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# EDITORIAL

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## The limits of Intervention in the Critically Ill Older Patient

Population ageing is one of the most significant transformations of contemporary societies. Today, the world's population is ageing at an unprecedented pace, with projections indicating a doubling of the number of people aged 60 years and over by 2050, as well as a marked increase in the population aged 80 years and over. This phenomenon is associated with a higher prevalence of multimorbidity, frailty and dependency, leading to a growing presence of older people in critical condition across different care settings[1,2]. At the same time, scientific and technological advances have significantly expanded the possibilities for intervention, making it possible to sustain vital functions and prolong survival in situations once considered irreversible. In this context, an unavoidable question emerges: how far should we intervene when technology no longer adds meaningful benefit to the life of the person we care for? In the critically ill older patient, the coexistence of multiple diseases, frailty and reduced functional reserve often make the real benefit of increasingly invasive interventions uncertain. Reflection on therapeutic appropriateness therefore becomes essential, requiring decisions that reconcile clinical criteria with values, preferences and life goals. Evidence shows that person-centred care promotes better health outcomes, greater satisfaction with care and more active participation in therapeutic decision-making[3]. However, adapting care goes beyond prognostic assessment. It requires understanding the uniqueness of each situation, recognising the person's life history, available resources and preserved abilities despite illness. Even in contexts of high dependency, self-care needs, preferences and opportunities for participation persist and should be valued. These dimensions remain relevant in older people with decompensated chronic disease and multimorbidity, reinforcing the importance of interventions aimed at maintaining the greatest possible autonomy and promoting participation in decisions that concern them[4]. On the other hand, assistive technologies are important resources to support self-care and promote functionality. When properly integrated into care processes, they may contribute to healthier ageing and to the preservation of independence and dignity throughout the illness trajectory, within a continuum marked by phases of stability, decompensation and possible clinical recovery[5]. Maintaining treatments along this pathway, when they offer no significant benefit, may increase the suffering of patients, families and professionals. Conversely, effective communication processes and shared decision-making foster care that is more appropriate, safer and more humane. At a time when technology continues to expand the possibilities for intervention, the real challenge does not lie in knowing how far we can go, but how far we should go. In the critically ill older patient, the limit of intervention lies precisely in this balance between technical possibility and clinical judgement, between prolonging life and preserving what gives it value and meaning. Excellence in care is not measured solely by the ability to sustain vital functions, but by the ability to recognise when dignity must guide the limits of intervention.

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