

COMMENTARY

Astefanos Al-Dalakta, MD

Department of Internal Medicine,
Cleveland Clinic, Cleveland, OH

Ruth Diana Lee, MD

Department of Internal Medicine,
Cleveland Clinic, Cleveland, OH

Chadi Tabaja, MD

Department of Internal Medicine,
Cleveland Clinic, Cleveland, OH

Issam Motairek, MD

Department of Internal Medicine,
Cleveland Clinic, Cleveland, OH

Eduardo Mireles-Cabodevila, MD

Department of Critical Care Medicine,
Cleveland Clinic, Cleveland, OH; Associate
Professor, Cleveland Clinic Lerner College of
Medicine of Case Western Reserve University,
Cleveland, OH

Fighting ageism: Preserving patient agency in critical care

THE INTENSIVE CARE UNIT compresses time. Decisions that shape outcomes are made amid the sounds of alarms and ventilators and constant motion. It was in this setting that an 87-year-old woman arrived, having been transferred from another hospital, her voice silenced by the tube that kept her alive. She'd been intubated for stridor, caused by a large mass in her neck that had collapsed her trachea.

She was a late admission, so we consulted the otorhinolaryngology team first. Given the degree of involvement by the mass, the otorhinolaryngology team focused on defining the goals of care. They were willing to perform a tracheostomy if the patient wanted one. If not, hospice care seemed appropriate. Since the patient was sedated and unable to communicate, we turned to her daughter, who had been by her mother's side throughout. We posed the questions: What did her mother want? How far should we go? What measures should we take? And we wondered, was the patient's age shaping our perception of benefit?

As clinicians at the bedside, we felt the weight of our own bias creeping in. Here was a woman nearing 90, intubated, with a large tumor for which all therapy seemed perhaps excessive. Given her age, it was tempting to think that hospice might be the kindest path. But her daughter hesitated. She said that before this illness, her mother lived independently, cooked for herself, and was enjoying her life. So, later that morning, sedation was held.

We reviewed the options with our patient. Our conversation demonstrated her ability to participate in decision-making (albeit intubated) and clearly express her preferences. She declined hospice care. She wished to continue living and was not prepared to transition to comfort-focused treatment. She also declined a trache-

ostomy, citing concern about long-term dependence on an artificial airway and the impact such an intervention could have on her quality of life. After discussing the risks, uncertainties, and alternatives, she made it clear that she wanted to remain intubated, provided that disease-directed treatment was offered.

The oncology team arrived that morning. We thought they would confirm our suspicions that therapy wasn't an option, given the patient's age. But that wasn't the case. To our surprise, the oncology team offered a one-time reduced-dose chemotherapy treatment. The patient agreed to it emphatically!

The oncology team suspected that the tumor was a thyroid diffuse large B-cell lymphoma, a disease that often responds to systemic therapy, with the potential to provide rapid reduction in mass effect and clinical improvement. We proceeded with a dose-attenuated regimen of rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone (R-mini-CHOP). Within days, the mass, once responsible for life-threatening airway compromise, began to regress. One week later, our patient was successfully extubated and discharged from the hospital.

■ THE BIAS OF AGEISM

Physicians are not immune to biases. Ageism, defined as stereotypes, prejudice, or discrimination based on a person's age,¹ often manifests in ways we may not immediately recognize, especially in healthcare. It's an attitude that can, consciously or unconsciously, influence how we view and treat older patients, affecting everything from the language we use to the medical decisions we make. This can sometimes lead to assumptions that older patients are less likely to benefit from aggressive treatments or that their frailty makes intensive care unwarranted. In the scenario described

doi:10.3949/cjfm.93a.25105

here, our patient's age and condition made us think that she might be better suited for hospice care. This bias, however well-meaning, could have prematurely closed the door to treatment options.

Bias toward older patients may arise through multiple mechanisms. One important factor is the historical underrepresentation of older patients in clinical trials; for example, between 1996 and 2002, patients age 75 and older accounted for only 8.3% of participants enrolled in National Cancer Institute–sponsored breast, colorectal, lung, and prostate cancer trials.² This exclusion may stem from a desire to reduce mortality rates or minimize confounding variables that arise from the increased medical complexity that is often present with older patients. Consequently, most of our guideline-directed care is derived from younger cohorts, which can make it challenging to generalize evidence to an older population. Extrapolating data from younger cohorts can potentially lead to suboptimal or even harmful treatments for an already vulnerable population.³

Similarly, age and frailty often coexist and influence perioperative and treatment-related risk,^{4,5} shaping clinicians' perception of risk at the time of hospital admission and becoming a source of anchoring bias. However, evidence consistently shows that chronological age alone should not be viewed as a contraindication to surgery or chemotherapy. Frailty indices, and not age per se, are among the strongest predictors of postoperative complications, length of stay, functional decline, and prolonged recovery in older adults.^{4,5}

At the same time, multiple geriatric-oncology studies show that carefully selected older patients, including those older than 80, can achieve postoperative morbidity, mortality, and cancer-control outcomes comparable to those in younger individuals when decisions are based on physiologic reserve, comorbidities, and goals of care rather than age alone.^{6–8} In hematologic malignancies, dose-attenuated regimens such as R-mini-CHOP have produced meaningful responses and survival in very elderly patients with diffuse large B-cell lymphoma, supporting individualized treatment even in advanced age.^{9,10} Standard R-CHOP remains the preferred regimen for patients with sufficient physiologic reserve; however, R-mini-CHOP was specifically developed to reduce treatment-related toxicity in patients age 80 or older, who are more vulnerable to chemotherapy-associated adverse effects.^{11,12}

In the case of our patient, the decision to start R-mini-CHOP, rather than full-dose R-CHOP, was informed by the patient's advanced age in conjunction with critical illness, including airway compromise. Importantly, age-informed dose selection did not preclude us from offering disease-directed therapy. Together, these data indicate that, while age-related vulnerabilities must be carefully assessed, advanced age by itself should not preclude offering surgery or systemic therapy when aligned with patient values.

MOVING BEYOND CHRONOLOGICAL AGE

Disparities in research and treatment options create a cycle of inequity in care, where older patients are frequently overlooked for treatments that may align with their health status or preferences. Acknowledging our vulnerabilities—whether stemming from ageism, the pressures of a critical care environment, or our own preconceived notions—requires humility and reflection. When caring for critically ill older adults, it's essential that we move beyond chronological age toward an assessment of biological age, taking into account frailty, baseline functional status, cognitive reserve, and physiologic resilience, which more accurately inform prognosis and treatment tolerance. Importantly, countering ageism requires intentionally exploring care pathways that may initially seem unreasonable or “not viable” by conventional clinical heuristics, but that, in the appropriate context—as in this case—emerge as both rational and clearly aligned with the patient's goals.

To avoid falling into ageism bias, we must maintain a framework grounded in respect for the patient, one that deliberately centers on the patient's voice, while bringing together the stakeholders required to clarify prognosis, options, and risk. We must remember that gaps in care often arise when age is used as a surrogate for physiologic reserve, decision-making capacity, or patient preference, leading to premature narrowing of options. By explicitly integrating biological age, decisional capacity, and patient-defined priorities, we can avoid the pitfall of age-based anchoring while ensuring that decisions remain individualized, clinically sound, and aligned with what matters most to the patient. ■

DISCLOSURES

Dr. Mireles-Cabodevila has reported consulting for IngMar Medical. The other authors report no relevant financial relationships which, in the context of their contributions, could be perceived as a potential conflict of interest.

REFERENCES

1. **World Health Organization.** Global report on ageism. March 18, 2021. www.un.org/development/desa/dspd/wp-content/uploads/sites/22/2021/03/9789240016866-eng.pdf. Accessed April 17, 2026.
2. **Murthy VH, Krumholz HM, Gross CP.** Participation in cancer clinical trials: race-, sex-, and age-based disparities. *JAMA* 2004; 291(22):2720–2726. doi:10.1001/jama.291.22.2720
3. **Drenth-van Maanen AC, Wilting I, Jansen PAF.** Prescribing medicines to older people—how to consider the impact of ageing on human organ and body functions. *Br J Clin Pharmacol* 2020; 86(10):1921–1930. doi:10.1111/bcp.14094
4. **Makary MA, Segev DL, Pronovost PJ, et al.** Frailty as a predictor of surgical outcomes in older patients. *J Am Coll Surg* 2010; 210(6):901–908. doi:10.1016/j.jamcollsurg.2010.01.028
5. **Lin HS, Watts JN, Peel NM, Hubbard RE.** Frailty and post-operative outcomes in older surgical patients: a systematic review. *BMC Geriatr* 2016; 16(1):157. doi:10.1186/s12877-016-0329-8
6. **Korc-Grodzicki B, Downey RJ, Shahrokni A, Kingham TP, Patel SG, Audisio RA.** Surgical considerations in older adults with cancer. *J Clin Oncol* 2014; 32(24):2647–2653. doi:10.1200/JCO.2014.55.0962
7. **Montroni I, Saur NM, Shahrokni A, Suwanabol PA, Chesney TR.** Surgical considerations for older adults with cancer: a multidimensional, multiphase pathway to improve care. *J Clin Oncol* 2021; 39(19):2090–2101. doi:10.1200/JCO.21.00143
8. **Monson K, Litvak DA, Bold RJ.** Surgery in the aged population: surgical oncology. *Arch Surg* 2003; 138(10):1061–1067. doi:10.1001/archsurg.138.10.1061
9. **Bairey O, Benjamini O, Blickstein D, Elis A, Ruchlemer R.** Non-Hodgkin's lymphoma in patients 80 years of age or older. *Ann Oncol* 2006; 17(6):928–934. doi:10.1093/annonc/mdl034
10. **Allen P.** Diffuse large B-cell lymphoma in the elderly: current approaches. *Curr Oncol Rep* 2020; 22(11):114. doi:10.1007/s11912-020-00976-x
11. **Peyrade F, Jardin F, Thieblemont C, et al.** Attenuated immunochemotherapy regimen (R-miniCHOP) in elderly patients older than 80 years with diffuse large B-cell lymphoma: a multicentre, single-arm, phase 2 trial. *Lancet Oncol* 2011; 12(5):460–468. doi:10.1016/S1470-2045(11)70069-9
12. **Al-Sarayfi D, Brink M, Chamuleau MED, et al.** R-miniCHOP versus R-CHOP in elderly patients with diffuse large B-cell lymphoma: a propensity matched population-based study. *Am J Hematol* 2024; 99(2):216–222. doi:10.1002/ajh.27151

Address: Astefanos Al-Dalakta, MD, Department of Internal Medicine, Cleveland Clinic, 9500 Euclid Avenue, Cleveland, OH 44195; ala41@ccf.org