„Teologia i Moralność", Volumen 20 (2025), numer 3 (40), s. 145–154
ISSN 1898-2964 eISSN 2450-4602
DOI: 10.14746/TIM.2025.40.3.9

# Ethics of working with the elderly

## Etyka pracy z osobami starszymi

Jarosław Czepczarz
Assistant Professor Academy of Social Sciences,
Academy of Management and Administration in Opole, Poland
Head of the Rehabilitation Department for organization Opole Rehabilitation Center in Korfantow
jczepczarz@tlen.pl
https://orcid.org/0000-0002-9307-2438

Agata Czepczarz
Sixth – year medical student at the University of Opole, Poland
aczepczarz@tlen.pl
https://orcid.org/0000-0003-0870-7986

**Abstract:** Contemporary demographic challenges, associated with a rapidly aging population, make it necessary for the medical community and the health care system to redefine ethical standards in working with the elderly. This paper attempts a multifaceted analysis of key ethical issues in the context of geriatric care, taking into account not only the fundamental principles of bioethics, but also the challenges posed by cognitive limitations, communication problems and the specifics of terminal care. Particular emphasis is placed on respecting patient autonomy, countering futile therapy and the need to develop interpersonal competence in the patient-medical staff relationship. The article is a voice in the discussion of the need to humanize modern geriatric medicine, advocating a model of care based on empathy, justice and human dignity in every phase of life.

**Keywords:** ethics; elderly

**Abstrakt:** Współczesne wyzwania demograficzne, związane z dynamicznie starzejącym się społeczeństwem, stawiają przed środowiskiem medycznym oraz systemem opieki zdrowotnej konieczność redefinicji standardów etycznych w pracy z osobami starszymi. W niniejszym opracowaniu podjęto próbę wieloaspektowej analizy kluczowych zagadnień etycznych w kontekście opieki geriatrycznej, uwzględniając nie tylko fundamentalne zasady

*Open Access article, distributed under the terms of the CC licence (CC-BY, https://creativecommons.org/licenses/by/4.0/)*

bioetyki, ale również wyzwania wynikające z ograniczeń poznawczych, problemów komunikacyjnych oraz specyfiki opieki terminalnej. Szczególny nacisk położono na poszanowanie autonomii pacjenta, przeciwdziałanie terapii daremnej oraz konieczność rozwijania kompetencji interpersonalnych w relacji pacjent–personel medyczny. Artykuł stanowi głos w dyskusji nad koniecznością humanizacji współczesnej medycyny geriatrycznej, postulując model opieki oparty na empatii, sprawiedliwości i godności człowieka w każdej fazie życia.

**Słowa kluczowe:** etyka; osoby starsze

The aim of this article is to provide a comprehensive ethical analysis of contemporary geriatric care in the context of a rapidly ageing society, with particular emphasis on European countries, including Poland. Drawing on the framework of biomedical ethics developed by Beauchamp and Childress, as well as selected literature from geriatrics, nursing, psychology and social sciences, the paper examines ethical dilemmas emerging at different stages of late life: from everyday care and health education, through institutional and long-term care, to end-of-lifedecision-making and futile therapy.

A key starting point is the recognition of the intrinsic value and inviolability of human life at every stage of its development – including advanced old age – and the obligation to protect human dignity even when curative treatment is no longer possible.

Agingisconsidered a natural developmental stage, characterized by specific, multifaceted changes that accompany each period of life. It is an inevitable process that is highly individual in people, depending on many factors. These changes progress gradually, are irreversible and affect various areas of life (Ziomek-Michalak 2016, 170). The aging process is associated with progressive deterioration of both physical and cognitive performance. These changes are manifested in the external appearance, including facial features, posture, the way of moving and gesticulation. A characteristic phenomenon is a decrease in height and a sloping figure. In addition, the elderly often experience impaired visual and auditory functions, which, combined with limitations in spatial orientation and practical abilities, can significantly impede daily functioning. The progressive process of aging generates new challenges for the health care system (Fobelová 2017, 160).

The population of people over the age of 65 is the largest group of patients receiving medical care, which requires adjustments to therapeutic and organizational strategies in health care facilities (Beet and Reczynska 2015, 218–226). Even with the use of medical technologies and the latest advances in science, it is impossible to forget the need to base care practices on fundamental ethical principles. Ethical issues related to geriatric care are multifaceted and arise from a variety of considerations. First, there is a strong demographic aspect – the process of aging of the population means that more and more elderly people

require specialized care. Second, socio-cultural issues, such as common attitudes, stereotypes or prejudices against seniors, significantly affect the way care is perceived and delivered. Third, political-organizational issues, concerning the structure of care systems and the rules of health institutions, also play an important role (Zurzycka and Radzik 2015, 423–424).

Ethics in geriatrics is a key aspect of the care of the elderly, who often face multimorbidity and limitations in independent decision-making. From an ethical perspective, not only is proper clinical management particularly important, but also respect for patients' autonomy and their individual values, needs and preferences. The literature emphasizes that the main ethical challenges in geriatrics focus on issues related to patients' right to self-determination, including respecting their decisions regarding therapeutic management and treatment directives (Podgorica et al. 2021, 895–910). The conflict between respecting a patient's autonomy and the duty to ensure his or her safety and protection from harm is one of the key ethical challenges in elderly care. Particularly relevant in this context are dementia disorders, which can significantly impair a patient's ability to make informed and rational decisions. In the case of these patients, it is necessary to balance the right to self-determination with the need for medical and caregiving interventions, so as to prevent situations in which their actions could negatively affect their health, safety and well-being (Mayo and Wallhagen 2009, 103–111; Zurzycka and Radzik 2015, 424).

Modern bioethics and medical ethics are based on four fundamental principles formulated by Beauchamp and Childress, which form the basis for decision-making in clinical practice:

- Principle of beneficence – obliges to take action for the benefit of the patient and strive to improve his health and quality of life. It is based on the moral obligation to provide assistance and undertake medical interventions that bring health and social benefits.
- The principle of non-harm – emphasizes the need to avoid actions that could harm the patient. It requires diligence in making therapeutic decisions and minimizing the risk of complications. This principle is also associated with respect for the physical and mental integrity of the individual and the protection of his or her rights in the context of medical interventions.
- The principle of autonomy – implies that every patient has the right to make his own decisions about his health, treatment and lifestyle. Doctors and other health care professionals are obliged to respect his choices, as long as they are informed and in accordance with current medical knowledge. Respect for autonomy requires providing the patient with reliable information to make informed decisions.

- The principle of equity – refers to the equal treatment of patients and the elimination of all forms of discrimination in access to health care. In the context of the organization of the health care system, this principle imposes an obligation to distribute resources fairly, so that they are used efficiently and in accordance with the actual needs of patients (Beauchamp and Childress 1996).

Ethical aspects of care for the elderly are the foundation of a professional approach to the provision of geriatric and long-term care services. Adherence to ethical principles assumes particular importance in the context of the increasing needs of this patient group, and their respect is a prerequisite for the provision of quality care. Among the key values are respect for the dignity of the human person, empathy, patience, protection of privacy and sensitivity to the individual needs of the senior. The principles of professional ethics set the framework for a relationship based on trust and mutual respect between the caregiver and the senior. One of the fundamental tenets is respect for the senior's autonomy, understood as the right to make independent decisions, even if they do not conform to the beliefs or judgment of the medical staff. Maintaining autonomy promotes a sense of agency and control over one's own life, which is important for the patient's psychological well-being. The second important pillar is the principle of confidentiality, which obliges the protection of personal and medical information and prohibits its sharing with third parties without the express consent of the patient or his legal representative. At the same time, the principle of non-maleficence must be observed, which obliges to take measures aimed at ensuring safety and preventing potential harm in daily care. Equality and fairness in the treatment of patients are other principles of fundamental importance – any form of discrimination based on age, health or background is incompatible with professional ethics. Empathy and patience are indispensable components of ethical care, forming the basis for effective communication and understanding of the needs of the geriatric patient. These competencies include, among others, the ability to empathize with the client, recognize non-verbally expressed needs, show understanding of difficulties resulting from the aging process, and actively listen and respond appropriately to signaled concerns (Beauchamp and Childress 1996). Integrating empathy and patience into professional practice fosters a therapeutic relationship based on trust, which translates into effective caregiving interventions. Therefore, contemporary education and training programs for those working with seniors should include the development of these skills, also offering psychological support in dealing with the emotional burdens associated with caring for a geriatric patient. Caring for the elderly often involves dealing with complex ethical dilemmas. One of the most common challenges is the need to strike a balance between respecting a senior's

autonomy and ensuring his or her safety. Caregivers must make decisions with care, assessing when intervention is warranted out of concern for the patient's health and when the patient's wishes should be accepted – even if controversial. Additional difficulties arise when the family's expectations conflict with the senior's own preferences. It then becomes necessary to skillfully navigate between different, often opposing interests, while maintaining the primacy of the patient's welfare. A special group requiring ethical sensitivity is people with cognitive disorders such as dementia. In such cases, caregivers are required to make decisions on behalf of the client, guided by the client's pre-existing values and wishes, and constantly striving to protect the client's dignity.

In the context of the ethics of working with the elderly, it is crucial to counter stereotypes about their cognitive abilities and educational opportunities. It is often assumed that age-related involutionary changes and neurodegenerative co-morbidities prevent the intellectual development of seniors, which leads to limiting their potential for health education. Meanwhile, research in the fields of educational gerontology and andragogy shows that older people can effectively acquire knowledge and develop skills in various areas, including cognitive, psychomotor and emotional. However, this process requires adapting teaching methods to their specific needs. In health education, it turns out to be particularly important to combine different forms of teaching – lectures, workshops or practical training – and to take into account the individual experiences and beliefs of seniors. It is also a key ethical consideration to ensure that they are able to participate in education both in group form, which promotes the exchange of experiences, and individually, tailored to their preferences and pace of learning. Properly planned health education, implemented in an interdisciplinary manner, allows not only to increase the health competence of the elderly, but also to strengthen their autonomy and sense of worth, which is consistent with the principles of professional ethics in working with this group of patients (Misiak 2011, 360).

Geriatric care covers patients not only for a short slice of theirlives, but often for the entire last stage of theirlives, whichmany of themspend in care institutions such as social welfare homes.It isnoteworthythat for mostelderly people, the choice of such a place to stayis not a voluntarydecision, but a result of necessity and the lack of alternatives in the support system (Frühwald 2012, 548). Institutional geriatric care carries the risk of limiting patient autonomy, which can lead to a sense of objectification. Being in a care facility often involves the loss of influence over the organization of daily life, including the daily schedule, the ability to choose roommates, and access to private space, media and cultural activities. A prolonged stay in such an institution can also result in a sense of loss of control over one's own life, loneliness and the impression of insufficient tailoring of care to individual needs, as well as a delayed response to the senior's ongoing needs (Teeri et al. 2007, 490–499).

A distinctive aspect of geriatrics is the care of patients at the end of life. Death in this field of medicine should not be treated solely as a therapeutic failure, but as a natural stage to be taken into account in the treatment process. (Frühwald 2012, 548). The proximity of death is an integral part of geriatrics, which leads to the need to balance two basic ethical principles: the desire to prolong life and the duty to prevent and alleviate suffering. In caring for patients of advanced age, it is crucial not only to provide palliative therapy and comprehensive care, but also to consciously accompany the patient in the dying process, while distinguishing this approach from euthanasia (Frühwald 2012, 553).

In the treatment process, informed and rational choice of therapy by an interdisciplinary medical team is crucial. Although death is a natural stage of human life, for a long time issues related to end-of-life care remained marginalized. Modern medicine, while focusing on optimizing therapeutic methods and seeking new treatments, often overlooks the aspect of the inevitability of disease progression. As a result, the medical interventions undertaken can be excessively invasive and aggressive, which can result in insufficient provision of dignified and adequate care for the patient in the last period of life (Lee 2002, 98–103).

In geriatrics, futile therapy refers to the prolongation of medical interventions in elderly patients despite the lack of real therapeutic benefits, such as improved quality of life or recovery of vital functions. In cases where the patient's condition is irreversible and treatment only leads to prolonging the dying process, suffering may escalate and the comfort of the last moments of life may reduced. Thus, in the geriatric context, an ethical evaluation of the actions taken is of particular importance, taking into account not only the medical aspect, but also the dignity of the patient and his right to decisions regarding the termination of therapy (Tuteja et al. 2024, 39–45). The decision to continue or stop futile therapy is one of the most difficult challenges the patient's family. It is an emotionally as well as ethically and legally taxing situation. Relatives should receive psychological support and be given the space to say goodbye to the patient with dignity and in accordance with their needs. In the case of a long-term illness, it is crucial to the family aware early on of the potential for dilemmas associated with futile therapy, allowing for more informed and thoughtful decision-making. In addition, an important part of terminal patient care is accompanying loved ones through the various stages of the illness, which can prevent them from demanding prolonged therapy despite its lack of effectiveness and potential increase in the patient's suffering (Hardwig 2005, 335–344).

The modern realities of geriatric care have meant that dying increasingly taking place in health care facilities rather than in a home environment. As a result, medical personnel, in addition to loved ones, play a key role in ensuring that the patient feels safe, understood and supported. In geriatrics, a holistic

approach to the patient is of particular importance, taking into account both the patient's somatic and psychosocial needs. Effective and empathetic communication becomes the foundation for building a partner relationship to respond appropriately to the patient's needs and support him or her in the most difficult period of life.

Proper interaction between the patient and medical staff requires developed communication competencies, which can be improved to increase awareness of their importance in geriatric care. Understanding the mechanisms of verbal and nonverbal communication, as well as identifying potential errors in this area, allows building a relationship based on trust and providing the patient with dignified and tailored care (Raniszewska-Wyrwa 2024, 109–122). for a patient in the terminal stage of an illness requires a high level of emotional maturity, sensitivity and professionalism on the part of medical personnel. Skilful demonstration of empathy, adapted to the situation and the individual needs of the patient, is crucial. Accompanying the patient in the last moments of life is not just about physical presence, but includes comprehensive care, active listening and careful observation, which allows you to respond adequately to the patient's needs and make him as comfortable as possible.

Communication limitations in the elderly require that their relatives or caregivers follow certain rules. First, it is necessary to express oneself as simply as possible; to formulate intelligible messages. Second, it is necessary to speak slowly and a little louder, as this way of speaking facilitates better hearing and understanding of the spoken words. Third, one must avoid correcting and criticizing, as this type of communication increases insecurity and can embarrass or even cause pain. Fourth, getting feedback from the elderly is an important factor, as this is conducive to seeing if they have properly read the words addressed to them. Fifth, it is necessary to express emotions and feelings directly, as this serves to improve understanding, as does accentuating and reinforcing the information conveyed with nonverbal behavior – facial expressions, gestures and body poses (Sikorski 2013, 71).

Maintaining eye contact, reducing physical distance, a slight hug, a gentle smile, a soft tone of voice – the totality of such nonverbal messages are understood by the elderly better than most words directed to them. Undoubtedly, a great advantage of nonverbal messages is that they can be readable even by people in the highly developed stages of various diseases of old age. In addition, the use of such messages is important because of the research-confirmed fact that they remain in memory for longer than spoken words (Sikorski 2021, p. 186).

During the conversation, information is exchanged, both parties evaluate the words of the predecessor, ask for additional clarification and pose questions. Each of these types of communication – both verbal and nonverbal – has a second dimension, namely relational, which informs the feelings and emotions of

the communicating people toward each other. Relational messages satisfy one or more social needs: closeness, control, esteem and belonging. For this reason, they are of great importance in communicating with the elderly, since, on the one hand, they are usually unable to understand the content of the messages addressed to them, and on the other hand, their utterances are increasingly incomplete or perfunctory. As a consequence, the content of the statements is increasingly opaque. Completely different is the relationship aspect. Through this sphere, family members can express their support, acceptance or closeness. They should also be aware as soon as possible that the content of communication is becoming less and less clear and at the same time less useful, while the relationship aspect is becoming more beneficial or even necessary. In view of the growing aging process, it becomes necessary not only to develop systems of care for the elderly, but also to deepen reflection on the ethical foundations of this care. A high level of professionalism cannot be treated in isolation from values such as respect for the autonomy, personal dignity and subjectivity of the senior. The partnership model, based on dialogue and mutual respect, is currently one of the most promising approaches in working with the elderly, as it minimizes the risk of dehumanization and exclusion. Care practice should be constantly evaluated in the light of ethical principles in order to counteract the phenomena of violating the dignity of the elderly – both structurally and individually. Overlooking a senior's opinion, limiting his privacy or excluding him from social life – even if motivated by care – are forms of symbolic violence that lead to the marginalization of this group. Therefore, it is necessary not only to train staff in soft and ethical skills, but also to build a culture of care based on a deep understanding of the needs and rights of the elderly. Only then will it be possible to provide care that not only meets biological needs, but also affirms humanity – regardless of age and physical condition.

In conclusion, this analysis shows that ethical geriatric care must be rooted in the recognition of the intrinsic value and inviolability of human life, as well as in the consistent respect for the dignity and autonomy of older adults. At the same time, the limits of contemporary medicine require avoiding futile interventions that prolong suffering rather than improve quality of life.The complexity of ageing underscores the need for strong interpersonal and communication competences among health-care professionals, as these skills are essential for maintaining trust, understanding and genuinely person-centred care. Equally important is the continuous evaluation of institutional practices to ensure that long-term and end-of-life care remain aligned with ethical principles and do not contribute to marginalisation or loss of autonomy.

Ultimately, the humanisation of geriatric medicine forms the core of good clinical practice, enabling care that responds to the biological, psychological and social needs of older adults while affirming their dignity at every stage of life.

## Bibliography

Beauchamp, Tom L., and James F. Childress. 1996. *Principles of Medical Ethics*. Translated by Witold Jacórzyński. Warsaw: Książka i Wiedza.

Beet, Anna, and Agnieszka Reczynska. 2015. "Discrimination against Patients by Health Care Workers." *Geriatrics*, 9: 218–226.

Fobelová, Drahomíra. 2017. "Models of Care in Experiencing Old Age – Ethical and Demographic Aspect." *Zeszyty Naukowe Politechniki Śląskiej. Organization and Management*, 112: 157–165.

Frühwald, T. 2012. "Ethik in der Geriatrie." *Zeitschrift für Gerontologie und Geriatrie*, 45: 545–557.

Hardwig, John. 2005. "Families and Futility: Forestalling Demands for Futile Treatment." *The Journal of Clinical Ethics*, 16(4): 335–344.

Lee, D. H. 2002. "Approach to End of Life Care." *Ochsner Journal*, 4(2): 98–103.

Mayo, Ann, and Margaret Wallhagen. 2009. "Considerations of Informed Consent and Decision-Making Competence in Older Adults with Cognitive Impairment." *Research in Gerontological Nursing*, 2(2): 103–111.

Misiak, Krystyna. 2011. "Tasks of the Primary Care Nurse in the Gerontological Perspective." *Nursing and Public Health*, 1(4): 359–366.

Podgorica, Nertila, Magdalena Flatscher-Thöni, Daniela Deufert, Uwe Siebert, and Michael Ganner. 2021. "A Systematic Review of Ethical and Legal Issues in Elder Care." *Nursing Ethics*, 28(6): 895–910.

Raniszewska-Wyrwa, Agnieszka. 2024. "Communication with the Patient at the End of Life." In: *On the Way to the Edge of Life*, edited by Elżbieta Krajewska-Kułak et al., vol. XXIII, 109–122. Białystok: Medical University of Białystok.

Sikorski, Wiesław. 2013. *Therapeutic Communication: The Nonverbal Relationship*. Kraków: Oficyna Wydawnicza Impuls.

Sikorski, Wiesław. 2021. *Psychology of Intra-family Relations: Communication and Psychotherapy*. Warsaw: Difin.

Teeri, S., M. Välimäki, J. Katajisto, and H. Leino-Kilpi. 2007. "Nurses' Perceptions of Older Patients' Integrity in Long-Term Institutions." *Scandinavian Journal of Caring Sciences*, 21(4): 490–499.

Tuteja, Alexander, Laura Więcko, Livia Olczyk, and Katarzyna Trela. 2024. "Life-sustaining Therapy: When to Say Stop." In: *On the Way to the Edge of Life*, edited by Elżbieta Krajewska-Kułak et al., vol. XXIII, 39–45. Białystok: Medical University of Białystok.

Ziomek-Michalak, Katarzyna. 2016. "Aging and Old Age in the Perception of Students Preparing for the Profession of Social Worker." *Gerontologia Polska*, 24(3): 167–175.

Zurzycka, Patrycja, and Teresa Radzik. 2015. "Ethical Dilemmas in Geriatric Nursing – Selected Issues." *Problems of Nursing*, 23(3): 423–427.

**Jarosław Czepczarz** – dr nauk społecznych, adiunkt w Akademii Nauk Stosowanych Wyższej Szkole Zarządzania i Administracji w Opolu, kierownik Oddziału Rehabilitacji ds. organizacji w Opolskim Centrum Rehabilitacji w Korfantowie. Członek Komisji Nauki Kształcenia i Rozwoju Zawodowego przy NRPiP w Warszawie, członek Zespołu ds. ewaluacji programów kształcenia przy CKPPiP w Warszawie, członek Komisji do spraw jakości i rozwoju zawodowego OIPiP w Opolu, wiceprzewodniczący ORPiP w Opolu, członek Rady Recenzentów kwartalnika *Pielęgniarstwo i Zdrowie Publiczne* (Uniwersytet Wrocławski), członek Wojewódzkiej Komisji do spraw orzekania o zdarzeniach medycznych w Opolu na kadencję 2018–2023. Autor i redaktor kilku monografii oraz kilkudziesięciu

artykułów naukowych krajowych i zagranicznych głównie z zakresu edukacji zdrowotnej, niepełnosprawności oraz gerontologii. Od wielu lat związany również z problematyką edukacji i szkolnictwa.

**Agata Czepczarz** – lekarka odbywająca staż podyplomowy, absolwentka kierunku lekarskiego Uniwersytetu Opolskiego. Zainteresowana medycyną ratunkową oraz intensywną terapią. W pracy klinicznej szczególną uwagę zwraca na etykę, komunikację i holistyczne podejście do pacjenta. Łączy praktyczne doświadczenie zdobywane na różnych oddziałach z rosnącym zainteresowaniem geriatrią, bioetyką i humanizacją opieki medycznej.