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# Ethical Principles and Challenges in End-of-Life Care for Frail Older Adults

## Abstract

This article examines the ethical complexities of providing end-of-life care to frail, older adults with multiple comorbidities. As frailty differs from single-terminal illness, end-of-life care requires a carefully considered, ethically informed approach. The paper applies the four core ethical principles of autonomy, beneficence, nonmaleficence, and justice within this context, exploring challenges specific to frail patients, including fluctuating mental capacity, the risks of aggressive interventions, and equitable access to resources. Key ethical issues such as Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders, confidentiality, mental capacity assessments, and palliative sedation are addressed, offering healthcare professionals a structured framework for decision-making. By balancing patient dignity, quality of life, and legal considerations, this article seeks to enhance healthcare professionals' understanding of ethical obligations and practical decision-making strategies. Ultimately, it advocates for a compassionate, patient-centred approach that prioritises comfort and dignity, especially as frail patients approach the end of life, ensuring that care aligns with both ethical and legal standards.

## Introduction

The global ageing population is expanding rapidly, with the UK experiencing a substantial increase in older adults, many of whom encounter complex end-of-life circumstances (British Geriatrics Society, 2023). According to the Office for National Statistics (ONS), the UK population aged 65 and over is anticipated to rise by nearly 8% over the next decade, intensifying demands on healthcare resources and creating more frequent encounters with multifaceted end-of-life scenarios (ONS, 2021). In addition, the population aged 85 and above is expected to double by 2045, further compounding these challenges (ONS, 2022).

End-of-life care for frail older adults, often living with multiple comorbidities, is significantly different from the care provided to individuals with a single terminal illness (National Institute for Health and Care Excellence, 2019). Frailty in advanced stages encompasses a range of decline trajectories, which may include gradual deterioration, as observed in advanced dementia, sudden life-limiting events such as stroke or hip fracture, and periods marked by unpredictable fluctuations, often precipitated by acute episodes such as delirium or functional decline (British Geriatrics Society, 2023). These variations in patterns of decline highlight the necessity for healthcare professionals to adopt a flexible, ethically rigorous approach that respects the unique needs of each patient (Van Den Noortgate and Van den Block, 2022). In addressing these complexities, the four core ethical principles of autonomy, beneficence, nonmaleficence, and justice provide a foundation for compassionate and ethically sound care. These principles collectively support healthcare professionals in respecting patient preferences, prioritising well-being, minimising harm, and ensuring equitable distribution of resources. While the four bioethical principles provide a

foundational framework for ethical decision-making in end-of-life care, they may not fully address the complexities of frailty and multimorbidity. Grealish (1997) argues that an 'Ethics of Care' perspective is essential in palliative care, as it shifts the focus from abstract principles to relational, contextual, and patient-centred ethics. Unlike traditional bioethics, which prioritises individual autonomy and rule-based decision-making, the Ethics of Care recognises the interdependence of frail patients and their caregivers, highlighting the importance of responsiveness, relational decision-making, and holistic well-being.

This article explores the application of these ethical principles within the context of frailty and end-of-life care, identifying both overarching ethical concerns and practical challenges encountered in clinical practice. By addressing key issues such as Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders, confidentiality, and mental capacity assessments, this article seeks to equip healthcare professionals with a structured framework for making balanced, ethically informed decisions. Ultimately, the goal is to uphold patient dignity and ensure that ethical considerations remain central to care for frail individuals approaching the end of life.

#### **Four pillars of ethical principles in end-of-life care for frailty**

In end-of-life care, the four pillars of ethical principles are essential in ensuring that healthcare professionals approach complex clinical and ethical dilemmas with a balanced, patient-centred perspective (Akdeniz et al., 2021). For frail patients, these pillars not only help frame decisions on whether to pursue, withhold, or withdraw treatment but also emphasise respect for patient dignity and quality of life as they approach the final stages.

##### **- Autonomy**

Autonomy, or the right of patients to make informed and independent decisions regarding their care, is a central principle of ethical practice (Yulianto and Awaludin, 2024). In end-of-life care, autonomy becomes especially important as patients face choices about life-prolonging treatments and comfort-focused palliative care (Rashid et al., 2024). According to Beauchamp and Childress (2012), supporting autonomy involves respecting patients' decisions about their care as long as they possess the capacity to make such decisions. In frailty and multimorbidity, autonomy is often compromised due to fluctuating cognitive function, communication barriers, and dependency on caregivers. The Ethics of Care framework acknowledges these challenges by emphasising relational autonomy, where decision-making is a shared and evolving process rather than a single event (Grealish, 1997). This perspective is particularly relevant in advance care planning, where decisions must be continuously revisited in light of the patient's changing condition and relational needs

In practical terms, respecting autonomy means that healthcare professionals should consider the patient's wishes as paramount, even when these conflict with clinical recommendations or family desires (Kumar et al., 2024). This is particularly complex in frailty, where physical and cognitive impairments may restrict patients' ability to communicate their wishes effectively. Legal tools such as advance care planning (ACP) and lasting powers of attorney (LPA) play a crucial role in preserving autonomy for these patients, enabling them to

document healthcare preferences in advance (Alzheimer's Society, 2024). The Mental Capacity Act 2005 supports this process in the UK by establishing guidelines for assessing mental capacity and mandating that patient wishes, as documented in ACP or LPAs, guide decision-making when capacity is reduced.

#### - **Beneficence and nonmaleficence: balancing benefit and burden**

The principles of beneficence (doing good) and nonmaleficence (avoiding harm) require healthcare professionals to prioritise interventions that enhance patient well-being while avoiding those that may cause unnecessary suffering (Cheraghi et al., 2023). In the context of frailty, these principles take on a distinct meaning as interventions that might benefit younger or healthier patients may be burdensome or even detrimental to frail patients. Frailty often involves complex comorbidities, physical limitations, and increased sensitivity to medical interventions, which can amplify the potential harm of aggressive treatments. In these cases, beneficence is often best served through palliative care approaches that prioritise comfort and quality of life over life-extending measures (Crooms and Gelfman, 2020).

For frail individuals, the balance between benefits and burdens is delicate (British Geriatrics Society, 2020). Invasive treatments or repeated hospitalisations may not only fail to improve outcomes but can also reduce the quality of life. Nonmaleficence, therefore, demands a careful weighing of treatment options, with a preference for those that alleviate suffering without exacerbating frailty or prolonging the dying process (Akdeniz et al., 2021). The decision to offer or withhold treatments should be based on a comprehensive understanding of the patient's physical condition, their wishes, and the likely outcomes of various interventions. When patients or families push for aggressive treatments that may yield minimal benefit, healthcare professionals face ethical challenges (Wiesen et al., 2021). Sensitive communication is crucial to explain the potential risks, likely outcomes, and ethical rationale behind opting for palliative rather than curative approaches.

#### - **Justice and fairness**

Justice in healthcare emphasises fairness, equity, and the ethical distribution of resources. This principle is especially relevant in end-of-life care for frail patients, who may face implicit biases or structural barriers that hinder their access to high-quality care (Koffman et al., 2023). The Human Rights Act (1998) provides an essential legal framework for end-of-life care, ensuring that decisions align with fundamental human rights, including dignity, autonomy, and the right to be free from degrading treatment. For frail patients, these rights are particularly significant, as they often experience vulnerability due to dependency, cognitive decline, and systemic biases in healthcare. Applying the Ethics of Care framework alongside the Human Rights Act enables a broader ethical approach that prioritises not only legal compliance but also the patient's relational and contextual well-being (Grealish, 1997). For frail patients, justice demands that these rights be respected fully, ensuring equitable access to appropriate, dignified care. Justice also challenges healthcare professionals to resist any inclination to allocate resources based on age or perceived utility, focusing instead on each individual's needs and preferences.

Fair allocation of healthcare resources is a critical component of justice, especially in settings like palliative care, where resources are often limited (Vergano et al., 2020; Berlinger et al., 2020; Satomi et al., 2020). Frail patients, who frequently require intensive support, may be affected by implicit or explicit biases that prioritise younger or more resilient individuals for scarce resources. Justice requires healthcare professionals to advocate for these patients, ensuring they receive fair access to services like pain management, psychological support, and hospice care.

### **Confidentiality and privacy**

Confidentiality is foundational in ethical healthcare, especially pertinent in end-of-life care where patients may share deeply sensitive information with their healthcare professionals (Akdeniz et al., 2021). This principle not only fosters trust but also enables patients to express their preferences, concerns, and expectations regarding their final stages of care. In frail individuals, often facing physical or cognitive decline, confidentiality takes on heightened significance, as they become more dependent on family for care and decision-making, increasing the risk of inadvertent breaches (Crotty et al., 2015). Protecting patient confidentiality is both an ethical duty and a legal requirement under the Human Rights Act 1998, which enshrines the right to privacy, mandating healthcare professionals handle personal information with the utmost discretion. In addition, the Data Protection Act 2018, in alignment with the General Data Protection Regulation (GDPR), establishes stringent guidelines for the lawful processing and safeguarding of patient data, underscoring that any sharing of health information must have a clear legal basis, such as explicit consent or valid medical justification. The Mental Capacity Act 2005 further reinforces these protections by providing guidelines for respecting privacy when a patient's cognitive decline limits their ability to consent to information sharing, emphasising that decisions should align with the patient's known wishes and best interests. Together, these legislative frameworks ensure that confidentiality in end-of-life care is preserved, safeguarding both the patient's dignity and autonomy, and necessitating that healthcare professionals implement clear protocols and maintain vigilance in information handling, even when family involvement is necessary for supportive care.

Substantive ethical principles, such as respect for dignity, relational autonomy, and equity, are particularly relevant in end-of-life care for frail patients. Unlike procedural ethics, which focuses on abstract principles, substantive ethics considers the lived experience of patients, their relationships, and the social determinants of care. Incorporating an Ethics of Care approach alongside substantive ethical principles ensures that ethical decision-making is context-sensitive, particularly in cases of frailty and multimorbidity where standard autonomy-based frameworks may be insufficient (Grealish, 1997).

### **Challenges in end-of-life care**

End-of-life care for frail individuals often involves close family members, who may play an active role in decision-making (Pun et al., 2023). This involvement, while supportive, poses risks of unintentional confidentiality breaches, particularly if healthcare professionals share patient information without explicit consent. For instance, a healthcare professional might

disclose prognosis details to family members without ensuring the patient's preferences for privacy are respected (Van den Block et al., 2019). This can lead to ethical conflicts, as frail patients may be unable to assert their privacy preferences due to cognitive decline or communication challenges.

- **Application of the human rights act**

The application of the human rights act (1998) in end-of-life care presents significant challenges, particularly regarding the right to privacy for frail patients. This act legally enshrines patient confidentiality, ensuring that information sharing aligns strictly with the patient's expressed preferences or legal directives. However, in cases where patients have cognitive impairments, cannot clearly articulate their wishes, or are under family pressure, it becomes ethically complex for healthcare professionals to balance respecting privacy with family members' desire to be involved.

Healthcare professionals should navigate situations where family involvement is essential yet does not overstep patient confidentiality rights. This balancing act is particularly challenging because the patient's right to confidentiality may come into conflict with the family's need to understand medical information for decision-making. In the absence of explicit patient consent, healthcare professionals are legally and ethically bound to maintain confidentiality, making clear communication and adherence to legal frameworks essential to prevent unintentional privacy breaches.

- **Do not attempt cardiopulmonary resuscitation (DNACPR)**

Decisions regarding DNACPR orders in frail, end-of-life scenarios present multifaceted ethical challenges due to the need to balance the principles of nonmaleficence, autonomy, and informed consent (Milling et al., 2023). From a nonmaleficence perspective, CPR might be withheld to prevent harm, particularly when it would likely cause distress or exacerbate suffering without meaningful benefit (Akdeniz et al., 2021). However, respecting autonomy demands that patients wherever feasible are actively involved in discussions around DNACPR, making their wishes central to decision-making. This is especially challenging in frailty, where patients may have limited capacity to engage in these discussions or face cognitive decline.

Contention around DNACPR orders often arises due to differing perceptions of quality of life, cultural values, or religious beliefs (Bremer et al., 2021). Families may insist on CPR despite clinical advice, viewing DNACPR orders as contrary to their beliefs about preserving life (Michalowski and Martin, 2022). Conversely, healthcare professionals may experience ethical tension in upholding a DNACPR recommendation when resuscitation is deemed futile or potentially harmful. Clear, compassionate communication and an understanding of each party's perspectives are crucial in addressing these challenges, as the ethical and cultural complexities of DNACPR decisions require professional teams to carefully navigate personal values, patient rights, and professional integrity (Sulmasy et al., 2019).

The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process, developed by the Resuscitation Council UK, offers a framework for creating personalized

emergency care plans through conversations between patients, their families, and healthcare professionals (Resuscitation Council UK, 2025). This approach ensures that decisions regarding interventions like CPR are informed by the patient's values and clinical context, promoting patient-centred care.

A study by Ibitoye et al. (2021) investigated the impact of frailty on outcomes following in-hospital cardiac arrest in patients aged over 60. The researchers retrospectively assigned Clinical Frailty Scale (CFS) scores to 90 patients who received cardiopulmonary resuscitation (CPR). They found that frailty was predictive of in-hospital mortality, independent of age, comorbidity, and cardiac arrest rhythm, with an odds ratio of 2.789 (95% CI 1.145–6.795). Notably, no patients with a CFS score greater than 4 survived to hospital discharge, whereas 26% of non-frail patients ( $CFS \leq 4$ ) did survive. These findings suggest that frail patients are unlikely to survive to hospital discharge following in-hospital cardiac arrest, indicating that CPR may often be futile in this population.

#### - **Capacity assessment in end-of-life care**

Assessing capacity is a critical ethical and legal obligation in end-of-life care, ensuring that healthcare decisions genuinely reflect the patient's wishes (Schweitzer et al., 2021). If a patient is found to lack decision-making capacity, it is essential to involve designated deputies or rely on advance directives, such as Advance Care Plans (ACP), which guide healthcare professionals in respecting the patient's preferences when direct communication is no longer possible (Jones and Morgan, 2024). The assumption in healthcare is that all patients possess capacity unless there is reason to question it. A capacity assessment is only initiated when there are reasonable grounds to doubt an individual's ability to make a specific decision. This doubt may arise due to medical diagnoses such as dementia or delirium or from observable signs, such as confusion or inconsistent behaviour. Importantly, capacity assessment is not a singular event but an ongoing process that requires continuous evaluation and tailored approaches.

To determine if a person has decision-making capacity, healthcare professionals assess four key abilities:

- **Understanding the information:** The individual must comprehend the details relevant to the decision at hand. Assessors must present information in accessible formats, such as diagrams, videos, or practical demonstrations, ensuring it is communicated in language the patient can understand.
- **Retaining information:** The person must retain the necessary information long enough to make a meaningful decision.
- **Weighing information:** The patient should be able to process or "weigh up" the implications of the decision for themselves and others, evaluating risks, benefits, and potential outcomes in a manner similar to clinical decision-making principles of beneficence and non-maleficence.
- **Communicating the decision:** Finally, the individual must be able to communicate their decision, whether verbally or non-verbally. This may require assistance from

specialists, such as speech and language therapists, or the use of assistive communication devices.

The outcome of a capacity assessment relies on the evidence collected during this process. If it cannot be shown that a person lacks the capacity for the specific decision, they should be presumed to have it. Capacity assessment, therefore, not only protects patient autonomy but also upholds the ethical standards of informed and respectful end-of-life care.

#### **- Decision-making**

The ability to make autonomous healthcare decisions rests on mental capacity, which determines whether a patient can understand, retain, and weigh information relevant to their care (Amaral et al., 2022). The Mental Capacity Act 2005 provides a framework for assessing capacity in the UK, emphasising that patients should be allowed to make their own choices unless proven otherwise. This principle is crucial in frailty, where mental capacity can fluctuate or decline over time.

For frail patients nearing the end of life, there is often a gradual loss of decision-making capacity. This can create ethical dilemmas, particularly when advance directives are absent or unclear. In such cases, determining the patient's best interests may involve consulting with family members or relying on previously expressed values. Healthcare professionals may face challenges in balancing respect for the patient's autonomy with ensuring decisions align with what would most benefit the patient.

The ability to make autonomous healthcare decisions is closely linked to mental capacity, and in the UK, the Mental Capacity Act 2005 provides a structured framework for its assessment, maintaining that patients should be presumed capable of decision-making unless shown otherwise. This principle becomes particularly significant in frailty, where mental capacity may fluctuate or gradually decline as patients approach the end of life. Such changes can introduce ethical challenges, particularly in cases where advance directives are absent or unclear, requiring healthcare professionals to balance respect for patient autonomy with decisions aimed at maximising benefit. When a patient lacks the capacity to decide, determining their best interests typically involves consulting family members or considering previously expressed values and preferences. For example, advance statements, such as a wish to remain at home in final days, though not legally binding, offer essential guidance for care planning. Where death is deemed inevitable, decisions should prioritise the patient's dignity and comfort, with no intent to hasten death, ensuring that actions align as closely as possible with the patient's values and fostering compassionate, ethically grounded end-of-life care.

#### **Other ethical issues in end-of-life care**

##### **- Palliative sedation**

Palliative sedation, used to relieve unmanageable symptoms by reducing consciousness, presents ethical complexities in end-of-life care for frail patients (Galea, 2020). This approach balances the principle of beneficence, aiming to alleviate suffering, with potential concerns about autonomy and nonmaleficence, as the patient's capacity to engage with their

surroundings and loved ones diminishes. While palliative sedation is intended to provide comfort without accelerating death, it requires a careful assessment to ensure that it aligns with the patient's values and previously expressed wishes (Etland, 2021). The ethical debate revolves around providing symptom relief without compromising dignity, highlighting the importance of clear consent and open communication with family members to ensure transparency (Beauchamp and Childress, 2012).

#### - **Withdrawing and withholding treatment**

In end-of-life care, the distinction between withdrawing and withholding treatment is significant, with each raising ethical implications (Etland, 2021). Withdrawing treatment involves stopping interventions that are already in place, while withholding means deciding not to initiate interventions (American Medical Association, 2023). For frail patients, who may experience limited benefit from aggressive treatments, decisions to withhold or withdraw life-sustaining measures are often guided by a focus on dignity, quality of life, and avoidance of unnecessary suffering (Beil et al., 2022). Healthcare professionals should navigate these choices by prioritising the patient's values and previously stated wishes, often involving family members and caregivers in discussions. This approach respects autonomy while aligning with beneficence and nonmaleficence, promoting a dignified approach to the patient's final stages of life (Wong et al., 2024).

#### - **Anticipatory prescribing**

Both the BMA, (2024) and NICE (2017) emphasise the importance of anticipatory prescribing to ensure that distressing symptoms such as pain, agitation, breathlessness, nausea, and respiratory secretions are managed pre-emptively. The GMC's guidance on end-of-life care advises that healthcare professionals should proactively assess symptom progression and prescribe medications in advance, reducing the likelihood of avoidable suffering or emergency interventions (BMA, 2024). Anticipatory prescribing should be based on an individualised clinical assessment, ensuring that frail patients receive timely and appropriate symptom control while avoiding unnecessary pharmacological burden. The GMC further stresses the importance of communicating prescribing decisions to patients, their families, and multidisciplinary teams, ensuring transparency in medication use and preventing inappropriate dose escalation or under-treatment (GMC, 2010). In addition, regular medication reviews, ensuring that prescriptions are adjusted in response to changing symptom burdens in the last hours and days of life (NICE, 2017 and Ellershaw and Wilkinson, 2010). Prescribers must remain aware of the risks associated with opioid accumulation in renal impairment and the potential for respiratory depression in frail patients, aligning with the Doctrine of Double Effect when managing symptoms safely and ethically (GMC, 2010).

#### - **Artificial nutrition and hydration (ANH)**

ANH presents a significant ethical challenge in frailty and multimorbidity (Rochford, 2021). While ANH can sustain life, its benefits must be weighed against potential burdens such as aspiration risk, infections, and increased discomfort. The GMC (2010) advises that decisions

regarding ANH should be individualised, considering the patient's prognosis, level of distress, and expressed wishes. In advanced frailty or terminal illness, withdrawing ANH may align with an approach focused on comfort rather than life prolongation, ensuring that interventions do not exacerbate suffering.

- **The doctrine of double effect (DDE)**

DDE is particularly relevant in end-of-life care for frail patients requiring opioid-based symptom management. In older adults with renal impairment, opioid accumulation can increase the risk of toxicity, necessitating careful titration (Faris et al., 2021). Similarly, in patients with respiratory insufficiency, opioids may reduce breathlessness but also depress respiratory drive. The GMC guidance on end-of-life care acknowledges that, when appropriately managed, the intent is symptom relief rather than hastening death.

- **Assisted dying**

Assisted dying is currently illegal in the UK, but debates continue regarding its potential legalisation (Mallion and Murphy, 2023). Advocates argue that it offers autonomy and relief from suffering, while others raise concerns about potential coercion and the sanctity of life (Nuffield Council on Bioethics, 2023). For frail patients, these discussions are particularly pertinent, as they often face prolonged suffering and diminished quality of life. Healthcare professionals must navigate these complex ethical landscapes, balancing respect for patient autonomy with professional and legal obligations (Alsaratee, 2024).

- **Quality of life considerations**

Quality of life is paramount in end-of-life care, especially for frail patients who may find invasive measures more challenging than beneficial (Lapid et al., 2020). Prioritising quality over mere survival aligns with the principle of beneficence, as it promotes interventions that enhance comfort and well-being rather than prolonging life at the cost of increased suffering. This approach challenges the traditional curative focus in healthcare, emphasising palliative care and symptom management as preferable alternatives. For frail individuals, interventions such as intensive care or aggressive treatments may not improve, and may even compromise, their quality of life. Thus, healthcare professionals are encouraged to adopt a holistic perspective that centres on comfort, respect, and dignity.

## **Conclusion**

End-of-life care for frail patients presents a range of ethical challenges that require healthcare professionals to apply a nuanced understanding of core ethical principles. These principles guide clinical decisions, from respecting a patient's right to self-determination to ensuring equitable access to compassionate care. In particular, palliative sedation, treatment withdrawal, and quality of life considerations emphasise the need to prioritise dignity and comfort for frail individuals nearing the end of life. This clinical review highlights the importance of upholding ethical standards within the legal frameworks that protect patient rights, such as the Mental Capacity Act 2005 and the Human Rights Act 1998. Healthcare professionals should navigate these complex scenarios with sensitivity, balancing ethical

principles with a commitment to compassionate, patient-centred care. Improving ethical standards and support systems in end-of-life care for frail patients will enhance the quality of life for this vulnerable population, ensuring that decisions are grounded in respect, empathy, and professional integrity.

### **Key points**

- End-of-life care for frail older adults necessitates a distinct approach, as their decline trajectories can vary widely, including gradual, catastrophic, and fluctuating patterns.
- Autonomy becomes particularly challenging in frail patients, where cognitive impairment may limit their decision-making ability, thereby increasing reliance on advance directives or family involvement.
- The ethical principles of beneficence and nonmaleficence require a careful balance in frail patients, as interventions beneficial for others may pose a higher risk of harm.
- Justice in healthcare demands equitable resource allocation, yet frail patients may encounter biases that affect the quality of their end-of-life care.

### **Reflective questions**

- How can healthcare professionals better anticipate and respond to the unique decline patterns in frail patients to provide patient-centred care and sensitive end-of-life care?
- In circumstances where a patient's autonomy is compromised, how can healthcare professionals ensure that care decisions remain consistent with the patient's known values and preferences?
- How can healthcare professionals achieve an optimal balance between benefiting and potentially harming frail patients when considering treatment options?
- What strategies can healthcare systems implement to mitigate biases and ensure fair distribution of resources, particularly in end-of-life care for frail individuals?

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