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Illness Severity and Moral Obligation: A Philosophical Inquiry into Intensive Care for the Oldest Patients

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Abstract

Intensive care for extremely elderly patients is expanding rapidly because of population aging and a trend toward more aggressive therapies. Yet, such care often delivers only marginal benefits for the oldest individuals, many of whom end up dying after lengthy periods of organ support. Taking a clinical perspective, this study examines the forces driving the growing use of critical care in advanced age, even though its potential drawbacks for patients, families, clinicians, and society are widely acknowledged. A theoretical examination of how the medicalization of aging and dying influences intensive care delivery for very old patients, using Ian Hacking's notions of human kinds, interactive kinds, and natural indifferent kinds as the guiding philosophical lens. Age-related bodily changes heighten the risk of developing critical illness and of dying from it. However, age by itself is not considered a disease — despite some recent attempts to classify it as such. Seeing advanced age as a human, interactive kind accounts for the medicalization of aging and dying as an ongoing, self-sustaining cycle. Labeling the natural course of aging and dying as diseases creates a strong moral pressure to offer life-prolonging treatments to very old patients, irrespective of the doubtful net benefit. As a result, sticking strictly to this medically framed connection between illness severity and treatment intensity generates far greater uncertainty in clinical decision-making for elderly patients in intensive care units than for younger ones. Delivering appropriate care to very old patients with critical illness requires a broader clinical framework in which philosophical ideas and social theories enrich and extend purely medical and scientific understanding.

Keywords: Aged, 80 and over, Critical care, Frailty, Death, Medicalization

Introduction

A robust, independent 86-year-old widower and farmer with no known prior medical issues or medications was admitted to the hospital with a large bowel obstruction caused by a mass. The on-call surgeon confirmed the diagnosis and planned emergency surgery. After several days of vomiting before arrival, the patient had developed major disturbances in his blood electrolytes and fluid balance. He was therefore admitted to the intensive care unit for preoperative stabilization. As the intensivist on duty, I met an alert, oriented, and cooperative elderly man who was extremely thankful for the relief of his nausea, vomiting, and abdominal pain. When the surgeon returned to obtain consent, the patient openly declared that he wished to decline the operation. The surgeon tried to convey that an underlying malignancy was probable and to stress the serious risks of refusing urgent surgery. At that moment, the patient grabbed his slipper, hurled it at the surgeon, and said: "Leave me alone, I am tied up with dying. I am not ill, and I don't need a doctor. I am only asking for a quiet space to die the death I am meant to die." After a brief multidisciplinary discussion, the patient's decision to forgo treatment was accepted, and the medical team's responsibility to preserve life was set aside.

The key element driving the ethical conflict in this scenario appeared to be the patient's advanced age.

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This case demonstrates the clear distinction between two of the three concepts of human suffering — disease and illness — and the contrasting perspectives they create for the same problem [1, 2]. Medically, there was unmistakable evidence of disease, a diagnosis was established, and an effective surgical option existed with strong prospects of at least short-term success. The clinician in charge may even have felt a duty to intervene given the emergency nature of the situation and the limited time for reflection. However, the patient did not view his situation as an illness; instead, he saw it as his personal journey toward death and asserted his basic right to a peaceful, dignified ending. Unlike many frail elderly patients in critical condition, he still possessed full mental capacity. He could clearly voice his preferences but felt he had to resort to forceful measures to ensure the care he received aligned with his life goals. The third angle — the societal perspective — is less immediately visible yet provides the broader backdrop for the ethical tension felt by everyone involved.

This essay seeks to analyze the outcomes of an expanding societal practice that increasingly treats aging and dying in later life as medical disorders, with particular attention to the role of intensive care for very old patients.

Background and framework

"In what manner is the arena of feasible and real conduct shaped, not merely through tangible and societal obstacles or prospects, but equally through how we frame and enact our identities and potential selves in the present moment?" Ian Hacking [3].

The Canadian philosopher and Holberg Prize recipient Ian Hacking (1936–2023) formulated the notions of 'making up people', dynamic nominalism, and the looping effect. While his primary focus was on mental illness, these ideas extend well beyond that domain. 'Making up people' captures how the options available to individuals are constrained by what society can envision and by the labels applied to them. Assigning categories to people is an evolving, back-and-forth process in which the labels and the individuals they describe continually influence one another — a phenomenon Hacking labeled dynamic nominalism. He distinguished human 'interactive' kinds from natural 'indifferent' kinds because the former actively respond to being classified. The ongoing cycle in which a description of a human category modifies the people it covers, thereby justifying updated classifications, is known as the looping effect [3-5].

Roughly one in five patients admitted to Western intensive care units (ICUs) are very old (here, older than 80), and this segment is increasing at a pace that outstrips simple demographic shifts. The rise is largely attributable to more forceful interventions now being extended to this group [6, 7]. Even so, the advantages of ICU admission for this sizable population remain debated [8, 9], and ICU admission carries a substantial risk of excessive treatment that can cause significant harm to patients, their relatives, and the broader community [10]. Clinicians who deliver intensive therapies of doubtful value to very old patients frequently describe a sensation of being steered by invisible underlying pressures they cannot easily master [11]; similar feelings are often reported by patients and families alike [12]. This impression of autonomous, self-reinforcing mechanisms indicates that Hacking's insights into interactive human kinds, the creation of people through classification, dynamic nominalism, and the looping effect, could serve as a productive framework for exploring how the medicalization of aging and dying takes shape and impacts elderly individuals, the closing phase of their existence, and the nature of their passing.

Results and Discussion

Is age a disease?

Crafting a precise definition of disease poses an enduring challenge for academics, decision-makers, clinicians, and ordinary citizens [13, 14]; some contend that pursuing such a definition may even be futile or deceptive [15]. In numerous instances, consensus emerges easily on statements like "X constitutes a disease" or "Y does not," no matter which theoretical lens is applied. The real complications arise in the hazy territory separating health from disease, where the absence of a universally accepted definition stands out. Nevertheless, the majority of commentators concur that a disease involves a detrimental or, at a minimum, unwelcome departure from typical biological architecture or function.

Age alone does not automatically inflict harm, and judgments about its desirability hinge predominantly on the cultural environment surrounding the experience of growing older. Western cultures, with their pervasive emphasis on youthful appearance and flawlessness, often attach negative meanings to aging. This mindset spurs demands for solutions intended to delay or reverse the process. In certain Eastern and African traditions,

however, advanced age may be celebrated as a reward of extended life, a mark of distinction and liberation from youthful obligations, and a repository of accumulated insight rather than a collection of shortcomings.

In day-to-day medical settings, either viewpoint can spark an eagerness for sophisticated therapies when sudden life-threatening illness strikes very old patients. Low- and middle-income nations often display an even stronger tendency toward excessive intervention for elderly individuals — above all those regarded with great esteem — in intensive care settings [16]. Within European countries as well, the aggressiveness of care delivered to very old ICU patients frequently shows an inverse relationship with national GDP per capita [17].

Deciding whether aging qualifies as a departure from standard bodily performance relies on the benchmark population selected. Aging represents a shared outcome of existence itself, with its underlying biological shifts commencing during fetal development [18]. Dying before reaching old age is generally traceable to conditions unambiguously labeled as disease, impairment, or injury; consequently, attaining advanced age functions more as an indicator of successful health than as a marker of pathology.

That said, the steady erosion of physiological capacity renders the very old particularly susceptible to illness and disability. It also elevates the likelihood of enduring functional decline and other adverse results after an acute health crisis or injury. Conditions typical of geriatric medicine, such as frailty, appear most frequently in the very old, although they are not confined exclusively to later life. The elevated health risks associated with an aging population drive up overall healthcare utilization. Healthcare services, in turn, make a modest contribution to longevity gains. In light of the evident association between greater age and heightened healthcare demands, I maintain that aging merits classification as a risk factor, rather than as a disease in and of itself.

How did age become a disease anyway?

The view expressed earlier — that age by itself does not constitute a disease — is widely shared among clinicians, policymakers, and the general public [19, 20]. For the 11th revision of the International Classification of Diseases (ICD), the World Health Organization suggested replacing the ICD-10 code R54 “senility” with the new code MG2A “old age”. This proposal was later withdrawn following strong objections from a wide range of interested parties, and was replaced by the extension code XT9T “aging-related” [21].

The creation of new disease categories and the setting of treatment thresholds are strongly shaped by competing interests of a financial, intellectual, and reputational nature [22-24]. In 2024, the global anti-aging and longevity markets were each estimated to be worth between $20–60 billion USD (compared with the United Nations annual budget of $3.6 billion USD), with projected annual growth exceeding 6%. Major pharmaceutical companies play a central role in these sectors. Moreover, the bulk of scientific research into physical and mental aspects of aging is conducted within the medical field. Together, these powerful drivers push the concept of aging deeper into the domain of healthcare and channel resources in the same direction.

Geriatric medicine is a relatively recent specialty. In many countries, formal training programs were only established less than 20 years ago [25]. This development has clearly brought advantages to very old patients by providing them with more comprehensive, whole-person medical care. These individuals often present with intricate, interconnected conditions affecting multiple organ systems, closely tied to broader aspects of their overall well-being. As a result, they face a heightened risk of receiving fragmented or insufficient care within today’s highly specialized, single-organ-focused, guideline-driven healthcare systems [26]. However, this vulnerability is not limited to the very old. Other groups with complex needs — such as patients with multiple traumas or substance use disorders — also gain from dedicated, holistic professional support.

Frailty, a geriatric syndrome that reflects underlying biological aging processes, has now been formally classified as a disease in ICD-11 under the code MG2A, described as “aging-associated decline in intrinsic capacity”. In an effort to avoid ageism, age has been reframed in biological rather than chronological terms. Consequently, through this frailty-labeled entry point, aging has formally entered the medical domain as a disease in the 11th revision of the ICD, propelled by strong financial, intellectual, and reputational incentives. From my perspective as an intensivist, even biological age, when understood through the lens of frailty, remains a risk factor rather than a disease [27]. As one observer noted, “the growing emphasis in medicine on detecting and altering risk factors can bring real advantages for individuals and public health, yet it also harbors genuine

dangers, chief among them the medicalization of ordinary life" [28].

Social constructionists maintain that biological understandings of disease are shaped through social negotiation. They argue that "if a condition counts as a disease in the social sense, we instantly recognize that the affected individuals merit special attention" [29]. The reverse, however, does not necessarily hold. Although there exists widespread societal consensus that older people deserve particular consideration, this does not logically lead to the conclusion that age itself should be labeled a disease and managed within the medical system. Very old individuals may warrant special attention because of their lifetime contributions to society, their accumulated wisdom and perspective, or due to established cultural and social expectations. In the words of Ian Hacking: "We must first address the purpose of social construction analyses. Do not inquire after the meaning — inquire after the point" [5].

Understanding very old age as an interactive, human kind – the medicalization of aging

The categories that Ian Hacking describes as human kinds are inherently value-laden. They carry a built-in expectation of assistance or cure, in contrast to indifferent natural kinds. "Classifying people influences people, alters them, and can even reshape their past. The process continues. The individuals belonging to that kind are themselves transformed. As a result, we — the specialists — are compelled to reconsider our classifications" [4]. The idea that age categories function as interactive kinds has been put forward in recent years [30].

Very old people are emerging as the prominent human kind of the 2020s, a development amplified by debates around ageism that intensified during the COVID-19 pandemic [21]. Drawing on Ian Hacking's framework, a cutting-edge humankind is marked by expert professional societies that investigate their conditions, regular academic conferences, and dedicated scientific journals. These journals both receive contributions from the experts and, in turn, help define who those experts are. This raises an important question: are we failing to support the very old "because all our efforts proceed on the assumption that we are handling a purely scientific kind? There exists a genuine tension here, since one major direction in research on human kinds is to biologize them. This drive ranks among the most potent themes in scientific thinking. Its achievements have filled us with confidence. We place enormous faith in its promise" [4].

Framing the lived experience of advanced age in biological terms accelerates its medicalization. At the same time, powerful influences lead us to believe that medical interventions can relieve our difficulties. Medicalization refers to the process by which everyday human challenges or experiences are redefined and managed as medical issues, typically framed as illnesses, diseases, or syndromes [23, 31]. As greater medical focus is placed on the challenges of aging, resources are increasingly diverted from other areas of life. This shift, in turn, alters how very old people themselves perceive and experience advanced age in daily life, as well as how society around them responds to them. One of the most concerning consequences is that "medicalization promotes medical answers while sidelining or minimizing the social dimensions of complex issues" [23, 32].

How much greater improvement in health for the very old population might be achieved by channeling more resources toward combating loneliness, addressing the disadvantages of reduced pace in a fast-moving analog and digital world, and reducing the stigma attached to frailty?

Diagnosing frailty and the looping effect – the medicalization of dying

Frailty involves the gradual loss of physical reserves that comes with aging, affecting both muscle and bone strength and the function of major internal organs. Reduced function in solid organs may go unnoticed during daily activities, yet it surfaces quickly when the body faces the strain of a sudden, serious illness. This progressive weakening forms a continuous path leading toward death. Consequently, in severely frail individuals, even a mild illness or seemingly trivial injury can trigger a dangerous cascade of deterioration. When medical attention in such situations focuses exclusively on the total of measurable physical abnormalities and listed diagnoses, death is framed as the final stage of widespread organ failure. This stands in stark contrast to how many very old patients themselves may view their situation — for instance, as simply being "full of days." The first description carries strongly negative and value-laden overtones, whereas the second evokes a sense of fulfillment and calm acceptance.

Ian Hacking points out that "biologizing human kinds does not shield them from looping effects […] because

the people in that category start behaving differently and therefore become different. In other words, the category itself evolves, creating fresh causal understanding while possibly discarding earlier insights. […] Groups of specialists now work together and identify themselves collectively as 'helping professionals'[…]" [4]. Being labeled as frail changes how very old individuals see their own condition, shapes the decisions they make about daily living, and influences the way society interacts with them. Heightened medical involvement with aging populations can intensify this looping process by introducing additional negative effects of healthcare itself — particularly the harms of multiple medications, reduced mobility, anxiety, and mental confusion.

In 1974, the Austrian priest, philosopher, and social critic Ivan Illich presented his critique titled "Medical Nemesis." What once appeared as a dark, exaggerated warning has turned into an increasingly accurate forecast: "Health […] refers to the capacity to adjust to shifting surroundings, to mature and to grow old, to recover from injury, to endure suffering, and to face death with tranquility. […] A person's conscious awareness of vulnerability, uniqueness, and connection to others turns the realities of pain, illness, and death into essential elements of existence. The power to handle this triad with self-determination lies at the heart of true health. […] The genuine marvel of contemporary medicine is profoundly troubling. It enables not only single persons but entire populations to persist at appallingly low levels of genuine personal health" [33].

His contemporary, the English priest and moral theologian Gordon Dunstan, voiced comparable worries in gentler language when addressing the British Society of Intensive Care in 1984: "The achievements of intensive care should therefore not be judged solely by survival statistics, as if every death represented a defeat for medicine. Instead, success should be assessed by the quality of the lives that are saved or restored, by the quality of the dying for those for whom death is the appropriate outcome, and by the quality of the human connections surrounding each death" [34]. These remarks went largely unheeded during the subsequent four decades of intensive care expansion and routine practice. The majority of studies in the field continue to prioritize mortality reduction as the main endpoint. Despite the large number of patients who die in intensive care units, the standard of support provided to dying patients and their families receives scant attention in research, everyday clinical work, or health system oversight [35]. Very old patients are often excluded from major intensive care trials. When they are included, studies rarely consider that these individuals might regard death as a more acceptable result than prolonged survival marked by total dependence [36].

In critically ill, very old patients, clinical attention is overwhelmingly focused on correcting the disrupted physiology of the weakened body, while largely overlooking other important aspects of human welfare. The involvement of intensive care in the final days of life for very old patients has grown dramatically, surpassing 50% in certain Western hospital settings [37]. Many of these patients ultimately die in intensive care units after extended periods of invasive organ support [9], as though death were merely an "industrial mishap" [38]. Although death announcements often portray the person as "dying peacefully surrounded by loved ones," the experience of dying while connected to machines and receiving aggressive organ support in an intensive care unit is markedly different. Beyond the direct harm inflicted on patients, families, and society, the delivery of what feels like pointless care also contributes heavily to interpersonal conflicts, moral distress, burnout, and high staff turnover among intensive care professionals [11].

Illness severity and the moral imperative to deliver lifesaving medical care

"… care is more and more guided by standardized protocols that aim to reduce uncertainty. Modern research on complex systems demonstrates that cause and effect are rarely straightforward, yet doctors and healthcare organizations continue to promote overly simple explanations […]. How many patients [and doctors] truly grasp the numbers-needed-to-treat they find themselves entangled in?" Iona Heath [39].

Hannah Wunsch, an American epidemiologist and intensivist, employed Frank-Starling curves to illustrate the connection between the scale of intensive care services and their broader impact on society. She examined how excessive provision of intensive care might harm society, likening it to the heart "falling off the Frank-Starling curve" when overfilled, leading to declining cardiac performance [40]. Comparable patterns seem to apply to individual patients in intensive care as well, with the curves for older patients reaching their maximum at lower levels of treatment intensity.

Ian Hacking noted that "the stronger the moral weight attached to a human kind, the greater its susceptibility to the looping effect" [4], and this observation appears particularly relevant to frailty. A powerful moral duty is linked to the severity of illness [41], creating an obligation to attempt life-saving measures even when the personal and societal costs are substantial. I propose conceptualizing the relationship between illness severity and treatment intensity using a similar set of curves **(Figure 1).** At a certain stage of escalating treatment, each patient reaches a saturation point, beyond which further intervention causes more harm than good. The blue curve (A) represents a young, previously healthy patient facing critical illness. Only at the outermost limits of physiological collapse, and when treatment is almost certainly ineffective, is the clinician freed from the responsibility to preserve life, allowing organ support to be withheld or stopped. The shaded zone indicates the area of decision-making uncertainty, which tends to be narrow for young patients without pre-existing conditions, no matter how severe the crisis. For very old patients, an entire family of orange curves (B) applies, varying according to their baseline physical reserves and individual treatment preferences. These curves often rise more sharply because the frail body may require organ support at lower levels of illness severity, and they typically peak sooner, when the drawbacks of aggressive therapy begin to outweigh any gains. The shaded area of decisional uncertainty is therefore considerably wider. Drawing on the looping effect described earlier, I suggest that framing aging as a disease shifts the curve for very old patients upward and to the left while slowing its decline (green curve B*). This illustrates how more intensive treatments are being offered to very old intensive care patients without fresh scientific data showing improved outcomes. The change also substantially enlarges the zone of related decision-making uncertainty **(Figure 1).**

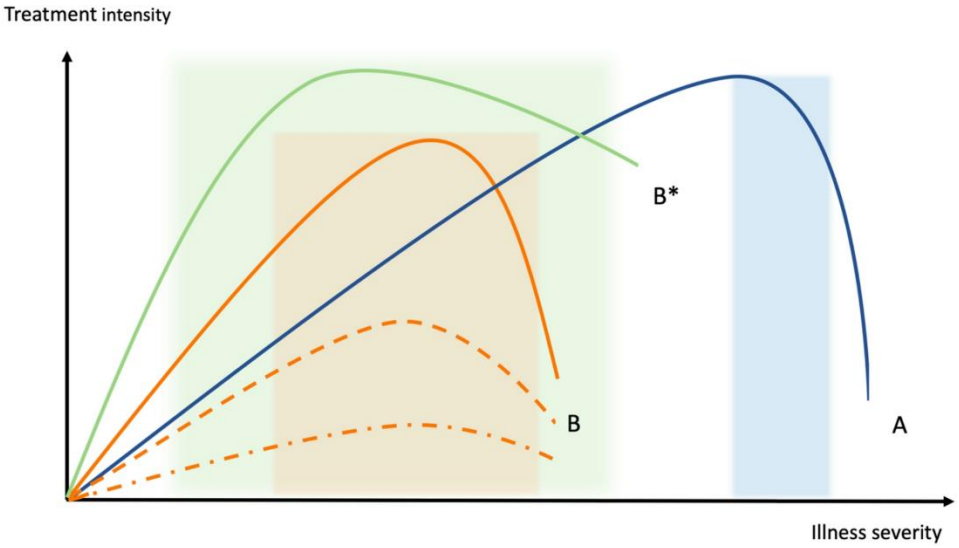

Figure 1. Schematic diagram of the relationship between illness severity and treatment intensity in ICU populations. The blue curve (A) corresponds to a typical life-threatening condition in a young, previously healthy patient, peaking at very high levels of illness severity. Older patients experiencing acute critical illness are represented by a family of orange curves (B) due to the marked diversity within this group. The green curve (B*) shows the impact of treating age-related loss of organ function as equivalent to acute organ failure, resulting in greater treatment intensity. The shaded areas under the curves indicate the range of uncertainty regarding appropriate treatment intensity. From: Intensive care of the very old – questioning the relationship between illness severity and the moral imperative to deliver life-saving care

Reducing a patient's presenting condition to its most essential elements and simplifying it is a routine habit in everyday medical work [42]. We might inquire about the survival statistics associated with the diagnosis given to the very old patient in the introductory case and then build a logical case linking that diagnosis to the medically most aggressive recommended treatment. In doing so, we often fail to consider the full complexity of

the circumstances that led the patient to seek medical attention. The ongoing reduction in physical reserves and organ performance not only heightens the vulnerability of the very old patient during critical illness, but it can also be understood and personally experienced as part of a steady, natural progression of the aging and dying body, in which the immediate diagnosis plays only a limited part.

Concluding remarks

"Ideas have real-world effects – the way we categorize something inevitably shapes how we act toward it," [43]. Viewing age as a disease brings a wide range of outcomes, some advantageous and others detrimental. I have contended that, for very old patients experiencing sudden critical illness that might require intensive care admission — particularly when nearing the end of life — the negative effects are likely to outweigh the positive ones. When this broadening of the disease concept heightens suffering, the resulting damage extends far beyond the individual patient. It does so by "eroding the foundations of medicine and weakening its most valuable resource: public confidence" [44].

The bodily disturbances caused by acute illness can be regarded as a natural kind open to investigation by the natural sciences. Nevertheless, the deeper forces behind the expansion of intensive care demand examination through additional lenses. Hacking's framework offers one useful approach among several for analyzing and clarifying the healthcare environment and the mechanisms operating within it. Providing appropriate care to a critically ill, very old patient requires a more complete understanding of the patient's overall situation and the influences shaping clinical choices.

The British general practitioner and author Iona Heath captures the interconnected pressures contributing to the growing shortcomings of contemporary healthcare: "The three currents of industrializing health services, medicalizing everyday existence, and politicizing medical practice are closely linked and strengthen one another. Each one relies on the illusion that we possess far greater certainty than we actually do" [39].

Up to now, across every domain of medicine — including education, research, day-to-day clinical work, health system management, and interactions with patients and the wider public — there has been insufficient recognition of a key reality: medicine is not solely a natural science. It is equally shaped by insights arising from the social and human sciences. Failing to adopt a far more inclusive perspective leaves both patients and healthcare professionals with an uneasy sense of being subject to hidden, uncontrollable forces. This produces an increasingly acute feeling of uncertainty and helplessness when confronting critical illness in advanced age.

Conclusion

Delivering appropriate care to very old patients with critical illness requires a broader clinical framework in which philosophical ideas and social theories enrich and extend purely medical and scientific understanding.

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