Essays

Ageism, Autonomy, and Justice in Healthcare and Clinical Research: A Structured Narrative Review of Bioethical and Legal-Governance Implications Beyond Chronological Age

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ABSTRACT: Ageism in healthcare and clinical research becomes a bioethical and legal-governance problem when chronological age is used as a proxy for clinically relevant heterogeneity. This structured narrative review integrates empirical, review-level and normative literature to distinguish legitimate age-sensitive reasoning, grounded in individualised assessment, from age-as-proxy shortcutting, where age substitutes for frailty, function, cognition, multimorbidity, treatment burden, communication needs and patient goals. The review examines effects on care pathways, autonomy, informed consent, rehabilitation, research inclusion and accountability, and argues for safeguards including multidimensional assessment, autonomy-preserving communication, supported decision-making, pathway audit and inclusive research governance.

KEYWORDS: ageism; older adults; informed consent; non-discrimination; healthcare governance

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1. Introduction and Methodological Note

Population ageing is reshaping healthcare systems worldwide, as older adults represent an increasing proportion of people living with multimorbidity, frailty, disability, and complex care needs. Yet chronological age is not, in itself, a clinically sufficient descriptor. Later life is marked by substantial heterogeneity in functional reserve, cognition, social support, treatment burden, and goals of care. The central question is therefore not whether age matters, but when it reflects a meaningful dimension of clinical diversity and when it instead becomes a crude proxy that obscures individual variability.[1]

Within this context, ageism may be understood as a constellation of stereotypes, prejudices, and discriminatory practices directed at individuals on the basis of age, operating across interpersonal, organisational, and structural levels.[2] In healthcare, these dynamics are not limited to overt exclusion. They may also emerge through seemingly routine assumptions about prognosis, adherence, decisional capacity, treatment tolerance, and the appropriateness of diagnostic or therapeutic effort.[3] Clinically relevant ageism is often paternalistic in form, presenting as prudence or protection while narrowing options and substituting assumptions for structured assessment and shared deliberation.[4]

Healthcare is a particularly sensitive arena because ageism may become consequential at predictable decision nodes. Across acute, primary, and long-term care settings, the literature describes age-related gradients in triage, referral thresholds, diagnostic work-up, and escalation to invasive or high-intensity interventions.[5] Some variation may reflect legitimate differences in baseline risk, frailty, or treatment toler-

[1] J. Rennes, *Unpacking age as a category: Chronological age, life stage, and bodily aging in age-based discrimination*, in *Revue Française de Sociologie*, 60, 2019, 257-284; A.R. Schwall, *Defining Age and Using Age-Relevant Constructs*, in J.W. Hedge, W.C. Borman (eds.), *The Oxford Handbook of Work and Aging*, Oxford, 2012, 169-186; J.D. Henry, S.P. Coundouris, M.R. Nangle, *Breaking the links between ageism and health: An integrated perspective*, in *Ageing Research Reviews*, 95, 2024, 102212; U.M. Staudinger, *Images of aging: Outside and inside perspectives*, in *Annual Review of Gerontology and Geriatrics*, 35, 2015, 187-209; O. Maximova, *Old age or 'third age'? Discourses of individuals' subjective perceptions of their own age-related changes*, in *Laboratorium*, 12, 2020, 22-44.

[2] J.D. Henry, S.P. Coundouris, M.R. Nangle, *op. cit.*; J.D. Henry, S.P. Coundouris, F.I.M. Craik, C. Von Hippel, S.A. Grainger, *The cognitive tenacity of self-directed ageism*, in *Trends in Cognitive Sciences*, 27, 2023, 713-725; C. Bratt, D. Abrams, H.J. Swift, *Supporting the Old but Neglecting the Young? The Two Faces of Ageism*, in *Developmental Psychology*, 56, 2020, 1029-1039.

[3] J.D. Henry, S.P. Coundouris, M.R. Nangle, *op. cit.*; J.D. Henry, S.P. Coundouris, F.I.M. Craik, C. Von Hippel, S.A. Grainger, *op. cit.*; K.P. Jones, I.E. Sabat, E.B. King, A. Ahmad, T.C. Mccausland, T.R. Chen, *Isms and schisms: A meta-analysis of the prejudice-discrimination relationship across racism, sexism, and ageism*, in *Journal of Organizational Behavior*, 38, 2017, 1076-1110.

[4] L.M. Joseph, *Ethical challenges in the care of aging population: Experience from the United States of America*, in M.K. Shankardass (ed.), *Care of Older Persons: Emerging International Perspectives*, London, 2024, 17-31; R.L. Van Bruchem-Visser, G. Van Dijk, I. De Beaufort, F. Mattace-Raso, *Ethical frameworks for complex medical decision making in older patients: A narrative review*, in *Archives of Gerontology and Geriatrics*, 90, 2020, 104160; G. Ghilardi, F. De Micco, L.L. Campanozzi, *Bioethical issues in gerosurgery*, in V. Boccardi, L. Marano (eds.), *The Frail Surgical Patient: A Geriatric Approach Beyond Age*, Cham, 2024, 423-434.

[5] P. Martínez-Angulo, M. Muñoz-Mora, M. Rich-Ruiz, P.E. Ventura-Puertos, V. Cantón-Habas, S. López-Quero, *With your age, what do you expect?: Ageism and healthcare of older adults in Spain*, in *Geriatric Nursing*, 51, 2023, 84-94; K.R. Haase, S. Sattar, S. Pilleron, Y. Lambrechts, M. Hannan, E. Navarrete *et al.*, *A scoping review of ageism towards older adults in cancer care*, in *Journal of Geriatric Oncology*, 14, 2023, 101385; L. Nemiroff, *We can do better: Ad-*

ance. The ethically and clinically relevant problem arises when chronological age is used in place of the variables that should instead justify the decision, including frailty, functional status, cognition, multimorbidity, treatment burden, communication needs, and patient goals. In this sense, age-based shortcutting does not merely risk exclusion; it also reduces clinical precision by replacing discriminating clinical variables with a coarse demographic label.[6]

A related mechanism concerns communication and participation in decision-making. Age-coded communication, including elderspeak, may displace patient agency, narrow shared decision-making, and shift interlocution toward relatives as a default rather than as a justified accommodation.[7] In dementia care, elderspeak has been associated with increased resistiveness to care and adverse interactional dynamics, while communication education and staff-focused interventions have been evaluated as possible corrective strategies.[8] These mechanisms matter not only because they affect dignity and the therapeutic relationship, but also because they may weaken consent processes and obscure whether capacity was actually assessed.[9]

Ageism may also be reinforced through organisational defaults. Discharge destination, rehabilitation intensity and duration, and access to community services are often shaped by service availability, pathway design, and local resource constraints rather than by an explicit, documented appraisal of needs.[10] When such defaults systematically channel older adults toward lower-resource trajectories, including reduced rehabilitation, earlier institutionalisation, or fragmented follow-up, age-based inequities may be normal-

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dressing ageism against older adults in healthcare, in *Healthcare Management Forum*, 35, 2022, 118-122; A. BOWLING, *Ageism in cardiology*, in *British Medical Journal*, 319, 1999, 1353-1355.

[6] K.R. HAASE *et al.*, *op. cit.*; L. FERNÁNDEZ-PUERTA, A. CABALLERO-BONAFÉ, J.R. DE-MOYA-ROMERO, A. MARTÍNEZ-SABATER, R. VALERA-LLORIS, *Ageism and associated factors in healthcare workers: A systematic review*, in *Nursing Reports*, 14, 2024, 4039-4059; T.W. FARRELL, W.W. HUNG, K.T. UNROE, T.R. BROWN, C.D. FURMAN, J. JIH *et al.*, *Exploring the intersection of structural racism and ageism in healthcare*, in *Journal of the American Geriatrics Society*, 70, 2022, 3366-3377.

[7] L.S. BETHEA, A.L. BALAZS, *Improving intergenerational health care communication*, in *Journal of Health Communication*, 2, 1997, 129-137; M. TOPAZ, I. DORON, *Nurses' attitudes toward older patients in acute care in Israel*, in *Online Journal of Issues in Nursing*, 18, 2013, 9; K.N. WILLIAMS, *Improving outcomes of nursing home interactions*, in *Research in Nursing & Health*, 29, 2006, 121-133; K. KYI, *Confronting ageism with language and lifestyle medicine*, in S.M. FRIEDMAN (ed.), *Geriatrics, Lifestyle Medicine and Healthy Aging: A Practical Guide*, Boca Raton, 2025.

[8] R.E. HERMAN, K.N. WILLIAMS, *Elderspeak's influence on resistiveness to care: Focus on behavioral events*, in *American Journal of Alzheimer's Disease and Other Dementias*, 24, 2009, 417-423; K.N. WILLIAMS, Y. PERKHOUNKOVA, R. HERMAN, A. BOSSEN, *A communication intervention to reduce resistiveness in dementia care: A cluster randomized controlled trial*, in *The Gerontologist*, 57, 2017, 707-718; K.N. WILLIAMS, C.K. COLEMAN, Y. PERKHOUNKOVA, T. BEACHY, M. HEIN, C.A. SHAW, A. BERKLEY, *Moving Online: A Pilot Clinical Trial of the Changing Talk Online Communication Education for Nursing Home Staff*, in *The Gerontologist*, 61, 2021, 1338-1345; K.N. WILLIAMS, C.K. COLEMAN, M. HEIN, C. SHAW, Y. PERKHOUNKOVA, T. BEACHY, *Promoting elderspeak awareness: Adapting Changing Talk Online communication education for adult day services staff*, in *Research in Gerontological Nursing*, 16, 2023, 85-94; K.N. WILLIAMS, R.E. HERMAN, *Linking resident behavior to dementia care communication: Effects of emotional tone*, in *Behavior Therapy*, 42, 2011, 42-46.

[9] L.M. JOSEPH, *op. cit.*; R.L. VAN BRUCHEM-VISSER *et al.*, *op. cit.*; L. SWAN, S. KOCHOVSKA, N. RIES, I. GILMORE, D. PARKER, C. SINCLAIR *et al.*, *Strategies to improve research participation by older people with cognitive impairment: A systematic review*, in *The Gerontologist*, 65, 2025, gnae188.

[10] K.R. HAASE *et al.*, *op. cit.*; L. FERNÁNDEZ-PUERTA *et al.*, *op. cit.*; P. THOMAS, C. HAZIF-THOMAS, *The individual and collective underpinnings of ageism*, in *NPG Neurologie – Psychiatrie – Gériatrie*, 23, 2023, 368-374.

ised as inevitable consequences of ageing rather than recognised as modifiable pathway effects.[11] These issues are especially relevant in geriatric care, where continuity, function, maintenance of independence, and alignment with patient goals are often more informative than chronological age alone.

A further and closely related problem concerns the production of medical evidence. Review-level literature documents the under-representation of older adults in clinical trials across major disease areas, particularly among the very old and among those living with frailty, multimorbidity, disability, cognitive impairment, or residence in long-term care.[12] Additional reviews and policy analyses confirm the persistence of this pattern across research settings.[13] Eligibility criteria, protocol burden, logistical barriers, and conservative interpretations of consent complexity all contribute to this representational deficit.[14] The result is an external-validity gap: uncertainty is displaced from research settings into routine care, where clinicians must still make high-stakes decisions for complex older adults despite a weaker evidence base and outcomes that are not always aligned with later-life priorities such as function, independence, symptom burden, and treatment burden.[15]

This problem is not only methodological but also normative. When older adults are systematically filtered out of clinical research, the populations most exposed to complex decisions in practice may be those least represented in the evidence base used to guide those decisions. Ethical analyses increasingly frame this deficit as a matter of justice, respect for persons, and research governance rather than as a merely technical limitation of study design.[16]

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[11] T.W. Farrell *et al.*, *op. cit.*; M. Purchase, É.R. Thériault, B. Collicutt, *Ageism healthcare: Implications for the psychological well-being of Atlantic Canadian healthcare professionals*, in *Journal of Applied Gerontology*, 43, 2024, 1355-1365.

[12] S. Florisson, E.K. Aagesen, A.S. Bertelsen, L.P. Nielsen, J.-U. Rosholm, *Are older adults insufficiently included in clinical trials? An umbrella review*, in *Basic & Clinical Pharmacology & Toxicology*, 128, 2021, 213-223; J. He, D.R. Morales, B. Guthrie, *Exclusion rates in randomized controlled trials of treatments for physical conditions: A systematic review*, in *Trials*, 21, 2020, 228; M. Tang, S.-A. Pearson, A.L. Schaffer, C.R. Lewis, T. John, R.J. Simes, C.K. Lee, *Are clinical trial eligibility criteria representative of older patients with lung cancer? A population-based data linkage study*, in *Journal of Geriatric Oncology*, 12, 2021, 930-936; K. Szlezinger, K. Pogoda, A. Jagiełło-Gruszfeld, D. Kłosowska, A. Górski, J. Borysowski, *Eligibility criteria in clinical trials in breast cancer: A cohort study*, in *BMC Medicine*, 21, 2023, 240.

[13] A.P. Herrera, S.A. Snipes, D.W. King, I. Torres-Vigil, D.S. Goldberg, A.D. Weinberg, *Disparate inclusion of older adults in clinical trials: Priorities and opportunities for policy and practice change*, in *American Journal of Public Health*, 100, 2010, S105-S112; L.E. Walker, M. Pirmohamed, *The status of drug evaluation in older adults in the United Kingdom: Bridging the representation gap*, in *Journal of the American Geriatrics Society*, 72, 2024, 2933-2941.

[14] A. Hosie, S. Kochovska, N. Ries, I. Gilmore, D. Parker, C. Sinclair *et al.*, *Older persons' and their caregivers' perspectives and experiences of research participation with impaired decision-making capacity: A scoping review*, in *The Gerontologist*, 62, 2022, e112-e122; J.S. Jensen, S. Reiter-Theil, D.A. Celio, M. Jakob, W. Vach, F.J. Saxer, *Handling of informed consent and patient inclusion in research with geriatric trauma patients - a matter of protection or disrespect?*, in *Clinical Interventions in Aging*, 14, 2019, 321-334; J. Withall, C.J. Greaves, J.L. Thompson, J.L. De Koning, J.C. Bollen, S.J. Moorlock *et al.*, *The Tribulations of Trials: Lessons Learnt Recruiting 777 Older Adults Into REtirement in ACTion (REACT)*, in *The Journals of Gerontology: Series A*, 75, 2020, 2387-2395; T. Buttgereit, A. Palmowski, N. Forsat, M. Boers, M.D. Witham, N. Rodondi *et al.*, *Barriers and potential solutions in the recruitment and retention of older patients in clinical trials - lessons learned from six large multicentre randomized controlled trials*, in *Age and Ageing*, 50, 2021, 1988-1996.

[15] S. Florisson *et al.*, *op. cit.*; J. He, D.R. Morales, B. Guthrie, *op. cit.*; K. Szlezinger *et al.*, *op. cit.*; J.S. Jensen *et al.*, *op. cit*.

[16] R.L. Van Bruchem-Visser *et al.*, *op. cit*.; L. Swan *et al.*, *op. cit.*; A.P. Herrera *et al.*, *op. cit.*; J.S. Jensen *et al.*, *op. cit*.

Against this background, this structured narrative review aims to: synthesise conceptual and empirical work on ageism in clinical practice and healthcare organisations affecting older adults; examine under-inclusion in clinical research as a bioethical and legal-governance problem that weakens the evidential basis of later-life care; and articulate practical implications for clinical decision-making, institutional governance, and the evaluation of age-influenced decisions, with particular attention to frailty, function, communication, supported decision-making, rehabilitation, and care transitions. In doing so, we advance the core proposition that chronological age is not a shortcut: it may represent a clinically relevant dimension of diversity when grounded in robust, individualised assessment, but it becomes ethically and legally problematic when it operates as a proxy for diminished priority, diminished agency, or diminished worth.

This review contributes to BioLaw scholarship by reframing ageism in healthcare and clinical research as a problem of proxy reasoning at the intersection of clinical evidence, autonomy, equality, informed consent, and institutional governance. Rather than treating ageism only as interpersonal prejudice or as a generic ethical concern, the article argues that chronological age becomes biolegally relevant when it silently replaces the patient-level variables that should justify decisions affecting access to care, treatment intensity, rehabilitation, consent, and research eligibility. The proposed distinction between legitimate age-sensitive reasoning and age-as-proxy shortcutting provides a practical framework for evaluating age-influenced decisions without denying the clinical relevance of ageing.

Methodological note. This article is a structured narrative review integrating empirical literature, review-level evidence, conceptual scholarship, and normative legal-governance analysis on ageism in healthcare and the under-representation of older adults in clinical research. A narrative design was selected because the topic spans heterogeneous forms of evidence, including quantitative, qualitative and mixed-methods studies, together with bioethical, governance and policy-oriented sources that are not readily amenable to a single risk-of-bias framework or to meta-analytic synthesis. The objective was not quantitative pooling, but a transparent and critically structured synthesis of recurrent mechanisms, decision nodes and practical implications relevant to later-life care and research.

Literature searches were performed in PubMed/MEDLINE, Scopus and Web of Science, and were last updated on 9 March 2026. Electronic database searches primarily covered the period 2000-2026. Because the review also aimed to provide conceptual framing, a limited number of seminal or foundational sources published before 2000 were retained through targeted citation tracking when directly relevant to the historical development or definition of ageism.

The search strategy was organised around three concept clusters: ageism and age-based discrimination; healthcare delivery, communication and clinical decision-making involving older adults; and clinical research participation and the under-representation of older populations, including frailty, multimorbidity, disability, cognitive impairment and residence in long-term care. Sources were considered relevant when they addressed one or more of these domains or contributed directly to the bioethical and legal-governance implications of age-influenced decision-making in care or research.

Consistent with a structured narrative review design, selection was thematic and relevance-based rather than based on systematic-screening procedures. No meta-analysis, quantitative pooling, PRISMA flow diagram or study-count reporting is claimed. The synthesis was developed through thematic aggregation rather than formal study-by-study appraisal and focused on care pathways, communication and autonomy, evidence production, and legal-governance implications of age-based proxy reasoning.

2. Chronological Age as Proxy Reasoning in Healthcare and Clinical Research

The core biolegal difficulty addressed in this article is the ambiguous role of chronological age in healthcare and clinical research. Age may be clinically relevant because it can correlate with risk, reserve, multimorbidity, functional status or treatment burden. It becomes problematic, however, when it is allowed to perform the justificatory work that should instead be carried out by patient-level variables. In that situation, chronological age is no longer one contextual element of assessment; it becomes a proxy for prognosis, agency, benefit, resilience or entitlement to care.

This distinction is important because proxy reasoning can appear administratively efficient while remaining evidentially weak and normatively hazardous. In clinical practice it may obscure the difference between robust and frail older adults, or between interventions that are genuinely disproportionate and interventions that are withheld because of age-coded expectations. In research governance, it may justify eligibility criteria, consent practices or protocol designs that exclude precisely those populations for whom evidence is most needed. The legal-governance question is therefore not whether age may ever be considered, but whether age-influenced decisions remain individualised, transparent, non-discriminatory and reviewable.

The proposed analytical distinction between legitimate age-sensitive reasoning and age-as-proxy shortcutting is intended to preserve clinical realism without normalising categorical disadvantage. It also links geriatric heterogeneity to the rights-sensitive domains of autonomy, informed consent, equality, access to care, research justice and institutional accountability.

3. Ageism in Care Pathways and Evidence Production

Ageism becomes clinically consequential when chronological age is used as a shortcut rather than incorporated into an individualised appraisal of the domains that actually shape prognosis, treatment tolerance, realistic outcomes, and patient priorities. In later-life care, these domains include frailty, function, cognition, communication needs, multimorbidity, treatment burden, and social context. In practice, these dynamics affect not only care pathways, but also the production of evidence used to justify care for older adults. Table 1 summarises the main domains through which ageism may operate across healthcare and clinical research involving older adults.

Table 1 is an original synthesis prepared by the authors from the literature discussed in this section. It groups the main contexts in which chronological age may operate as a proxy for clinically relevant variables and indicates the corresponding bioethical and legal-governance implications.

Table 1. Main domains of ageism in healthcare and clinical research involving older adults and their bioethical and legal-governance implications

Domain	How ageism appears	Bioethical and legal-governance implications
Clinical decision-making	Chronological age is used as a shortcut for prognosis, treatment intensity, escalation, surgical candidacy, or rehabilitation planning instead of documented assessment of frailty, function, cog-	Raises the risk of unjustified differential treatment and weakens the transparency of benefit-burden reasoning. Engages benefi-

Domain	How ageism appears	Bioethical and legal-governance implications
	nition, multimorbidity, treatment burden, and patient goals.	cence/non-maleficence, proportionality, and fairness in age-influenced clinical judgment.
Access to services and care pathways	Older adults may receive lower priority in access to specialist referral, intensive treatments, rehabilitation slots, or community services, especially where pathway rules and resource pressures favour younger or less complex patients.	May generate direct or indirect age-based disadvantage. Requires scrutiny of allocation criteria, reasonable accommodations, and the fairness of pathway design under constrained resources.
Communication and supported decision-making	Infantilising language, reduced information, speaking mainly to relatives, or presuming reduced understanding or reduced decisional capacity because of age.	Affects autonomy, dignity, informed consent quality, and the defensibility of participation in decision-making. Supports the need for autonomy-preserving communication and supported decision-making practices.
Organisational structures and care transitions	Care pathways, staffing models, scheduling rules, discharge defaults, and rehabilitation practices may systematically channel older adults toward lower-resource trajectories, fragmented follow-up, or premature institutionalisation.	Highlights that ageism may be structural rather than only interpersonal. Engages justice, non-maleficence, continuity of care, and organisational accountability for foreseeable inequities.
Inclusion in clinical research	Older adults, especially those living with frailty, multimorbidity, disability, cognitive impairment, or residence in long-term care, may be excluded through upper age limits, restrictive eligibility criteria, protocol burden, or defensive consent practices.	Weakens external validity and shifts uncertainty into routine care. Engages justice, respect for persons, and research-governance responsibility regarding unjustified exclusion.
Development and use of guidelines	Guidelines, risk scores, and treatment pathways may be derived mainly from younger or healthier populations and then extended to older adults without sufficient attention to frailty, multimorbidity, cognition, or outcomes meaningful in later life.	Increases uncertainty in later-life care and requires careful interpretation of evidence in relation to individual patients. Engages fairness, proportionality, and the responsible application of evidence in geriatrics.
Intersection with other forms of disadvantage	Ageism may overlap with sexism, racism, disability-related disadvantage, and social vulnerability, particularly affecting older women, minoritised groups, migrants, and socioeconomically disadvantaged persons.	Requires context-sensitive analysis rather than treating age in isolation. Highlights compound injustice and the need for equity-oriented interpretation of pathways and outcomes.

3.1. Care Pathways: Decision Nodes, Proxy Reasoning and Communication-Mediated Exclusion

Across acute, primary, and long-term care settings, the literature describes age-related gradients in triage, referral thresholds, diagnostic work-up, and escalation to invasive or high-intensity interventions. These gradients are not always the product of explicit age cut-offs; they may also emerge through pathway design, service organisation, staffing constraints, and implicit assumptions about what constitutes "appro-

priate" care for older adults. At the same time, not every age-associated difference in care is necessarily unjustified. Some variation may reflect legitimate differences in baseline risk, frailty, treatment tolerance, or expected burden. The clinically and ethically relevant concern arises when chronological age substitutes for the variables that should instead justify the decision, including frailty, function, cognition, multimorbidity, treatment burden, communication needs, and patient goals.[17]

Later life is heterogeneous, and that heterogeneity is clinically decisive. Individuals of the same chronological age may differ markedly in frailty, functional reserve, cognition, social support, and goals of care. When age categories replace multidimensional assessment, two symmetrical errors become more likely. Robust older adults may be under-investigated, under-treated, or denied rehabilitation intensity on the basis of assumptions tied more to age category than to measured condition. Frail older adults, by contrast, may receive formally "equal" but poorly calibrated interventions that inadequately reflect realistic benefit, treatment burden, or patient priorities. Age-based shortcutting therefore does not merely risk exclusion; it also reduces clinical precision by replacing discriminating patient-level variables with a coarse demographic label.[18]

Communication practices are a further site through which ageism may alter pathways of care. Age-coded communication, including elderspeak, may displace patient agency, narrow shared decision-making, and shift interlocution toward relatives as a default rather than as a justified accommodation. In dementia care, elderspeak has been associated with increased resistiveness to care, while communication education and staff-focused interventions have been evaluated as potential corrective strategies. These patterns matter because they affect not only dignity and the therapeutic relationship, but also the visibility of participation in decision-making. In this sense, communication is not peripheral to clinical decision-making; it is one of the mechanisms through which age-based assumptions may become normalised and rendered less visible.[19]

A related issue concerns care transitions. Discharge destination, rehabilitation intensity and duration, and access to community services are often shaped not only by patient need, but also by service availability, organisational defaults, and local capacity constraints. When such defaults systematically channel older adults toward lower-resource trajectories, including reduced rehabilitation, earlier institutionalisation, or fragmented follow-up, age-based inequities may be normalised as inevitable consequences of ageing rather than recognised as modifiable pathway effects. These downstream pathways are especially important in geriatric care, where function, continuity, maintenance of independence, and alignment with patient goals are often more informative than chronological age alone. Intersectional analyses also suggest that ageism may overlap with sexism and structural racism, amplifying disadvantage in access, continuity, and quality of care for some groups of older adults.[20]

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[17] P. Martínez-Angulo *et al.*, *op. cit.*; K.R. Haase *et al.*, *op. cit.*; L. Nemiroff, *op. cit.*; L. Fernández-Puerta *et al.*, *op. cit.*

[18] P. Martínez-Angulo *et al.*, *op. cit.*; L. Fernández-Puerta *et al.*, *op. cit.*; T T.W. Farrell *et al.*, *op. cit.*; J.C. Chrisler, A. Barney, B. Palatino, *Ageism can be hazardous to women's health: Ageism, sexism, and stereotypes of older women in the healthcare system*, in *Journal of Social Issues*, 72, 2016, 86-104.

[19] L.S. Bethea, A.L. Balazs, *op. cit.*; R.E. Herman, K.N. Williams, *Elderspeak's influence on resistiveness to care*, cit.; K.N. Williams *et al.*, *A communication intervention to reduce resistiveness in dementia care*, cit.; K.N. Williams *et al.*, *Moving Online*, cit.

[20] L. Fernández-Puerta *et al.*, *op. cit.*; T.W. Farrell *et al.*, *op. cit.*; P. Thomas, C. Hazif-Thomas, *op. cit.*; M. Purchase, É.R. Thériault, B. Collicutt, *op. cit*.

Taken together, the literature suggests that ageism in care pathways is best understood not as a single event, but as a recurrent tendency for chronological age to become over-weighted at predictable decision nodes. The evidence is stronger in some domains than in others, and the mechanisms are not identical across specialties or settings. Even so, a consistent pattern emerges: when age is allowed to stand in for multidimensional assessment, decisions become less transparent, less individualised, and potentially less fair.

3.2. Evidence Production: Under-Inclusion of Older Adults and the External-Validity Gap

Ageism also shapes the production of medical evidence. Review-level literature documents the systematic under-representation of older adults in clinical trials, particularly among the very old and among those living with multimorbidity, frailty, disability, cognitive impairment, or residence in long-term care.[21] Additional reviews and policy analyses confirm the persistence of this pattern across research settings.[22] Systematic and umbrella reviews attribute these patterns to both explicit and implicit exclusion mechanisms, including upper age limits in some domains and restrictive eligibility criteria related to comorbidity, performance status, and polypharmacy.[23] Oncology provides a recurrent illustration of these dynamics.[24] Practical barriers and protocol burden, including travel demands, frequent visits, procedural load, and digital-only participation routes, further select for healthier and better-supported participants.[25] Similar exclusion has also been described in behavioural and prevention trials.[26]

Consent and decisional capacity constitute a specific pressure point in studies involving older adults, especially where acute illness, trauma, or cognitive impairment complicate recruitment and enrolment.[27] In such contexts, investigators may adopt "protective" exclusion strategies or gatekeeping practices in order to reduce ethical, procedural, or administrative complexity.[28] Protection from exploitation is plainly necessary; however, overly rigid interpretations of consent requirements can systematically exclude precisely those populations for whom evidence is most needed.[29] The result is a governance paradox: uncertainty is displaced from the research setting, where protocolised safeguards and monitoring exist, into routine

[21] S. Florisson *et al.*, *op. cit.*; J. He, D.R. Morales, B. Guthrie, *op. cit.*; M. Tang *et al.*, *op. cit.*; K. Szlezinger *et al.*, *op. cit.*
[22] A.P. Herrera *et al.*, *op. cit.*; L.E. Walker, M. Pirmohamed, *op. cit*.
[23] S. Florisson *et al.*, *op. cit.*; J. He, D.R. Morales, B. Guthrie, *op. cit.*; K. Szlezinger *et al.*, *op. cit.*; L.E. Walker, M. Pirmohamed, *op. cit.*
[24] L.E. Walker, M. Pirmohamed, *op. cit.*; C.A. Carmona-Gonzalez, M.T. Cunha, I.B. Menjak, *Bridging research gaps in geriatric oncology: Unraveling the potential of pragmatic clinical trials*, in *Current Opinion in Supportive and Palliative Care*, 18, 2024, 3-8; L. Biganzoli, M. Aapro, L. Balducci, D. Crivellari, A. Minisini, M. Piccart, *Adjuvant therapy in elderly patients with breast cancer*, in *Clinical Breast Cancer*, 5, 2004, 188-195.
[25] J. Withall *et al.*, *op. cit.*; T. Buttgereit *et al.*, *op. cit.*; M. Michelet, A. Lund, U. Sveen, *Strategies to recruit and retain older adults in intervention studies: A quantitative comparative study*, in *Archives of Gerontology and Geriatrics*, 59, 2014, 25-31; C. Hernandez-Torres, W.Y. Cheung, S. Kong, C.J. O'callaghan, T. Hsu, *Accrual of older adults to cancer clinical trials led by the Canadian Cancer Trials Group - Is trial design a barrier?*, in *Journal of Geriatric Oncology*, 11, 2020, 455-462.
[26] C. Hernandez-Torres *et al.*, *op. cit.*; B. Levy, J. Kosteas, M. Slade, L. Myers, *Exclusion of elderly persons from health-risk behavior clinical trials*, in *Preventive Medicine*, 43, 2006, 80-85.
[27] L. Swan *et al.*, *op. cit.*; A. Hosie *et al.*, *op. cit.*; J.S. Jensen *et al.*, *op. cit*.
[28] R.L. Van Bruchem-Visser *et al.*, *op. cit.*; A. Hosie *et al.*, *op. cit.*; J.S. Jensen *et al.*, *op. cit*.
[29] L. Swan *et al.*, *op. cit.*; L.E. Walker, M. Pirmohamed, *op. cit.*; J.S. Jensen *et al.*, *op. cit*.

practice, where clinicians must still make high-stakes decisions for complex older adults under less structured conditions.[30]

Even when older adults are included, the evidential base may remain only partially useful if endpoint selection is poorly aligned with later-life priorities.[31] Trials may privilege narrow biomedical or survival outcomes without adequately capturing domains that are often decisive for older patients, including functional status, maintenance of independence, symptom burden, and treatment burden. Reviews and policy-oriented analyses suggest that outcome-misaligned evidence can further weaken the practical value of guidelines for complex older populations.[32] Under these conditions, guideline extrapolation remains important but becomes more uncertain, particularly in patients who are highly multimorbid, frail, cognitively impaired, or socially vulnerable.[33]

These patterns may create a self-reinforcing loop. Limited generalisability encourages conservative practice, which may in turn slide into age-based proxy reasoning.[34] Conservative pathways then reduce incentives and infrastructure for inclusive evidence generation, thereby perpetuating the evidentiary gap.[35] Under-inclusion should therefore be understood simultaneously as a validity problem and as a justice problem, shaped not only by gatekeeping at the point of recruitment but also by broader choices concerning eligibility criteria, logistical accessibility, recruitment practices, and inclusion incentives.[36] From a geriatric perspective, this problem is especially serious because the populations most exposed to complex care decisions are often those least represented in the evidence base used to guide those decisions.[37]

4. Autonomy, Justice and Accountability in Age-Influenced Decisions

Ageism in healthcare is normatively significant because it can distort both the justification and the execution of clinical and organisational decisions. When chronological age is treated as a proxy for diminished benefit, diminished agency, or reduced entitlement to resources, decisions may appear prudent while resting on assumptions that have not been adequately individualised, discussed, or documented.[38] From a biolegal perspective, this distinction also has rights-sensitive implications: age-influenced healthcare and research decisions sit at the intersection of non-discrimination, the dignity and participation of older persons, access to care, respect for bodily integrity in biomedicine, and the requirement that medical treatment be grounded in free and informed consent.[39] The central task is therefore not to exclude age

[30] S. Florisson *et al.*, *op. cit.*; K. Szlezinger *et al.*, *op. cit.*; L.E. Walker, M. Pirmohamed, *op. cit.*

[31] S. Florisson *et al.*, *op. cit.*; J. He, D.R. Morales, B. Guthrie, *op. cit.*; B. Levy *et al.*, *op. cit*.

[32] A.P. Herrera *et al.*, *op. cit.*; L.E. Walker, M. Pirmohamed, *op. cit.*; J.S. Jensen *et al.*, *op. cit*.

[33] S. Florisson *et al.*, *op. cit.*; J.S. Jensen *et al.*, *op. cit*.; M. Wehling, *Critical extrapolation of guidelines and study results: Risk-benefit assessment for patients with reduced life expectancy and a new classification of drugs according to their fitness for the aged*, in M. Wehling (ed.), *Drug Therapy for the Elderly*, Vienna, 2013, 35-42.

[34] S. Florisson *et al.*, *op. cit.*; K. Szlezinger *et al.*, *op. cit*.; L.E. Walker, M. Pirmohamed, *op. cit.*

[35] S. Florisson *et al.*, *op. cit.*; K. Szlezinger *et al.*, *op. cit.*

[36] A.P. Herrera *et al.*, *op. cit.*; L.E. Walker, M. Pirmohamed, *The status of drug evaluation in older adults in the United Kingdom*, cit.; A. Hosie *et al.*, *op. cit.*; J.S. Jensen *et al.*, *op. cit*.

[37] S. Florisson *et al.*, *op. cit.*; J. He, D.R. Morales, B. Guthrie, *op. cit.*; L.E. Walker, M. Pirmohamed, *op. cit.*

[38] L.M. Joseph, *op. cit.*; R.L. Van Bruchem-Visser *et al.*, *op. cit*.; G. Ghilardi, F. De Micco, L.L. Campanozzi, *op. cit.*; S.M. White, *Ethical and legal aspects of anaesthesia for the elderly*, in *Anaesthesia*, 69, 2014, 45-53.

[39] Charter of Fundamental Rights of the European Union, in *Official Journal of the European Union*, C 326, 2012, 391-407, arts. 1, 3, 21, 25 and 35; Council of Europe, *Convention for the Protection of Human Rights and Dignity of the*

from reasoning, but to distinguish legitimate age-sensitive judgment from age-as-proxy shortcutting. This distinction is especially important in later-life care, where frailty, multimorbidity, cognitive vulnerability, care transitions, supported decision-making, and preference-sensitive choices frequently complicate clinical reasoning.[40] It is also relevant where ageism intersects with sexism and structural racism, thereby compounding disadvantage for older women and racially minoritised older adults.[41]

4.1. 4.1. Autonomy, Informed Consent and Supported Decision-Making

A first risk arises when clinicians presume reduced decisional capacity because of age. Decisional capacity is task-specific and time-specific; it cannot be inferred from chronological age, residence, dependency, or diagnostic labels. An age-based presumption may therefore narrow participation before any assessment has occurred, converting a question that should be examined in relation to the particular decision into a categorical judgment about older persons as a group.

A related risk concerns the confusion of sensory impairment with cognitive impairment. Hearing loss, visual limitations, fatigue, pain, or unfamiliar clinical environments may affect the patient's ability to receive and process information without demonstrating inability to decide. Autonomy-preserving practice requires accommodations: adequate time, clear speech, written summaries, assistive devices, quiet settings, and repeated opportunities to ask questions. These measures are not merely courtesy; they are preconditions for a valid and individualised consent process.

A further risk is the default displacement of the patient by relatives or carers as interlocutors. Family participation may be valuable and sometimes necessary, but it should not replace direct engagement with the patient unless there is a specific and documented reason. Speaking about the older person rather than with the older person risks treating age, dependency, or cognitive vulnerability as evidence of diminished agency. It also weakens the traceability of whether preferences, goals, and understanding were actually elicited from the person affected by the decision.

Another recurrent problem is informational narrowing. Older patients may be offered fewer options, less demanding explanations, or more directive recommendations when clinicians assume that some interventions are inappropriate, burdensome, or unwanted because of age. Such protective communication can be ethically misleading: it may present a narrowed clinical field as if it were the patient's own prefer-

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Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Oviedo, 4 April 1997, ETS No. 164; Italian Law 22 December 2017, No. 219, *Norme in materia di consenso informato e di disposizioni anticipate di trattamento*, in *Gazzetta Ufficiale della Repubblica Italiana*, No. 12, 16 January 2018.

[40] H.H. Hamdan Alshehri, C. Mcparland, H.A. Bahri, B. Johnston, *Spiritual and cultural influences on end-of-life care decision-making: A comparative analysis of the Arab Middle East and the United Kingdom*, in *Current Opinion in Supportive and Palliative Care*, 19, 2025, 242-247; T. Tannou, F. Gzil, S.P. Kennelly, J. Tournoy, V. Frisardi, P. Soysal, *How do geriatricians evaluate decision-making ability for older adults with cognitive impairment? Results from an European survey*, in *European Geriatric Medicine*, 14, 2023, 953-960; L.Y.W. Ho, E.W.Y. Kwong, M.S. Song, A. Kawakami, S. Boo, C.K.Y. Lai, N. Yamamoto-Mitani, *Decision-making preferences on end-of-life care for older people: Exploration and comparison of Japan, the Hong Kong SAR and South Korea in East Asia*, in *Journal of Clinical Nursing*, 31, 2022, 3498-3509; Y.-A. Shih, C. Wang, J. Ding, Y. Zhou, Q. Lu, *Cultural and ethical barriers to implementing end-of-life advance care planning among oncology nursing professionals: A content analysis of open-ended questions*, in *BMC Medical Ethics*, 26, 2025, 96.

[41] T.W. Farrell *et al.*, *op. cit.*; J.C. Chrisler, A. Barney, B. Palatino, *op. cit*.

ence. Shared decision-making in later-life care requires disclosure and deliberation calibrated to the patient's actual informational needs, communication profile, and goals, not to age-coded expectations.
Where cognition is impaired or fluctuating, supported decision-making is generally more defensible than automatic substitution. Support may include simplified explanations, staged conversations, involvement of trusted persons, timing discussions for periods of lucidity, and documenting the patient's values and expressed preferences. Autonomy is not exercised in isolation; it develops within the care relationship. Communication must therefore be tailored to the individuality and vulnerabilities of the person before the clinician. This mirrors clinical judgment itself: both good judgment and good communication require recognition of the singularity of the patient. Ageism in either domain obstructs an authentic care relationship because it prevents recognition of the older person in full complexity and specificity.[42]

4.2. Beneficence, Non-Maleficence and Proportionality in Later-Life Care

Beneficence and non-maleficence are implicated when age-based assumptions distort the benefit-harm appraisal. Under uncertainty, appeals to non-maleficence may be used to justify de-escalation, non-referral, reduced rehabilitation intensity, or exclusion from burdensome interventions.[43] That reasoning becomes ethically problematic when it relies on categorical age judgments rather than on explicit assessment of frailty, functional reserve, multimorbidity, treatment burden, realistic outcomes, and patient goals.[44] Conversely, a rigid equal-treatment approach may itself be harmful if it ignores multimorbidity interactions or the burdens imposed by intervention. The normative aim is therefore neither maximal treatment nor reflexive therapeutic restraint, but proportionate and goal-concordant care grounded in individualised assessment.[45]
Across these domains, proportionality remains a useful analytic heuristic. Where age or age-correlated criteria constrain access, escalation, rehabilitation, or research participation, a defensible decision should be articulable through a legitimate aim, a rational connection to measurable patient-level variables, consideration of feasible alternatives, and a balance between expected benefits and burdens. In this review, proportionality is retained as an ethical and legal-governance tool for transparency and accountability rather than as a jurisdiction-specific legal test.[46]

4.3. Justice, Non-Discrimination and Research Governance

Justice is engaged through both direct and indirect age-based disadvantage. Direct forms include explicit age cut-offs or categorical exclusions. Indirect forms arise when formally neutral rules, service configurations, pathway defaults, or rehabilitation and discharge practices predictably generate age gradients without adequate justification.[47] Comparable concerns arise in research when restrictive eligibility criteria, protocol burden, or conservative consent practices systematically exclude frail or cognitively impaired

[42] R.L. VAN BRUCHEM-VISSER *et al.*, *op. cit.*; L.S. BETHEA, A.L. BALAZS, *op. cit.*; K.N. WILLIAMS, *Improving outcomes of nursing home interactions*, cit.; L. SWAN *et al.*, *op. cit.*
[43] L.M. JOSEPH, *op. cit.*; R.L. VAN BRUCHEM-VISSER *et al.*, *op. cit.*; H.H. HAMDAN ALSHEHRI *et al.*, *op. cit.*
[44] R.L. VAN BRUCHEM-VISSER *et al.*, *op. cit.*; T.W. FARRELL *et al.*, *op. cit.*; T. TANNOU *et al.*, *op. cit.*
[45] H.H. HAMDAN ALSHEHRI *et al.*, *op. cit.*; T. TANNOU *et al.*, *op. cit.*; L.Y.W. HO *et al.*, *op. cit.*; Y.-A. SHIH *et al.*, *op. cit.*
[46] R.L. VAN BRUCHEM-VISSER *et al.*, *op. cit.*; T. TANNOU *et al.*, *op. cit.*
[47] K.R. HAASE *et al.*, *op. cit.*; L. FERNÁNDEZ-PUERTA *et al.*, *op. cit.*; T.W. FARRELL *et al.*, *op. cit* S. FLORISSON *et al.*, *op. cit.*

older adults.[48] A justice-oriented analysis therefore requires attention not only to equal treatment in the abstract, but also to reasonable accommodation, pathway design, and the distribution of burdens and opportunities across populations.[49]

Ageism acquires particular practical relevance because older adults are often treated in contexts where the evidential basis of care is weaker or only partially transferable. Review-level literature consistently documents the under-representation of older adults in clinical trials across major disease areas, particularly among the very old and among those living with frailty, multimorbidity, disability, cognitive impairment, or residence in long-term care.[50] This does not make evidence unusable, but it does increase the importance of showing how population-level recommendations were interpreted in relation to the individual case.[51]

In practice, the defensibility of care often depends on whether the record shows a transparent bridge between general evidence and the patient's actual condition. When age appears to have influenced a decision node–whether in triage, diagnostic escalation, therapeutic intensity, ICU admission, discharge destination, rehabilitation allocation, or trial enrolment–a defensible record should ordinarily make visible at least the patient's baseline function or frailty, comorbidity interactions, cognition and communication needs, treatment burden, realistic endpoints, patient values, and the alternatives considered. When these elements are absent, advanced age may begin to operate as a stand-alone rationale, making conservative management difficult to distinguish from proxy reasoning.[52]

Communication is especially important in this respect. When the patient is not addressed directly, when decision-making is displaced to relatives by default, or when capacity is presumed rather than assessed, disagreements about outcome may quickly become disagreements about whether the process was genuinely individualised and whether preferences were actually elicited. In this sense, documentation is not merely administrative; it is central to accountability, continuity, and retrospective evaluation of whether age-sensitive reasoning remained genuinely patient-centred.[53]

4.4. A Legal-Governance Framework for Evaluating Age-Influenced Decisions

To translate the normative analysis into a practical framework, age-influenced decisions may be examined through four sequential questions. This framework is intended as an ethical and legal-governance tool for analysing clinical and organisational decision-making, rather than as a formal legal test.

First, the decision node should be identified. Where, precisely, did the pathway diverge: at access or triage, diagnostics, therapeutic escalation, rehabilitation, discharge, consent, or trial eligibility? At the or-

[48] S. Florisson *et al.*, *op. cit.*; J. He, D.R. Morales, B. Guthrie, *op. cit.*; L.E. Walker, M. Pirmohamed, *op. cit.*; C.A. Carmona-Gonzalez, M.T. Cunha, I.B. Menjak, *op. cit.*

[49] R.L. Van Bruchem-Visser *et al.*, *op. cit.*; L. Fernández-Puerta *et al.*, *op. cit.*; T.W. Farrell *et al.*, *op. cit.*; L. Swan *et al.*, *op. cit.*

[50] S. Florisson *et al.*, *op. cit.*; J. He, D.R. Morales, B. Guthrie, *op. cit.*; M. Tang *et al.*, *op. cit.*; K. Szlezinger *et al.*, *op. cit.*

[51] S S. Florisson *et al.*, *op. cit.*; A.P. Herrera *et al.*, *op. cit.*; J.S. Jensen *et al.*, *op. cit*.

[52] R.L. Van Bruchem-Visser *et al.*, *op. cit*.; T.W. Farrell *et al.*, *op. cit.*; J.C. Chrisler, A. Barney, B. Palatino, *op. cit*.; T. Tannou *et al.*, *op. cit.*

[53] K.N. Williams, *Improving outcomes of nursing home interactions*, cit.; R.E. Herman, K.N. Williams, *Elderspeak's influence on resistiveness to care*, cit.; K.N. Williams *et al.*, *A communication intervention to reduce resistiveness in dementia care*, cit.; L. Swan *et al.*, *op. cit.*

ganisational level, this inquiry should also extend to pathway rules, service design, and recurring age gradients that suggest structural rather than purely individual mechanisms. This matters because ageism may be embedded not only in bedside decisions, but also in default rules, service availability, and pathway architecture.[54]

Second, a counterfactual comparator should be articulated. What would reasonably be expected for a patient with a comparable functional profile, comorbidity burden, cognitive status, and goals of care, but a different chronological age? This question makes explicit the equality problem that often remains hidden within age-influenced pathways and helps shift the analysis away from age categories and toward clinically relevant comparators.[55]

Third, the analysis should examine individualisation and justification. Was the decision anchored to measurable domains such as frailty, function, cognition, treatment burden, communication needs, and patient goals? Were feasible alternatives actually considered, or did chronological age function as a sufficient explanation in practice? Where relevant, this inquiry should also address supported decision-making, fluctuating capacity, and the influence of relational or cultural factors on preference-sensitive care.[56]

Fourth, traceability and governance should be assessed. Does the documentation show how the decision was reached? Do local rules, audit systems, pathway data, or service configurations reveal persistent age gradients relevant to the event under consideration? This final step matters because ageism may be structural. Pathway design, eligibility criteria, resource constraints, decision-support tools, and audit systems may all contribute to the production or persistence of age-related inequities. Evaluation should therefore not be confined to the conduct of an individual clinician alone.[57]

5. Beneficence, Non-Maleficence and Proportionality in Later-Life Care

Mitigating ageism requires system design rather than reliance on individual goodwill alone. Age-based proxy reasoning tends to emerge under conditions of time pressure, fragmented pathways, limited assessment infrastructure, and weak accountability for downstream age gradients. Because the risk is legal-governance as well as clinical, effective countermeasures should be understood as safeguards that make individualisation routine at predictable decision nodes and render pathway performance visible through age-stratified monitoring.[58] In practical terms, mitigation is a governance task: systems should be organised so that chronological age does not displace the measurable variables that ought to guide decisions, including frailty, function, cognition, treatment burden, communication needs, and patient goals.[59] Table

[54] P. Martínez-Angulo *et al.*, *op. cit.*; K.R. Haase *et al.*, *op. cit.*; L. Nemiroff, *op. cit.*; L. Fernández-Puerta *et al.*, *op. cit.*

[55] L. Fernández-Puerta *et al.*, *op. cit.*; T.W. Farrell *et al.*, *op. cit.*; P. Thomas, C. Hazif-Thomas, *op. cit.*; M. Purchase, É.R. Thériault, B. Collicutt, *op. cit*.

[56] R.L. Van Bruchem-Visser *et al.*, *op. cit.*; T. Tannou *et al.*, *op. cit.*; L.Y.W. Ho *et al.*, *op. cit.*; Y.-A. Shih *et al.*, *op. cit.*

[57] L. Fernández-Puerta *et al.*, *op. cit.*; T.W. Farrell *et al.*, *op. cit.*; P. Thomas, C. Hazif-Thomas, *op. cit.*; M. Purchase, É.R. Thériault, B. Collicutt, *op. cit*.

[58] L. Fernández-Puerta *et al.*, *op. cit.*; T.W. Farrell *et al.*, *op. cit.*; P. Thomas, C. Hazif-Thomas, *op. cit.*; M. Purchase, É.R. Thériault, B. Collicutt, *op. cit*.

[59] P. Martínez-Angulo *et al.*, *op. cit.*; K.R. Haase *et al.*, *op. cit.*; L. Fernández-Puerta *et al.*, *op. cit.*; T.W. Farrell *et al.*, *op. cit.*; J.C. Chrisler, A. Barney, B. Palatino, *op. cit*.

2 summarises the principal safeguards across clinical practice, organisational governance and research oversight.

Table 2 is proposed by the authors as an original evaluative framework derived from the analysis developed in this article. It is intended to make age-influenced decisions more transparent by linking each decision point to safeguards and documentation requirements.

Table 2. Legal-governance safeguards to reduce ageism in healthcare and clinical research involving older adults

Level / target	Safeguard and operational actions	Monitoring and legal-governance rationale
Clinical decision nodes (triage, escalation, discharge, rehabilitation)	Replace age proxies with structured individualised assessment: Routine frailty and functional screening; cognition and communication-needs check; multimorbidity and polypharmacy review; explicit goals-of-care note; structured benefit-burden appraisal including treatment burden	Monitoring: Triage and escalation rates; diagnostic intensity; procedure rates; rehabilitation allocation and intensity; discharge destination; readmissions; adverse events Legal-governance rationale: Makes reasoning more visible and defensible, reduces age-as-proxy shortcutting, and supports proportionate, patient-centred decision-making.
Communication and supported decision-making	Autonomy-preserving communication standards: Address the patient directly by default; avoid infantilising language; provide sensory accommodations; use written summaries when useful; document capacity assessment where relevant; document patient goals, preferences, and who participated in the discussion	Monitoring: Documentation completeness (capacity, goals, alternatives, participants in decision-making); complaints; consent-related disputes; patient-reported experience measures Legal-governance rationale: Supports autonomy, informed consent quality, dignity, and traceable patient participation in later-life care.
Pathway design and access	Remove direct and indirect age barriers: Eliminate unjustified upper age cut-offs; replace rigid age criteria with function- and risk-centred criteria; offer non-digital access routes; reduce logistical barriers such as transport burden and excessive visit requirements	Monitoring: Age gradients in access and eligibility; waiting times; pathway drop-off points; indicators of digital exclusion; service uptake Legal-governance rationale: Helps prevent indirect age-based disadvantage and supports accountable, equitable pathway design.
Care transitions (rehabilitation, community services, long-term care)	Goal- and function-centred discharge and rehabilitation planning: Standard triggers for rehabilitation assessment; explicit functional targets; reassessment schedules; avoid premature institutionalisation defaults when feasible community alternatives exist	Monitoring: Rehabilitation referral and intensity by age; home versus institutional discharge; functional outcomes; 30- and 90-day readmissions Legal-governance rationale: Reduces structurally embedded ageism in downstream pathways and supports continuity, function, and independence as meaningful geriatric outcomes.
Workforce and organisational culture	Competence-based training plus decision support: Training on hostile versus benevolent ageism; recognising proxy reasoning; shared decision-making skills; use of tem-	Monitoring: Uptake of decision aids and templates; staff adherence to communication standards; audit improvement over time Legal-governance rationale: Moves beyond generic awareness-raising

Level / target	Safeguard and operational actions	Monitoring and legal-governance rationale
	plates and checklists for high-stakes decision nodes	toward measurable practice change and strengthens organisational accountability.
Quality governance	Audit-feedback loops linked to corrective action: Define core indicators; routine dashboard review; case-mix-aware interpretation where feasible; pathway revision when persistent age gradients occur; escalation to governance committees when needed	Monitoring: Age-stratified dashboards for diagnostics, escalation, rehabilitation, outcomes, and consent/documentation quality Legal-governance rationale: Turns equity concerns into auditable governance processes and supports visible corrective action rather than passive monitoring alone.
Clinical research design and conduct	Inclusive-by-default trial design: Avoid unjustified exclusions; incorporate frailty or risk stratification where appropriate; reduce protocol burden; enable supported or proxy consent pathways where lawful and ethical; recruit from multimorbidity and long-term-care settings where feasible	Monitoring: Eligibility exclusion rates by age and frailty; recruitment and retention; adverse events; representativeness of enrolled populations; endpoints meaningful to older adults Legal-governance rationale: Improves external validity and reduces downstream uncertainty in the care of older adults.
Research oversight (ethics committees, sponsors, investigators)	Justification requirements and inclusion planning: Require explicit rationale for exclusions; require recruitment plans addressing foreseeable barriers; prespecify subgroup analyses where plausible effect heterogeneity exists; promote outcomes relevant to later life, including function and treatment burden	Monitoring: Whether approval conditions are met; protocol amendments; inclusion metrics reported; transparency of exclusion rationale Legal-governance rationale: Treats inclusion as both a validity issue and a justice issue, distributing accountability across research actors.

5.1. Clinical Safeguards

At the clinical level, the most important response to age-based shortcutting is the routine assessment of the domains for which age is often used as an unjustified surrogate. These include frailty and functional status, which are central to treatment calibration, rehabilitation planning, and discharge decisions, as well as cognition, communication needs, multimorbidity, treatment burden, and relevant social context. Embedding these domains into triage, escalation, discharge, and rehabilitation pathways reduces reliance on categorical assumptions and improves both fairness and clinical precision. This is particularly relevant in geriatric care, where the appropriateness of intervention often depends less on chronological age than on reserve, goals, and likely burden-benefit balance in the individual patient.[60]

Communication standards should support direct patient engagement, avoid infantilising language, provide sensory accommodations where needed, and document how preferences and goals were elicited.[61] Where cognition is impaired or fluctuating, supported decision-making should be treated as a structured

[60] P. Martínez-Angulo *et al.*, *op. cit.*; L. Fernández-Puerta *et al.*, *op. cit.*; T.W. Farrell *et al.*, *op. cit.*; J.C. Chrisler, A. Barney, B. Palatino, *op. cit*.

[61] L.S. Bethea, A.L. Balazs, *op. cit.*; M. Topaz, I. Doron, *op. cit.;* K.N. Williams, *Improving outcomes of nursing home interactions*, cit.

clinical requirement rather than as an optional courtesy.[62] Documentation tools are also useful where high-stakes decisions may otherwise rely on implicit assumptions.[63] Templates that record baseline function or frailty, benefit-burden reasoning, patient goals, alternatives considered, and criteria for reassessment can improve the visibility and traceability of reasoning in routine care.[64]

5.2. Organisational and Pathway Safeguards

Many age gradients are produced not by explicit exclusion, but by indirect disadvantage embedded in apparently neutral pathway rules and service configurations. These include digital-only access routes, transport burdens, rigid scheduling, and default assumptions about discharge or rehabilitation trajectories. Organisational mitigation therefore requires pathway redesign rather than generic awareness-raising alone. Unjustified age cut-offs should be removed, and rigid criteria should be replaced with function- and risk-centred criteria. Reasonable accommodations are also necessary so that access is not silently restricted for older adults who are frail, multimorbid, cognitively impaired, or socially disadvantaged.[65]

This is particularly important at care transitions, where rehabilitation intensity, discharge destination, and access to community services should reflect documented function and goals rather than age-coded expectations or resource-driven defaults. Because these downstream pathways are highly relevant to older adults, mitigation in geriatrics cannot stop at the point of diagnosis or acute treatment; it must also address what happens after the immediate event, including access to rehabilitation, continuity of care, and maintenance of independence wherever feasible.[66]

Age-stratified audit and feedback systems are essential if these problems are to become governable rather than anecdotal. Organisational monitoring should include indicators relating to diagnostic access, specialist referral, therapeutic escalation, rehabilitation allocation, discharge destination, outcomes, and documentation quality. Monitoring alone, however, is insufficient. To have preventive value, audit findings must be linked to corrective action, including revision of criteria, decision-support tools, staff training, and service reconfiguration. Where persistent age gradients remain visible without adequate case-mix justification, organisational accountability becomes salient because pathway defaults, documentation standards, and capacity constraints all shape the conditions under which clinical decisions are made. Workforce measures also matter, but they should be framed as competence-building rather than as generic exhortation. Training is most useful when it focuses on recognising proxy reasoning, distinguishing hostile from benevolent ageism, improving shared decision-making, and using structured prompts at high-stakes decision nodes. The relevant outcome is not awareness in the abstract, but measurable practice change over time.[67]

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[62] R.L. Van Bruchem-Visser *et al.*, *op. cit.*; L. Swan *et al.*, *op. cit.*

[63] R.L. Van Bruchem-Visser *et al.*, *op. cit.*; G. Ghilardi, F. De Micco, L.L. Campanozzi, *op. cit.*; H.H. Hamdan Alshehri *et al.*, *op. cit.*

[64] G. Ghilardi, F. De Micco, L.L. Campanozzi, *op. cit.*; M. WEHLING, *op. cit.*; H.H. Hamdan Alshehri *et al.*, *op. cit.*

[65] P. Martínez-Angulo *et al.*, *op. cit.*; L. Fernández-Puerta *et al.*, *op. cit.*; T.W. Farrell *et al.*, *op. cit.*; P. Thomas, C. Hazif-Thomas, *op. cit.*

[66] K.R. Haase *et al.*, *op. cit.*; L. Fernández-Puerta *et al.*, *op. cit.*; T.W. Farrell *et al.*, *op. cit.*

[67] K.R. Haase *et al.*, *op. cit.*; P. Thomas, C. Hazif-Thomas, *op. cit.*; M. Purchase, É.R. Thériault, B. Collicutt, *op. cit.*; J.C. Chrisler, A. Barney, B. Palatino, *op. cit*.

5.3. Research Governance Safeguards

Inclusive evidence production should itself be understood as a mitigation strategy. The under-inclusion of older adults weakens external validity and shifts uncertainty into routine care.[68] It also raises concerns of justice, because the populations most exposed to complex clinical decisions may be those least represented in the evidence base.[69] Operational priorities therefore include revising restrictive eligibility criteria, eliminating unjustified upper age limits, reducing protocol burden, enabling non-digital participation routes, and selecting endpoints that are meaningful in later life.[70] Particularly important outcomes include function, maintenance of independence, symptom burden, and treatment burden.[71]

Particular attention is required for consent and enrolment procedures in populations with cognitive impairment, frailty, or residence in long-term care.[72] Overly rigid or purely defensive consent practices may function as gatekeeping mechanisms that exclude precisely those groups for whom evidence is most needed.[73] Research governance should therefore support lawful and ethically robust pathways for supported or proxy consent where appropriate, while avoiding the automatic displacement of older adults from research because of anticipated complexity.[74] Trial designs should also recruit from settings more representative of real-world older populations, including multimorbidity and long-term-care contexts where feasible.[75] Responsibility in this area is distributed rather than individual. Sponsors, investigators, ethics committees, and regulators all influence whether inclusion is treated as optional rhetoric or as a real feature of study quality.[76] Monitoring should extend beyond crude enrolment counts to include exclusion rates by age and frailty, recruitment and retention patterns, adverse events, protocol amendments, and the reporting of inclusion metrics. In this way, representational equity becomes a measurable feature of research quality rather than an aspirational statement in study protocols.[77]

The proposed safeguards should not be treated as a single homogeneous category. Some measures can be implemented directly at the point of care: autonomy-preserving communication, sensory accommodations, direct engagement with the patient, documentation of capacity, goals and preferences, and multidimensional assessment at high-stakes decision nodes. These measures also have the closest connection to evaluated communication-focused interventions in older-adult settings. Other safeguards depend on institutional governance: pathway redesign, age-stratified audit, dashboard monitoring, inclusive-by-default research governance, ethics-committee justification requirements, sponsor and investigator accountability, and monitoring of exclusion metrics. These measures rest on convergent empirical and normative reasoning, but generally require organisational design and evaluation rather than bedside imple-

[68] S. Florisson *et al.*, *op. cit.*; J. He, D.R. Morales, B. Guthrie, *op. cit.*; K. Szlezinger *et al.*, *op. cit.*; A.P. Herrera *et al.*, *op. cit.*

[69] S. Florisson *et al.*, *op. cit.*; A.P. Herrera *et al.*, *op. cit.*; L.E. Walker, M. Pirmohamed, *op. cit.*; J.S. Jensen *et al.*, *op. cit*.

[70] S. Florisson *et al.*, *op. cit.*; J. He, D.R. Morales, B. Guthrie, *op. cit.*; L.E. Walker, M. Pirmohamed, *op. cit.*; C.A. Carmona-Gonzalez, M.T. Cunha, I.B. Menjak, *op. cit.*

[71] J. He, D.R. Morales, B. Guthrie, *op. cit.*; L.E. Walker, M. Pirmohamed, *op. cit.*; J.S. Jensen *et al.*, *op. cit*.; . Levy *et al.*, *op. cit*.

[72] L. Swan *et al.*, *op. cit.*; A. Hosie *et al.*, *op. cit.*; J.S. Jensen *et al.*, *op. cit*.

[73] R.L. Van Bruchem-Visser *et al.*, *op. cit*.; A. Hosie *et al.*, *op. cit.*; J.S. Jensen *et al.*, *op. cit*.

[74] R.L. Van Bruchem-Visser *et al.*, *op. cit*.; L. Swan *et al.*, *op. cit.*; J.S. Jensen *et al.*, *op. cit*.

[75] S. Florisson *et al.*, *op. cit.*; L.E. Walker, M. Pirmohamed, *op. cit.*; T. Buttgereit *et al.*, *op. cit.*

[76] A.P. Herrera *et al.*, *op. cit.*; L.E. Walker, M. Pirmohamed, *op. cit.*

[77] S. Florisson *et al.*, *op. cit.*; A.P. Herrera *et al.*, *op. cit.*; L.E. Walker, M. Pirmohamed, *op. cit.*; J.S. Jensen *et al.*, *op. cit*.

mentation alone. Separating the two levels improves practical guidance and avoids presenting all anti-ageism measures as equally tested or equally immediate.[78]

6. Conclusion

Ageism in healthcare and clinical research should be understood as a multi-level phenomenon that affects care pathways, communication practices, and the evidential foundations of medicine. Across the literature synthesised in this structured narrative review, a recurrent mechanism emerges: chronological age is repeatedly allowed to stand in for clinically and ethically relevant dimensions of heterogeneity, including frailty and functional status, cognition and communication needs, multimorbidity, treatment burden, and patient goals. When this occurs, age no longer functions as one relevant element within individualised assessment, but as a proxy that may narrow options, weaken participation, and reduce the transparency of decision-making.

This review also shows that ageism is not confined to bedside interactions. It may be reproduced through pathway design, communication norms, rehabilitation and discharge defaults, and the persistent underrepresentation of older adults in clinical research. This latter problem is especially important in geriatric care. When frail, multimorbid, cognitively impaired, or long-term-care populations remain poorly represented in trials, uncertainty is displaced into routine practice, where clinicians must still make high-stakes decisions for the very patients least well represented in the evidence base.

Several practical implications follow. First, multidimensional assessment should be routine at high-stakes decision nodes, particularly in relation to triage, escalation, discharge, rehabilitation, and trial eligibility. Second, communication standards and supported decision-making practices should be treated as core components of quality geriatric care rather than as optional relational refinements. Third, organisational pathways should be reviewed for direct and indirect age barriers, especially where persistent age gradients are visible in access, rehabilitation, transitions of care, or consent-related processes. Fourth, inclusive research governance should be recognised as both a validity issue and a justice issue, with greater attention to eligibility criteria, protocol burden, consent pathways, and outcomes meaningful in later life.

This review has limitations. As a structured narrative synthesis spanning heterogeneous empirical, conceptual, bioethical, and governance-oriented sources, it does not provide pooled effect estimates and cannot eliminate the interpretive variability inherent in mixed normative-empirical integration. In addition, the strength of available evidence is uneven across domains and specialties, and the implications discussed should be interpreted with awareness of variation across healthcare systems and institutional settings.

Even with these limitations, the central implication remains clear. Chronological age is not a shortcut. In contemporary geriatric care and older-adult research, preventing ageism requires systems that make reasoning more individualised, more transparent, more rights-sensitive, and more accountable across the full pathway from access to evidence generation.

[78] K.N. Williams *et al.*, *Moving Online*, cit.; K.N. Williams *et al.*, *Promoting elderspeak awareness*, cit.; K.N. Williams, N.H. Abd-Hamid, Y. Perkhounkova, *Transitioning communication education to an interactive online module format*, in *Journal of Continuing Education in Nursing*, 48, 2017, 320-328.