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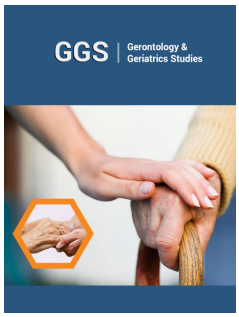
Opinion

Beyond Survival: Therapeutic Proportionality in the Critically Ill Older Adult

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Opinion

Modern critical care can sustain failing organs with a precision that would have been unimaginable a generation ago. Yet in critically ill older adults, technical success and clinical success are not always synonymous. A recent editorial on the limits of intervention in the critically ill older patient appropriately centered the dilemma on the tension between technological possibility, clinical judgment, and dignity [1]. The next step is to make that tension clinically actionable. The relevant question is not simply whether an intervention can prolong life, but whether its expected benefits remain proportionate to its burdens and to the probability of achieving an outcome the patient would regard as meaningful.

Age is not a Prognosis

Chronological age is an administratively convenient variable, but it is a poor substitute for biological reserve, functional status, cognition, frailty, or the reversibility of acute illness. Treating age itself as a threshold for intensive care risks reproducing a form of institutional ageism that is already documented across health care [2]. The opposite error is equally problematic: assuming that access to every available life-sustaining intervention is inherently beneficial simply because the intervention is technically feasible. Frailty offers clinically relevant information that chronological age alone cannot provide, but it must not become a new categorical gatekeeper. In an individual patient-data meta-analysis of 23,989 acutely admitted ICU patients, frailty measured with the Clinical Frailty Scale was independently associated with ICU mortality in older adults after adjustment for illness severity [3]. That association is prognostic, not determinative. A frailty score should therefore inform clinical reasoning, communication, and risk stratification; it should not function as a stand-alone decision to admit, withhold, continue, or withdraw intensive treatment.

From Survival to Meaningful Recovery

Survival remains a fundamental outcome of critical care, but it is an incomplete measure of benefit. For older adults, the consequences of critical illness extend beyond hospital discharge and may include new dependence, cognitive impairment, reduced mobility, persistent symptoms, and changes in living arrangements. Studies of critically ill older populations increasingly incorporate activities of daily living, health-related quality of life, and functional independence alongside mortality [4,5]. This shift matters because two patients who both survive an ICU admission may experience profoundly different recoveries.

Meaningful recovery cannot be defined universally by clinicians. For one person, survival with substantial physical dependency may be entirely acceptable if cognition and communication are preserved; for another, loss of independence may be an outcome they would

not choose to endure for a small probability of prolonged survival. The purpose of discussing functional trajectory is therefore not to assign an external value to a life with disability. It is to understand which outcomes are acceptable to the individual patient and to incorporate that information into treatment decisions. Prognosis should describe possible trajectories, not prescribe whose life is worth sustaining.

Proportionality under Uncertainty

Therapeutic proportionality provides a more useful framework than either "do everything" or premature limitation of treatment. Proportionality asks whether the expected benefit of an intervention is reasonable in relation to its physiological burden, complications, discomfort, loss of function, and the likelihood of achieving the patient's goals. This assessment is dynamic. An intervention that is proportionate during the first hours of a potentially reversible crisis may become disproportionate when organ failure progresses despite maximal treatment and the probability of an acceptable recovery change. This is also why the language of "futility" should be used sparingly. Mult society guidance recommends distinguishing treatments that cannot accomplish their physiological purpose from treatments that may have some physiological effect but are judged potentially inappropriate because the broader goals of treatment are unlikely to be achieved [6]. That distinction is especially important in older adults, in whom prognostic uncertainty can be substantial and value judgments can be mistaken for clinical facts.

When prognosis is uncertain but a potentially reversible pathway exists, a time-limited trial of intensive treatment can provide a disciplined alternative to both indefinite escalation and immediate limitation. The American Thoracic Society defines a time-limited trial as a collaborative plan to use life-sustaining therapy for a defined period, followed by reassessment of the patient's response and reconsideration of the treatment plan [7]. In a multicenter quality-improvement study, implementation of structured time-limited trials was associated with shorter ICU stays and fewer invasive procedures among patients with advanced illness, without significant changes in hospital mortality or family satisfaction [8]. The central requirement is not simply "trying treatment for a few days," but agreeing in advance on the purpose of treatment, measurable markers of improvement or deterioration, and what will happen if those markers are not achieved.

Shared Decisions are Clinical Work

Proportional care cannot be derived from physiology alone. Shared decision-making brings together the best available clinical evidence with the patient's values, goals, and preferences and is specifically recommended for major value-sensitive decisions in the ICU [9]. When a patient retains decision-making capacity, that patient remains the primary participant in decisions. When capacity is absent, surrogates should be supported in representing the patients previously expressed wishes and values rather than being asked what they personally want clinicians to do. This process also requires interprofessional coherence. Patients and families should not receive fragmented messages from different members of the team. Interprofessional shared decision-making has been proposed as a structured approach to exchanging information, deliberating, and reaching balanced treatment decisions across disciplines [10]. In practice, proportionality is strongest when geriatric, intensive care, nursing, palliative care, and other relevant perspectives are integrated early rather than introduced only after conflict or deterioration.

The Nursing Contribution

Nurses occupy a distinctive position in this process because they continuously observe the patient's response to treatment, symptom burden, communication, functional changes, and interactions with family members. Their contribution is not to determine treatment ceilings independently, but to bring clinically relevant bedside knowledge into deliberation and to help ensure that expressed patient preferences remain visible as treatment intensity changes. A qualitative systematic review found that critical care nurses contribute to withdrawal-of-treatment decision processes by safeguarding patients' needs and wishes, supporting families, and coordinating communication [11].

This role is particularly relevant when there is discordance between the stated goals of care and the lived reality of treatment. Repeated distress during procedures, progressive loss of interaction, escalating organ support, or family uncertainty may not independently justify treatment limitation, but they are clinically relevant observations that should trigger reassessment. Nursing surveillance therefore contributes not only to detecting physiological deterioration but also to recognizing when the benefit-burden relationship of treatment may have changed.

The Measure of Good Critical Care

Good critical care for older adults is not defined by maximal intervention, and it is not defined by therapeutic restraint based on age. It is defined by disciplined individualization. Severity and reversibility of acute illness, frailty, baseline function and cognition, physiological reserve, expected treatment burden, and possible recovery trajectories must be interpreted alongside what matters to the person receiving care. The aim is neither to prolong life at any cost nor to withdraw treatment because recovery may be difficult. It is to pursue treatments whose expected benefits remain proportionate to their burdens and aligned with the patient's goals. The most consequential question in geriatric critical care is therefore not whether medicine can sustain life, but whether the treatment being offered still serves the life this particular person would choose to sustain. Technical possibility sets the boundaries of what can be done; clinical judgment, evidence, and the patient's values should determine what ought to be done.

Conflict of Interest

The author declares no conflicts of interest.

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