other experts. Clinicians in Lauren's case stated the harm of not placing and using an NG tube is likely to be of intermediate imminence (i.e., within weeks, but not days). The risks of the intervention are important to consider as they help to determine whether, in aggregate, it remains in her best interests. Using the example of insulin for a diabetic, the intervention is not particularly harmful. By comparison, placement of an NG tube is painful and more invasive, and this must be weighed against the potential benefits. This leads to the 5th question (emotional effect). The more awake, alert, and attentive the patient, the higher the emotional burden will be likely.

The 6th question (reason for refusal) points at whether it is consistent with the patient's previously stated goals, values, and preferences and overall life narrative. If the patient's refusal is consistent with prior wishes, a strong case can be made that substituted judgment supports not providing the intervention [13]. If the refusal is not consistent with the patient's prior wishes, and she is typically in favor of medical interventions, arguments can be made for not treating over objection.

Lastly, the 7th question considers the importance of the logistics of this intervention. Once an NG tube is in place, it will need to remain in place to effectively administer nutrition. If the patient exhibits continued resistance, restraints of varied kinds may be required. These additional interventions must be included in the overall calculation regarding the risks versus the benefits of intervening over the patient's objection.

In sum, the likelihood, severity, and imminence of harms of not placing an NG and providing artificial nutrition for Lauren will determine the ethics of treating her despite her refusal. If the risks for harm are high, this does not mean proceeding is justified or mandated. It must then be weighed

against the decrement to the patient's best interest and quality of life should we intervene without her assent. One practical way to approach this is to proceed with attempt for NG tube placement (once she has been deemed to lack decision-making and after the surrogate has provided consent). If the attempt quickly results in great distress and/or requires aggressive restraint, pausing to consider the negative effects of proceeding are suggested. However, it still may be that placing the NG is justified if distress is well managed. Then, after placement, observation for the patient's reaction is essential. If she attempts to remove it repeatedly and requires constant restraint, this negative effect on her quality of life must again be weighed against continued benefits. Logistics of forcing treatment is usually the reason teams forgo treating over objection [42].

5.2 Ethics of Treating Despite Refusals

The right to decline treatment is grounded in both ethics [13] and law [43] (Cruzan v Director, Missouri Department of Health, 1990) stating that competent patients can refuse offered treatments even if the decision results in a poor outcome, and even death. Treatment refusals often conflict with clinician's non-maleficence precept ("do no harm") and is a common source for clinician moral distress and burnout [44]. Moral distress happens when clinicians are unable to exercise agency to provide care that is consistent with their personal and [professional] ethical ideals. One process to deliberate the ethics of treating patient refusals when the patient lacks capacity to refuse is described above in Rubin and Pager's seven questions [40] that can help inform considerations. Consulting with a geriatrician may also be helpful to guide whether the medical team's treatment plan for the older adult is consistent with evidence-based geriatric care.

In cases of advanced dementia, where individuals need help with activities of daily living, refusal of consequential care can be challenging for clinicians, and in some cases may prompt discussions of medicating the individual so that care can be provided. In these cases, a thorough evidence-based approach to assessing and treating behavioral issues is key to promote autonomy and avoid unnecessary pharmacological interventions or safety risks [45].

Another source of stress for clinicians is when patients request treatments that clinicians deem nonbeneficial.

5.3 Demands for Inappropriate or Nonbeneficial Treatment

Patients frequently make requests for treatments after reading something on the internet or based on a family or friend's experience. Requests can be granted if the request is reasonable and within standards of care; clinical practise should match clinical evidence. There is no obligation to offer or provide a treatment that is outside standards of practise [9, 46]. It is valuable to explore the underlying reasons for requests for nonbeneficial treatments, especially when these reasons are not clear. Patients may make strong requests driven by fear or anticipatory grief [47]. In such situations, the best approach is to actively listen to the patient's concerns, validate their emotions, and provide both emotional support and concrete facts to guide them towards a mutually acceptable resolution. If patients are seeking a "miracle", the hospital chaplain may be helpful [48]. If conflict persists, a second medical opinion may be helpful if there are barriers to accepting the medical recommendations.

5.4 Complex Comorbidities

In cases of multi-morbidity [30], in which a person has numerous chronic end-stage illnesses, the balance between autonomy and clinical intervention can be quite complex [20]. For example, a medication that may carry few side effects in healthier individuals can have more serious implications when added to an already lengthy list of prescriptions. In these cases, interprofessional teams are well-positioned to help tease out clinical nuance in service of supporting an older adult's wishes. For example, pharmacists [49] can partner with prescribers, nurses, patients, and caregivers to help optimize medications and avoid medication errors, especially during transitions of care.

5.5 Aging and the Principle of Non-Maleficence

The principle of "do no harm" is what people usually think about when considering healthcare ethics. Realistically, "harm" is unavoidable in medicine. Most medical interventions have some side effect or risk, even drawing blood may cause bruising or bleeding [10]. The best that clinicians can do is to estimate risks and benefits and weigh if the benefits outweigh the risks. The moral justification is what matters with nonmaleficence, meaning harm can be justified if the harm is caused by some greater benefit to the patient. Non-maleficence and beneficence are complementary ethical principles that when countered, serve as the fundamentals of ethical clinical care - clinicians have an obligation to promote the well-being of patients while mindfully balancing potential or inevitable "harms."

6. **Dignity**

The principle of dignity emphasizes the inherent value of every individual, underscoring the importance of treating every person with respect and recognizing their worth [31]. Dignity is highly relevant when older adults need care from others in any caregiving setting, and in our communities [3]. A significant challenge when treating older adults is to not *overestimate* their capabilities and overlook a genuine need for extra help and then not providing sufficient supports, and likelwise, to not *underestimate* their capabilities and predispose them to paternalism or ageism [11]. Clinicians must determine the proper balance of respecting autonomy and protecting older adults who may need help due to cognitive or other impairments [16]. Having autonomy to make decisions is a hallmark of dignity [31].

6.1 Case Example: Principle of Dignity

Tom is a 90-year-old man residing in a community living center. He has moderate heart failure that has been well compensated for until recently, with a hospitalization one month ago. He was an avid traveler and professional photographer in his younger years. He wants to take a trip to Scotland with his younger brother, Doug (aged 80). Tom's caregivers do not believe it is safe for him to travel without a professional healthcare escort, but he cannot afford one nor does he want one. They would like justification for not permitting him to go on the trip. Tom lacks decision making capacity and Doug is his surrogate decision maker. When talking to Tom about the team's unease, Tom says the risks of "anything happening" is worth his completing the remaining item on his bucket list "even if bad things happen." Tom's clinical team is concerned that the risk of re-hospitalization is reasonably high and if he travels abroad, he will not be able to weigh himself daily and have access

to the healthcare clinicians who know him best if he becomes symptomatic. In addition, Tom has been known to self-adjust his diuretic to control (usually decrease) frequency of urinations. If he were to become volume overloaded, he would need to titrate his diuretic and possibly need more frequent labs to monitor electrolytes and kidney function to prevent a hospitalization. The scenarios the clinical team want to avoid are an international hospitalization while traveling and/or his health deteriorating and requiring a delay to tolerate the long flight home, or the most unfavorable scenario of him dying overseas.

6.1.1 Ethical Response: Dignity of Risk

Robert Perske [50] introduced the concept of dignity of risk relating to people with mental retardation in the early 1970s. Dignity of risk permits individuals to take reasonable risks even if risks are involved. Dignity of risk applies to healthcare ethics by balancing our duties to care (respecting autonomy, beneficence, non-maleficence) with the dignity of risk. In this case, caregivers must transparently and thoroughly explain their concerns and associated risks. Tom is not capable or competent to make decisions based on the clinicians' assessment. However, his surrogate decision maker, Doug, appears to be exercising substituted judgment. If Tom was of sound mind, Doug believes Tom would deem the benefits of going on a trip with his brother, who is in relatively good health, outweigh the risks of "bad things happening." If the travel is concordant with Tom's values and preferences, and the risks are reasonable, caregivers should support Tom's request and maximize his chance for success.

Ethically, Tom's clinicians should ensure that both he and Doug (surrogate and travel companion) are fully informed about specific concerns of the team and make sincere effort to optimize Tom's health during the trip, and augment ways to mitigate risks [11]. Clinical team members should meet with both Tom and his brother to discuss symptom prevention and management and proactively assist in locating available and accessible healthcare resources in Scotland should Tom need medical advice or treatment.

Other common examples of patient behaviors affecting dignity of risk include when competent older adults refuse the recommended "safe" discharge plan causing conflict between the patient and clinicians and/or patient and the institution ("complex discharges" [25]) and when older adults choose to drink alcohol despite taking several medications with contraindications.

6.2 Dignity and Care Settings

Dignity is important in all settings where older adults receive care or assistance.

Studies report descriptions from older individuals' subjective experiences of dignified care in acute care [1], long-term care [51], and homecare [52] settings. Reported impacts on personal dignity in acute care settings include how hospital wards often all seem to look alike and cause disorientation, and caregivers in acute care are accustomed to treating all ages and therefore conceive all patients as a homogenous group [1]. Another reported challenge on dignity while receiving care in acute care was that patients and clinicians to do have an already established relationship [12]. Relating to dignity, older adults in both long-term care and home-care settings expressed a desire to be treated as a person needing care rather than a "task" needing to be completed. One suggestion from older adults to enhance subjective dignified personal care is to

broaden the role of caregivers to include other tasks meaningful to patients, such as things that they can no longer do for themselves like watering their plants or writing a thank you letter [52].

6.3 Advance Directives (AD)

Advance directives (AD) are one way to operationalize the core ethical principles of autonomy, non-maleficence, and beneficence, and dignity within healthcare. Advance directives preserve dignity by allowing competent patients to make decisions about life sustaining treatments (LST) in the event they become incapacitated. In the United States, the Patient Self-Determination Act of 1990, is a federal law attempting to address concerns about the underutilization of advanced directive. The law requires hospitals, nursing homes, hospices, and psychiatric facilities to inform patients of their right to accept or refuse medical care, and to share hospital policies that uphold these rights. Embedded in this Act is the requirement for healthcare facilities to offer opportunities for patients to formulate advance directives [13]. The Living Will and a Durable power of attorney (POA) are two common types of advance directives.

6.3.1 Living Will and Durable Power of Attorney (POA)

A living will is a legal document supporting individual's preferences regarding what kinds of treatments they would or would not accept, such as chest compressions, intubation, artificial nutrition, and dialysis, and can also list preferences for organ donation as well as authorization for autopsy. A durable Power of Attorney (POA) is another form of legal document where individuals authorize another person, often a family member, to make decisions on their behalf, including medical decisions, and can also incorporate legal or financial decisions. Individuals can designate a POA to have limited or broad authorities and specify details and when they want it to take effect. If effective immediately, the POA stays in effect (endures) even if the person loses capacity [13]. Both types of advance directives govern future decisions about medical treatment and allows surrogates and medical teams to represent patient preferences about what is important to them when receiving healthcare.

6.3.2 Limitations of Advance Directives (AD)

Although advance directives (AD) have good intentions of ensuring goal-concordant care, especially near the end of life, ADs have several noteworthy limitations [53]. First, ADs are not used often. A published analysis indicated that only one in three Americans has prepared an AD, the Patient Self Determination Act notwithstanding [24]. Other shortcomings of ADs are that people cannot foresee circumstances during the construction of ADs, and that ADs address the procedures rather than the outcomes, all of which can demand substantial interpretation by the clinicians and surrogates when making detailed decisions. For example, an otherwise healthy older adult may have an acute pneumonia or infection that requires temporary intubation. They may have a Do Not Intubate order in their AD ("I do not want to *ever* depend on a machine") but in this circumstance, intubation would be temporary (a few days), and a full recovery is highly expected. If this person could speak for themselves, they may agree to a few days of intubation to facilitate full recovery rather than end their entire life. Following strictly to procedures rather than outcomes, is why ethicists warn against making "rule-based "decisions, and instead recommend a "values based"

approach to clinical practise [54]. Another limitation can occur when patients or surrogates change their mind [12, 17]. A population-level study found changes in life sustaining treatment (LST) orders are commonplace among hospitalized older adults who were full code when admitted to the hospital. The changes in LST orders of adding new restrictions was about equal proportion to the changes in LST orders of removing prior restrictions to the LST preferences [55].

6.4 Aging and the Principle of Dignity

In the context of aging, people may face challenges in maintaining independence due to cognitive or physical decline, which cause personal and ethical dilemmas for both patients and their clinicians [4]. As one's ability to complete activities of daily living become impaired, others (whether formal or informal caregivers) may begin to provide assistance. Having others help with personal care, showering, dressing, and bathing puts older adults in a vulnerable and sometimes uncomfortable situation, particularly if the person has past trauma [51]. Ethical care delivery, whether from families or formal caregivers, should be provided by individuals trained in person-centered care provision [1]. These caregivers should understand how to help older adults feel comfortable with care, maintain strong interpersonal boundaries, and ensure instructions are given in line with individual learning and mental health needs [56]. In cases where these approaches are not utilized, not only dignity but safety issues may arise, and individuals may risk needing higher levels of care (when they could have been safely maintained instead with well-trained caregivers).

7. Dementia & Ethics

An 85-year-old woman with mild to moderate dementia is hospitalized following a sudden stroke which causes moderate expressive aphasia, and executive dysfunction. During the hospitalization, her team identifies that her advance directive, naming her husband as decision-maker, had not been updated in 10 years. In the intervening years, they separated, and she now lives with her new partner of 5 years. The team has determined that she lacks medical decision-making capacity, however she has not spoken to her husband in years and conveys that she does not want the team to contact him.

7.1 Ethical Response: Dementia and Selecting a Surrogate

The patient has an outdated advance directive selecting her husband who she has not seen in ten years and does not want the team to contact him to serve as her surrogate decision maker. In this case, the patient lacks decision-making capacity to make treatment decisions, and a surrogate will assume the same authority and responsibilities as the patient in the informed consent process. Although the patient lacks capacity to consent to treatment, because decisional capacity is task specific and not all or nothing, she may retain the capacity to exercise her right to appoint a new surrogate if she understands she is making this choice and the implications of her choice. Criteria for decisional capacity are when a person appreciates and understands their choice with a form of reasoning and is able to express their choice. Having expressive aphasia may require alternative forms of communication, but expressive aphasia or cognitive impairments alone does not automatically indicate lack of decision-making capacity [26].

7.2 Dementia and Advance Directives (AD): Former Wishes and Current Desires

People with dementia usually experience considerable changes in their personality, preferences, and interests as their dementia progresses. These variances can create a conflict between their pre-dementia wishes and their current preferences [57]. For instance, a person may have strongly expressed in their AD or during conversations stating preference for comfort measures only when in the mid to late stages of dementia. However, when the person reaches this stage, they appear happy, or content, displaying signs of pleasure despite the advancing dementia. Conversely, someone who previously declared wanting all efforts to sustain life as long as humanly possible now appear miserable, refusing to eat or drink and take medications. Their initial preferences do not appear applicable.

Typically, we rely on ADs and previous declared preferences to guide our decisions when a person loses decisional capacity. What happens when new wishes are not aligned with former intentions? Should we honor their previous stated interests while they had decisional capacity, or should we honor their new interests in their new circumstances?

Some argue that changing our minds is a prerogative often exercised by competent people at the end of life [55] and this prerogative should extend to people with dementia; circumstances change, and interests change accordingly (e.g., Dresser's argument) [53, 58]. Others (e.g., Dworkin) argue that the fundamental choices a competent person makes regarding the way they want to live their life and how they want to be remembered should take priority ("critical interests") over things that simply bring pleasure ("experiential interests"). The reasoning here is that critical interests are deemed more sustainable, and therefore, should be prioritized over experiential interests [58].

7.3 Therapeutic Untruths and Dementia

Should truth telling remain sweeping ethical tenet? Older people with dementia may regress back in time and ask for a relative or a person who has died long ago [59]. "Validation theory" is to accept the older person(s) as they are, consider them valuable even when disoriented, and recognize they are in the final stages of life and are trying to resolve unfinished business [60]. We should listen and validate their feelings. Rather than admonishing the person by correcting them with the facts ("Your mother died forty years ago), acknowledge and validate the person's reality at that moment, and speak in the present tense (e.g., "You miss your mother. What would you like to tell your mother?"). This approach is considered distinguished from lying [60]. Some argue that judicial use of "lies" can be justified when the older person's anxiety and irritability are abated, and the lies can even be considered therapeutic [61].

7.3.1 Robotic Pets

Some people view neurogenerative dementias as having the opposite effect of aging – rather than getting older, individuals with these conditions seem to regress, becoming more childlike, only without the promise of a future [60, 61]. Then it is not surprising that many clinicians believe robotic pets can offer therapeutic value for those with dementia. These robotic pets are designed to look and act like real animals, typically resembling cats and dogs. Research shows that robotic pets can provide multiple psychosocial benefits, such as reducing agitation, improving mood, increasing social engagement, and controlling pain [62].

However, a few studies argue that robotic animals can be patronizing, potentially diminishing a patient's dignity, and conflicting with the principles of truth telling in medicine [60]. Some also raise cautionary ethical concerns about the overuse of robotics, noting that the convenience of robotics can easily replace more important human interactions for people with dementia [63]. Comparatively, more studies support the use of robotic pets than not, especially when low-cost robotic pet options are shown to be equally effective in generating psychosocial benefits, making these accessible to a wider range of individuals and settings [64].

7.4 Dementia and Aging

Clinicians should optimize participation in decision even when a person has dementia. Addressing sensory deficits (e.g., use visual aids or pocket talkers), asking simple questions with ample time to respond, and reducing distractions can facilitate engagement. Caregiver stress and burnout can also affect decision-making, jeopardize patient independence, and put both patients and caregivers at risk of harm [44]. Clinicians should regularly assess caregiver well-being and provide ongoing supports to assist with this physically and emotionally challenging work. When behavioral issues or caregiver strain arises, engaging a geriatric mental health clinician is also prudent.

8. Aging in the Technological Era

Major changes and prolific growth happened with personal use of technology over the course of most of our lives, and much more for older adults [31]. Older adults are now expected to utilize automated healthcare portals to make appointments, pay medical bills, and wield computer applications for coupon savings for medications and other discounts. Smart technologies for aging adults are fraught with ethical challenges regarding principles of autonomy, beneficence, non-maleficence, and justice, along with subprinciples of confidentiality, privacy, equity, independence, and consent. Of all these challenges, privacy and confidentiality reportedly are older adults' largest concerns [65], with little to no concern about their ability to learn the technologies if necessary [66]. With instruction and opportunity, many older adults are readily able to navigate and adapt to current technological changes and it is unethical to automatically underestimate their capabilities [11].

8.1 Case Example: Technological Challenges

Mr. Jones, a 78-year-old man, has regularly come to his primary care (PC) appointments for decades and set a series of appointments after each clinic visit. He did not show for most appointments in the past six months, and missed the past four consecutive appointments. Telehealth appointments were offered but he does not have a computer and must use the local library's public computer. The clinic has been unable to directly speak with Mr. Jones because no one answers the phone when called. The clinic manager would like to disenroll Mr. Jones from the PC panel because he is not participating in his care and there is a waitlist of other patients who really need the care. The team asks if it is ethical to disenroll Mr. Jones from the program.

8.1.1 Ethical Response: Patient Abandonment

Clinicians must use due diligence to help patients overcome barriers to accessing care [65], notably when the patient is in high need of care, and available alternatives are few. In this case, the next step would be for the PC clinic to send a letter explaining clinic policy, along with a direct line to the clinic director to help avoid the sequence of prompts in the telephone menu and asking Mr. Jones to contact the clinic within two weeks. After receiving the letter, Mr. Jones responds immediately. He explains that his phone was disconnected because he could not afford payments because of an increase in the cost of his partner's medicines. In addition, he states that he has been unable to attend his scheduled appointments because he is the sole caregiver for his partner with advanced cancer and cannot afford someone to stay with them. Given presence of explainable barriers and Mr. Jones' declaration that he genuinely wants to continue receiving care in the clinic ("I will do better, I promise."), it is unethical to disenroll him without attempting to mitigate barriers [3]. Involving the PC social worker could help with addressing these barriers such as checking his eligibility for home care services for both him and his partner, funding sources for help with prescription medications, and other resources. Ethically, failing to contact Mr. Jones after his missed appointments and stopping clinical care abruptly could be considered a form of professional abandonment.

8.2 Technology in an Aging Society

In the case above, Mr. Jones has never had to learn how to navigate computerized phone systems, use online hospital portals to make or change appointments, or use this method to contact his providers. His old way of doing his business is no longer working. He does not know how to begin to look for ways to "learn" these things, and especially now that he is sole caregiver for his partner. Mr. Jones is capable of learning, but he does not have someone to teach him technology and how to access and operate hospital online portals that he is expected to use to create or cancel appointments, order refilled prescriptions, and is the preferred way to communicate with his care team. Fairness would entail giving older adults access to and the opportunity to learn how to use technology [66].

8.3 Summary Aging in the Technological Era

The fundamental aim of justice in caring for aging individuals includes equity and protection against discrimination [11]. Unfortunately, as noted in Mr. Jones' scenario above, healthcare access and opportunities are not always distributed equitably and fairly [25], and the reasons are multifactorial and challenging to ameliorate.

In addition, the clinic manager was placed in a difficult situation where she had to run the clinic in accordance with clinic policy and rules, which concerns supply and demand, limited clinicians and clinic hours, and more patients needing care than she can provide. According to her rules, she could not keep Tom as a patient when other patients could be utilizing the services if Tom missed four appointments. Tom was not aware of this rule even if it was stated in the small print. The emphasis on the business of healthcare instead of on human needs can work against patient welfare [44]. Institutional frameworks and social structures, unfortunately, shape people's options and thus decision-making (for both clinicians and patients) [67]. This not only creates unjust disparities in

treatment amongst aging people [44], but it also interferes and counters the core principle of autonomy and self-determination [67] and the preferences for how patients and clinicians would like to conduct their practise [30].

9. Ethics in the Intensive Care Unit (ICU)

Ethical issues in intensive care units (ICU) are exceedingly relevant for older adults. The age of people admitted to ICU has been increasing greatly in the past several years [17, 29] because of an aging population, advances in medical treatments, and an increasing number of comorbidities [30]. One study estimated that approximately half of all people in the United States receive ICU care during their final year of life [68].

9.1 Case Example: Ethics in the ICU

Joe is an 80-year-old man in the intensive care unit (ICU) actively dying from cardiac failure and kidney failure. Joe is unconscious. His family is acting as his surrogate and is insisting that Joe receive hemodialysis. The treating physician and nephrologist do not believe hemodialysis would provide any substantial change to improve his quality or quantity of life. Providing hemodialysis will not harm Joe, however. Prior to Joe becoming unconscious, he stated a strong desire to "stop the nonsense and just die in peace." Are the physicians obligated to provide dialysis despite it adding no value to his care?

Beneficence (from the family's view) is to keep Joe alive. From the perspective of the professional, beneficence is honoring the patient's wishes and preventing suffering. The challenge is navigating between family emotions and ethical obligations to the patient.

9.1.1 Ethical Response: Negative Rights and Positive Rights

From a general medical ethics perspective, medical practitioners should engage the patient with decision making in a process of shared medical decision making [12, 30]. Ethically, a patient with decision making capacity has the right to refuse any treatment offered (even if it may result in death). This is called 'negative right,' the right to be left alone. However, the process of shared medical decision making does not imply that a patient may require medical practitioners to provide specific medical treatments. This would be a 'positive right,' the right to oblige others. The medical clinician has an ethical obligation to uphold the integrity of their profession by refusing to provide treatment interventions that are outside the boundaries of accepted medical standards or are likely to produce more harm or burden than benefit to the patient [9]. If the harm or burden outweighs potential physiological benefits, hemodialysis should be withheld.

On the other hand, it is reasonable to negotiate with patients or families and avoid taking a rigid position that may undermine the shared medical decision-making process. The risk of harm or burden to the patient must be carefully assessed in these circumstances. If the risk of harm or burden in acceding to the family's demand is greater than refusing the demand, the practitioner is ethically obligated to refuse. If the risk of harm or burden of providing the treatment is low, resources are available, and it will preserve valuable trust in the clinicians and the institution [6, 25], then a time-limited trial of hemodialysis may be an appropriate compromise. Time-limited trials

have been correlated with surrogates having less regret and feeling supported in the decision-making process [17].

9.1.2 Guidance for Intractable Disagreements in ICU Settings

Although treatment demands by patients and surrogates span a range of medical interventions, requests for end-of-life care generate the most stress for clinicians and patients/families [12, 46]. Further complicating matters, most patients in the ICU do not have decision making capacity and clinicians must rely on surrogates [12]. To assist clinicians working in an intensive care unit (ICU), a multi-society published guidance aimed at preventing and resolving intractable disagreements regarding care within ICUs [41]. Although medical physicians are the decision makers for critical care interventions, this guidance is helpful for other clinicians to understand guidance that often serves as an ethical framework when addressing challenges in the ICU. Specific recommendations from this group include: 1.) proactively communicate with the patient/family and involve expert consultants, including palliative care clinicians, social workers, and chaplains, who have expertise in helping patients and families navigate these challenging decisions [17, 21, 48]. 2.) Rather than use the word "futile", use the term "inappropriate treatment", as treatments often have some chance of making a physiological change. Clinicians should thoughtfully explain their reasons and advocate for a plan that they deem more appropriate. If conflict remains despite negotiation and intensive communication, the process of conflict resolution should be instituted by the facility's procedure. 3.) "Futility" as a term should rarely be used and only used when the requested treatment will not accomplish an intended physiological benefit [9].

ICU care triggers existential issues for patients and their families, thus support from multiple disciplines is vital. Palliative care team interventions can occur concurrently with teams intervening with life-sustaining treatments to offer added supports of symptom management, communication with patients and surrogates, family support, and assist with transitions of care [17].

9.2 Surrogates Making Hard Decisions

Both surrogates and clinicians want the best outcome for the patient and selecting "the best option" is often difficult when none of the choices are favorable. As previously stated, when a person lacks the capacity to make medical decisions for themselves, medical teams work with surrogates to forward medical decision making. Ideally, the surrogate knows the patient's values and wishes and can exercise substituted judgment (what the patient would want, not what others would want). Added challenges occur when a surrogate does not have knowledge of the patient's personal values and wishes regarding the proposed medical options [12], or if there is disagreement within families of how much or little their loved one would want done [10]. Surrogates, like patients, work with the healthcare team in a shared-decision making model and determine which interventions are most likely to produce the best outcomes. This is called the Best Interest Standard [13].

Acting as a surrogate and making life-altering or life-ending decisions is difficult [12] and can have lasting emotional effects on some individuals. About one third of surrogates reported a negative emotional toll from serving in the surrogate position that persisted for months or even years [69]. Surrogates have lower confidence in their role when they lack prior experience, have not previously discussed the patient's preferences, or experience inadequate communication with the medical

team [17, 70]. It is imperative for clinicians to communicate medical information clearly and according to a surrogate's health literacy to ensure that they fully understand the situation and available options to make informed decisions. For example, it is often confusing for surrogates when a patient has lost higher brain function but appears awake and responsive to stimuli. Clinicians should convey small amounts of information, then assess their understanding before proceeding with more details [12].

9.2.1 Endorsed Life vs Isolated Decisions

One approach to guide surrogates making decisions on behalf of someone else is using the "endorsed life" interpretation of substituted judgment presented by Phillips and Wendler [35]. This strategy directs surrogates and clinicians to make decisions that promote the values supporting the life the patient wanted to live, more broadly, rather than focus on an isolated decision. This approach for substituted judgment helps amplify a patient's voice when they cannot speak for themselves.

10. End-of-Life (EOL) Care

End of life (EOL) care has many controversies [9]. Interventions at EOL do not cure, but they may keep people alive for prolonged periods of time [10]. End of life issues involve both moral issues and practical concerns. Decisions often affect functional status, quality of life, or lead to death [12]. As people are living longer, and medical comorbidities are emerging more complex [30], EOL care planning is becoming even more crucial. Ubiquitous challenges in EOL care include withholding and withdrawing treatment, clinically assisted nutrition and hydration, cardiopulmonary resuscitation, use of opioids, and terminal sedation [10].

10.1 Case Example: End-of-Life (EOL) Care

Carol is a 90-year-old woman is in a hospice unit at the end stage of life after a long battle with Parkinson's disease. She is unconscious and unable to speak for herself. She has no advance directives, other than at the time of hospice admission, she clearly expressed to her team that she wants "to finally be comfortable." Carol's daughter is her surrogate and is helping with medical decision making with the clinicians. According to her daughter, Carol has rare and brief moments when she seems lucid and "smiles." To the team, Carol appears to be in significant pain as demonstrated by nonverbal cues, and breathing is becoming progressively labored. The clinical team wants to treat the pain and honor Carol's wish to be comfortable. However, Carol's daughter is insisting they not administer morphine, saying that it will "surely kill her" quickly and may prevent any lingering chance that Carol will become more lucid and can say her final good-byes.

10.1.1 Ethical Response: Doctrine Double Effect and Sedation

Surrogates report experiencing distress while making EOL decisions [10] and this distress continues for some time [69]. The trepidation spoken by Carol's daughter is well understood by Carol's clinical team. While exploring Carol's daughter's perspective, they learn that her prior experience involved her father's hospice care and "they morphined him up until he died to make room for the next patient." She is highly suspicious of the motivation and intention of the team's

recommendation to use morphine based on this experience (past experiences are the most common source of medical mistrust [6]). The team had a lengthy discussion about the illegality to hasten death by euthanasia in the United States and explained that palliative and hospice care teams are experts at reducing discomfort and respecting patients' verbalized preferences, all while having mindfulness about the patient's quality of life [10, 17]. In addition, they explained that when opioids and sedatives are used with best practise, rarely are doses needed high enough to risk shortening life [20].

Carol clearly identified pain management as a high priority and value for her EOL care, (which is what many patients state at the end of life) [10, 17] and should remain a priority [17], as Carol's stated preference. However, the team must work with Carol's daughter who is the authority over Carol's care as Carol's designated surrogate.

After learning Carol's daughter's perspective and concerns, the team reviewed the philosophical construct of the doctrine of double effect with her. This doctrine justifies a "good action" even when there is a potential "bad effect." These actions are ethically permissible under certain conditions: 1) The act itself is good, or neutral, 2) The intention is the good effect, and not the bad effect, 3) The good effect is not caused by the bad effect, and 4) There is a very good reason for allowing the bad effect to happen [71]. Critically, the intention here is to reduce pain and treat shortness of breath, which is a good act and good effect. The bad effect is that morphine affects respirations and is sedating.

Unfortunately, the bad effect is that Carol will be drowsier and the chances of her ability to become lucid before dying are substantially decreased. The good effects of morphine is that it helps Carol not gasp for air by opening the blood vessels to let more blood circulation with the respiratory system, which will make her more comfortable and subsequently able to rest. Carol's daughter agreed that Carol prioritized comfort in her EOL care and that she wanted what was best for her mother, and not herself (substituted judgment). She wanted her mother to be comfortable and die as peacefully as possible.

Use of morphine at the end of Carol's life aligns with ethical principles of beneficence, non-maleficence, and respect for autonomy. Providing pain relieve to Carol is morally justifiable despite the risk of sedating her and the chances of her resting until her body naturally dies. Of note, there is much scrutiny about the rule of double effect [72].

10.2 A Good Death, Fears, and Successful Aging

A recent review of several studies [73] revealed what older people believe would be a "good death" for themselves along with what they deem as successful aging. The oldest cohort (85 and older) portrayed a good death as when they retain their dignity and autonomous choice, and successful aging included their ability to enhance their quality of life and death as they age. Other older adults (65 and older) likened both a good death and successful aging as having choices, being able to choose where they die and who will be present. Almost all older adults reported some fears of dying, including the dying process itself, and being alone at the time of death.

10.3 Aging and End of Life Care

Relieving or preventing suffering care while respecting the wishes of the dying patient are the primary goals of end-of-life care [10].

Many ethical dilemmas during end-of-life care can be remedied with open communication and shared-decision making with clinicians, patients, and families [12, 17]. Disagreements may appear to be about a particular intervention, but looking deeper, often the issue is more about values than medical probabilities. Every dying patient should be considered a unique entity, with rights to self-determination and preservation of dignity during the end-of-life process [10]. Broader factors are important to consider when an aging person may request withdrawal of treatments that may end their lives [67]. For example, having few social supports or having financial concerns may drive a decision to hasten death rather than a genuine desire to die.

Some religions such as Orthodox Judaism, fundamental Protestant and conservative Catholics may regard the sanctity of human life a religious obligation and may seek out life-prolonging treatment. This is within their legal rights and can constitute discrimination if not respected.

11. Conclusion and Final Remarks

Ethical approaches and analysis do not only occur during times of crisis or extreme challenge. Ethical behaviors happen in our day-to-day commitment to caring for older people with the utmost respect and a broader understanding of patients' concerns, preferences, and needs. This paper reviewed common scenarios with ethical responses and concepts. Reminders of how our culture is often ridden with bias and assumptions about older individuals, and influences that need to be taken into consideration are embedded throughout, such as lack of experience with technology, dementia care, and patients' core values that may challenge a clinician's desire for beneficence and nonmaleficence. In addition, the paper pointed to relational asymmetries, socio-economic factors, and ableist viewpoints that may disempower older individuals.

For those working with older adults, practical recommendations to strengthen ethical geriatric practice include:

1. Engaging in empathic interpersonal care, utilizing active listening, assessing and understanding patient's perspectives and values, an awareness of the clinician's own attitudes and biases around aging, and openness to treat all cases individually and irrespective of social and cultural backgrounds.
2. Ensure patients fully understand important components of informed consent, with mindfulness about their health literacy [17], hearing ability, and command of the spoken language – all of which may affect how information is received. Optimize participation in decision making by addressing sensory and functional impairments, use visual aids, simplify questions, and reduce distractions.
3. Thoughtful involvement of caregivers and families in ways that support the autonomy of the individual whenever possible, while recognizing the important roles that friends and families play in care delivery.
4. Engaging patients and their families in discussions of what matters most, early on in care, can help avoid difficult ethical situations later in care [74]. Careful documentation of these can be very helpful.
5. Utilizing regular discussion of ethical issues within geriatric clinical teams, as these can be thorny, challenging to resolve, and emotionally taxing. Specific ethical approaches may vary across team members of different disciplines and experience, and teams may wish to identify a specific ethical model to help resolve dilemmas.

6. Implementing age-friendly practices within healthcare systems to support holistic care practices and reduce bias [75].
7. Support older adults' use of technologies to enhance access to care, to support autonomy, and to promote justice [76]. Such technologies should be adapted to a broad-user base that may have specific learning or functional needs.

Basic everyday healthcare goals are to promote autonomy and self-determination and relieve pain while protecting safety and doing no harm. When these goals do not converge, ethical frameworks can guide our responses. Balancing values is challenging because healthcare clinicians have individual personality styles, different breadth and depth of ethical training, and various experiences that may lead us to our response to challenges. Given the current healthcare culture of less time and less personalization (larger practices, more specialists), it is incumbent for us to broaden our ethical frameworks to optimize older individual's participation in their healthcare.

While caring for older adults can be ethically complicated, having a strong ethical framework to draw on and working with interdisciplinary team members can help clinicians address these challenges. Local ethics committees can also be a useful and neutral resource in navigating complex issues [25]. Older adults make decisions in context of a lifetime of experiences and wisdom, and so having an appreciation for what those experiences have been can also facilitate a shared understanding and partnership between patients and clinicians. Narrative medicine programs like the "My Life My Story" programs [77] and Five Wishes (https://www.fivewishes.org/) can foster conversations about end of life and other difficult decisions that may be needed in the future. Lastly, for the clinician, engaging in self-care practises can also promote ethical behavior by reducing burnout. Although older adults have an inherent right for self-determination when making decisions, mindful consideration of broader contextual factors such as oppression, family and social situations and expectation are imperative [67] to promote and optimize patient-centered care.

Acknowledgments

The contents do not represent the views of the U.S. Department of Veterans Affairs or the U.S. government.

Author Contributions

Each author contributed equally to the conceptualization, content, writing, and editing.

Funding

There was no funding from any source.

Competing Interests

The authors have declared that no competing interests exist.

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