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Original Study

“Yes, I Consent!” Prevalence and Role of Guardianship in Older Inpatients: Findings From an Italian Multicenter Survey

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ABSTRACT

Objective: Guardianship is increasingly important as society ages, especially for people living with dementia (PWDs). This multicenter study assessed guardianship prevalence, practices, and caregiver engagement among hospitalized older adults, comparing those with and without dementia.
Design: Multicenter cross-sectional survey.
Setting and participants: Patients aged ≥65 years and their caregivers.
Methods: The survey was conducted in 11 tertiary Italian hospitals. Data on sociodemographics, clinical status, guardianship, and caregiver knowledge were collected.
Results: Among 409 patients (mean age 83.8 years; 63.1% needing daily assistance), only 8.8% had a legal guardian. Familiarity with guardianship laws was higher among caregivers of PWDs (61% vs 45.7%). Misconceptions were common: 70.3% of PWD caregivers reported making medical decisions without formal authority. Only 40% of PWD caregivers and 32.8% of others correctly recognized the need for legal guardianship.
Conclusions and Implications: A significant gap between the need for and use of legal guardianship emerged. Enhancing caregiver education is crucial to protect older adults’ rights and autonomy.

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Background

In later life there is a progressive increase in dependency for activities of daily living, alongside a higher prevalence of cognitive decline and multiple chronic conditions.[1] In Europe, nearly 1 in 4 adults aged ≥65 years report limitations in at least 1 daily activity of daily living,[2] and approximately 9.8 to 9.9 million people live with mild to severe dementia.[3] Italy is one of the European countries with the highest proportion of the older population,[4] with about 1.28 million people living with mild to severe dementia.[5] Overall, these epidemiologic data highlight the increasing relevance of guardianship in supporting decision making in older age; however, evidence on this issue in the current literature is still scarce, as is awareness in geriatric clinical practice.

Guardianship is a legal process in which an individual (preferably known to the patient) is appointed to make decisions for someone deemed incapable of informed consent. Full guardianship covers legal, financial, and health care decisions, ensuring appropriate care for those with cognitive or functional impairments.[6] In Italy, in line with constitutional principles, informed consent is regulated by Law 219/2017, which states that only a conscious and competent patient or, if incapable by law, a legal representative appointed by an overseeing judge, can provide informed consent.[7,8] In Italy, family members can legally express consent on behalf of a patient only in 2 situations: when the patient is a minor, or when a competent patient has explicitly delegated this role. In all other cases—such as dementia or temporary incapacity without applicable advance directives—relatives have no automatic decision-making authority. Physicians may involve them in shared decision making to optimize care, but their opinions are not legally binding.[7,8] Until 2004, valid informed consent in Italy could only be given by a full guardian appointed through interdiction—an approach often too restrictive for older adults with partial decision-making capacity. To overcome these limitations, the Law 6/2004 introduced the "support administrator" (internationally recognized as a guardian), a more flexible alternative assignable to a family member or, if unavailable, a designated professional.[7-10] The introduction of the support administrator aligns with the Oviedo Convention, which states that when an adult is unable to provide informed consent because of disability or cognitive impairment, consent must be obtained from a legally recognized representative or competent authority, as defined by national legislation.[11] The Convention also emphasizes the importance of involving individuals with reduced decision-making capacity in health-related matters (Art. 6 of the Oviedo Convention), promoting collaboration between the medical team, family members, and the patient whenever possible.[8,10,11]

Despite the increasing interest in guardianship for older adults from a legal point of view,[12-19] comprehensive data on guardianship remain scarce worldwide,[6,20,21] making it challenging to quantify the extent to which guardians are being used and understand the reasons for its limited adoption in individuals with reduced autonomy, particularly those with cognitive impairments.[19,22] Caregivers of people living with dementia (PWDs), in particular, face unique challenges, including emotional and financial burdens and the need for constant supervision of the assisted persons, especially when cared for at home. In this sense, guardianship, having identified the person in charge of decision making, in line with the patient's wishes and values, may help ease the burden of care in complex situations and provide formal support for the person in need.[22,23]

A recurrent theme across European studies is limited legal literacy among clinicians working with older adults. Two medicolegal reviews identified limited knowledge of legal frameworks and difficulty distinguishing the patient's will from the caregiver's in clinical contexts.[6,8] Another study of physicians caring for patients under guardianship found widespread misconceptions and overconfidence among resident physicians regarding the role and responsibility of guardians, underscoring the need for structured education.[24] Understanding these legal mechanisms is crucial to upholding self-determination, fronting ageist assumptions, and providing appropriate support for older adults.

In this context, our study examines the prevalence of guardianship use among hospitalized older adults and the knowledge about guardianship among older adults and their caregivers in Italian tertiary care hospitals. Additionally, we assess differences in awareness and perceptions of legal guardianship between caregivers of PWDs and those caring for individuals without dementia.

Methods

Study Design and Participants

The "YES, I Consent!" study is a cross-sectional, multicenter, nationwide initiative that enrolled patients aged 65 years and older, along with their caregivers, who were consecutively admitted to the Geriatrics, Geriatric Internal Medicine, and Orthogeriatric departments between July and October 2023. The study was conducted in 11 tertiary centers located across Italy, university-affiliated or referral centers with specialized geriatric and/or internal medicine wards, ensuring a study population representative of older adults hospitalized for acute medical or surgical conditions relevant to the study aims, as they often involve major clinical and ethical decisions, such as surgery or invasive interventions. In these centers, acute conditions may generally resolve with home discharge, return to a nursing home, or transfer to long-term care facilities, with or without the involvement of a care management team, depending on the patient's condition and regional regulations.

The eligibility criteria included the ability to participate in the survey. The exclusion criteria were subsequent or prior hospitalization before the enrollment start date and refusal to sign informed consent.

This study was conducted by researchers from the YES Group (Young Epidemiologists SIGG—Società Italiana di Geriatria e Gerontologia), founded in 2019 to foster collaboration among young SIGG members in clinical and epidemiologic research on aging. Open to SIGG members aged <40 years, the group has nearly 100 active participants engaged in projects aimed at promoting healthy aging and enhancing care for older adults. The detailed list of participating researchers and study sites is reported in Supplementary Table 1.

The study protocol was approved by the ethics committee of the coordinating center (protocol number 0003346/23) and the local ethics committees of the participating centers. The study complied with the guidelines of the Declaration of Helsinki, and each involved individual provided written consent to participate in the research. When patients were unable to provide informed consent because of cognitive impairment, consent was obtained from a recognized representative. Data collection and sharing were conducted in line with national data protection laws, and the privacy of the participants was guaranteed by anonymized data.

Data Collection

A semistructured form developed specifically for this study was used to complete the data collection of the recruited sample (see Supplementary Form 1 in the Supplementary Appendix). Trained departmental personnel assisted with the form completion, ensuring accuracy and completeness, supplementing information with data from clinical records when needed. Study data were collected and managed using REDCap electronic data capture tools hosted by SIGG. The data collection form covered 4 main domains, with sections tailored separately for patient-reported information and caregiver input:

- Sociodemographic characteristics: age, sex, education, marital status, and/or having children.
- Clinical characteristics included the diagnosis of chronic conditions, substance/alcohol abuse history, and medication use (antipsychotics, antidepressants, anxiolytics, dementia and Parkinson disease drugs).
- Patients' clinical, social, and cognitive vulnerabilities were assessed using the Blaylock Risk Assessment Screening Score (BRASS).[25-27]
- Informal care was evaluated through 10 questions to determine the presence of an informal caregiver or guardianship and their understanding of relevant laws. Additionally, an optional section addressing caregiver stress was included.
- Diagnosis of dementia was obtained using multiple sources of information, including anamnestic history, caregiver interviews, and medical records. More specifically, dementia status was coded as binary variable, and patients were classified as PWD if at least 1 of the following criteria was met: (1) a documented diagnosis of Alzheimer disease or another type of dementia in the medical record; (2) a positive response to the data collection questionnaire: "Known diagnosis of Alzheimer's disease? Yes/No"; "Known diagnosis of other type of dementia (unspecified)? Yes/No"; or "Is the patient taking anti-dementia medication (eg, rivastigmine, memantine)? Yes/No." In cases with a formal diagnosis, ascertainment was generally aligned with the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*) criteria and confirmed by the treating physician.

Operational Definition and Classification of Guardianship

For the purposes of this study, guardianship was classified based on the extent of legal authority granted to the designated individual according to the Italian Law. Full guardians were defined as those with comprehensive decision-making authority over administrative, medical, and legal matters. Guardians or support administrators, appointed by a judicial authority, provided varying degrees of assistance and oversight.

Statistical Analysis

Categorical variables were presented as absolute frequencies and relative percentages, whereas quantitative variables were reported as means and SDs, depending on their distribution, assessed using the Shapiro-Wilk test. Differences between participants with and without dementia were calculated using χ^2 or Fisher exact tests for categorical variables and Student *t* test or Mann-Whitney *U* test for quantitative variables. Analyses were performed using R v. 432 software[28] (R Foundation for Statistical Computing).

Sample Size Determination

Sample size estimation was calculated considering the main scope of the project, which aimed to evaluate the prevalence of use of the legal figure of "support administrator" among older inpatients. Based on ISTAT [Istituto Nazionale di Statistica (Italian National Institute of Statistics)] data for the population aged 65 years or older as of January 1, 2022 (n = 14,046,359),[29] and prepandemic hospitalization rates of 13.9% from 2019,[29,30] a hospitalization rate of 13% for 2022 was assumed. Setting a 95% CI with a 5% margin of error and estimating a 20% response rate, it was calculated that 385 participants needed to be recruited and evenly distributed among different centers. This calculation was not intended for hypothesis testing but rather to ensure that the sample was sufficiently large to provide precise and reliable prevalence estimates in this descriptive context. Sample size estimation was performed using R and was supervised by an expert statistician at the coordinating center.

Results

Study Population and Patients' Characteristics

Of the 412 patient-caregiver dyads enrolled, 3 were excluded because of incomplete data, leaving 409 dyads in the final analysis. In 73.6% of cases, the questionnaire was completed by the patient's son or daughter, who also served as the primary caregiver in 72.4% of instances. In contrast, only 18% of spouses or partners identified as the primary caregiver.

Table 1 summarizes patients' characteristics stratified by dementia diagnosis. Among the 409 patients (mean age, 83.8 ± 7.7 years; 55% female), 31.8% had a dementia diagnosis. Education levels were comparable between participants with and without dementia, with 76.9% of those with dementia and 69.9% of those without having attained at most a primary school education. According to the Blaylock Risk Assessment Screening Score, the majority of participants lived with a spouse or family member (62.5%), whereas a smaller proportion lived with paid caregivers (15.4%). Overall, 258 patients (63.1%) required assistance with daily activities, particularly those with dementia (93.1%). Specifically, 43.3% needed help with toileting (50.6% with bathing), and approximately 54% required assistance with transfers, meals, medication management, and financial tasks. Furthermore, more than 60% of assisted individuals needed help with shopping and transportation. The most common comorbidities were hypertension (65.3%), heart failure (30.1%), and diabetes (27.1%), and 60.3% of patients had sensory deficits. Regarding the number of medications taken, 6.9% of the participants consumed more than 5 medications per day, with no significant differences between those with dementia and those without.

Full Guardianship and Guardianship

Overall, 12 patients (3.0%) had a full guardian, 91.7% of them being adult children, with 58.3% caring for PWDs. An additional 23 (5.8%) patients had a legally recognized guardian/support administrator, most commonly an adult child (78.3%), followed by a spouse or partner (13.4%). Notably, 69.6% of the individuals under guardianship had dementia.

Knowledge of Caregivers

Figure 1 presents the responses to the key survey questions assessing decision-making capacity, caregiver involvement, and knowledge of legal frameworks among caregivers of patients living with and without dementia. Approximately 60% of the interviewed caregivers reported that their assisted PWDs are not able to make decisions independently compared with the almost 12% in the nondementia group (Figure 1A). Conversely, 56.5% reported that their assisted patient without dementia was able to make decisions independently, whereas this was the case for only 6.3% of those with dementia. Moreover, 70.4% of caregivers of PWDs stated that they had made clinical decisions on behalf of the patient, whereas 70.1% of caregivers of patients without dementia had never made such decisions (Figure 1B).

Knowledge of the caregiver's legal role varied between groups (Figure 1C). Among caregivers of PWDs, 63.6% reported awareness of the legal role of caregivers, compared with 48.1% of those caring for

Table 1
Demographic and Health Characteristics of the Assisted Persons, Stratified by Dementia Diagnosis

Variables	All (N = 409; 100%)	Dementia (n = 130; 31.8%)	No Dementia (n = 279; 68.2%)	*P* Value
Age, y, mean ± SD	83.8 ± 7.7	83.0 ± 7.7	85.5 ± 7.3	.005
Age, n (%)				
65-79 y	105 (25.7)	26 (18.4)	79 (28.3)	.17
≥80 y	304 (74.3)	104 (80)	200 (71.7)	
Sex: female	225 (55.0)	87 (66.9)	138 (49.5)	.002
Education: none/elementary	295 (72.1)	100 (76.9)	195 (69.9)	.12
Living status				<.001
Alone	90 (22.1)	19 (14.6)	71 (25.5)	
With spouse or family	255 (62.5)	68 (52.3)	187 (67)	
With paid caregivers	63 (15.4)	42 (32.3)	21 (7.5)	
Functional status: dependent in daily activities	258 (63.1)	121 (93.1)	137 (49.1)	
Mobility				<.001
Walks independently	152 (37.3)	17 (13.1)	135 (48.4)	
Walks with assistance	155 (38.3)	56 (43.1)	99 (35.4)	
No walking	99 (24.4)	56 (43.1)	43 (15.4)	
Comorbidities				
Sensory deficits	246 (60.1)	99 (76.1)	147 (52.7)	<.001
Hypertension	267 (65.3)	84 (64.6)	183 (65.6)	.91
Diabetes	111 (27.1)	31 (23.8)	80 (25.6)	.34
Ischemic heart disease	95 (23.2)	28 (21.6)	67 (24)	.80
Heart failure	123 (30.1)	47 (36.2)	76 (27.2)	.13
Atrial fibrillation	112 (27.4)	38 (29.2)	74 (26.5)	.92
COPD	69 (16.9)	27 (20.8)	42 (15)	.26
Cerebrovascular disease	87 (21.3)	46 (35.4)	41 (14.7)	<.001
Chronic kidney disease	123 (30.1)	34 (26.1)	89 (31.9)	.36
Cancer	74 (18.1)	18 (13.8)	56 (20)	.17
Psychiatric disease	14 (3.4)	5 (3.8)	9 (3.2)	.53
Depression	88 (21.5)	42 (32.3)	46 (16.5)	<.001
Drugs assumption				
Antipsychotics	81 (19.8)	59 (45.4)	22 (7.9)	<.001
Antidepressants	133 (32.5)	60 (46.2)	73 (17.8)	<.001
Anti-Parkinson drugs	22 (5.4)	15 (11.5)	7 (1.7)	<.001
Total number of drugs per day				.68
1-2	35 (8.6)	9 (7.0)	26 (9.3)	
3-5	89 (21.9)	27 (20.1)	62 (22.3)	
>5	282 (68.9)	92 (70.8)	190 (68.4)	

COPD, chronic obstructive pulmonary disease.
Unless otherwise noted, values are mean ± SD.

patients without dementia. Conversely, 32.2% of caregivers of PWDs and 45.8% of those without dementia stated that they did not know the legal role of caregivers. Regarding awareness of Italian Law 6/2004, caregivers demonstrated limited knowledge, with 61% of those caring for patients without dementia and 45.2% of those caring for PWDs unaware of the law (Figure 1D).

Caregivers were assessed on their understanding of the extent of their legal authority in making medical decisions on behalf of the patient (Figure 1E). Among caregivers of PWDs, 22% believed that they could make any medical legal decision, compared with 5.1% of those caring for patients without dementia. Decision making in consultation with the patient was selected by 25.4% of caregivers of PWDs and 42% of those caring for patients without dementia. A higher percentage of caregivers of patients without dementia (19.8%) believed that decision making is only permitted if the patient is legally interdicted, compared with 12.7% of caregivers of PWDs. Finally, about 40% of caregivers of patients with dementia identified that decisions can only be made if they are appointed as legal guardians, compared with 33.1% of those caring for patients without dementia.

Discussion

Our multicenter, nationwide survey revealed 2 key findings: (1) the prevalence of use of guardians or full guardians is remarkably low in Italy, even in settings with a high prevalence of dementia; (2) a significant gap persists in legal awareness and formal caregiving structures, particularly among caregivers of individuals with dementia.

Despite the high prevalence of cognitive impairment and functional dependency among acutely hospitalized older adults, only a small fraction had a legally recognized guardian. Additionally, knowledge of the legal framework surrounding guardianship varied considerably, with a significant proportion of caregivers unaware of their legal responsibilities or the conditions under which they could make decisions on behalf of the patient. This lack of awareness, combined with the widespread but incorrect assumption that informal caregiving roles confer legal authority, raises important concerns for clinical practice, especially regarding informed consent. In situations where a physician recommends a diagnostic or therapeutic procedure, uncertainty about who is legally entitled to provide consent can delay care, create conflict, or lead to decisions that do not reflect the patient's preferences. Targeted educational interventions and clear institutional policies are therefore essential to ensure that vulnerable older adults receive both appropriate medical care and the legal protection to which they are entitled.[31-33]

The perceptions of legal decision-making roles among caregivers revealed a significant gap in understanding not only legal support structures and their legal and ethical impact on the care of a vulnerable person but also children's rights and required roles in supporting the patient's decision making.[34-37] These misconceptions can lead to several legal and ethical dilemmas, especially when

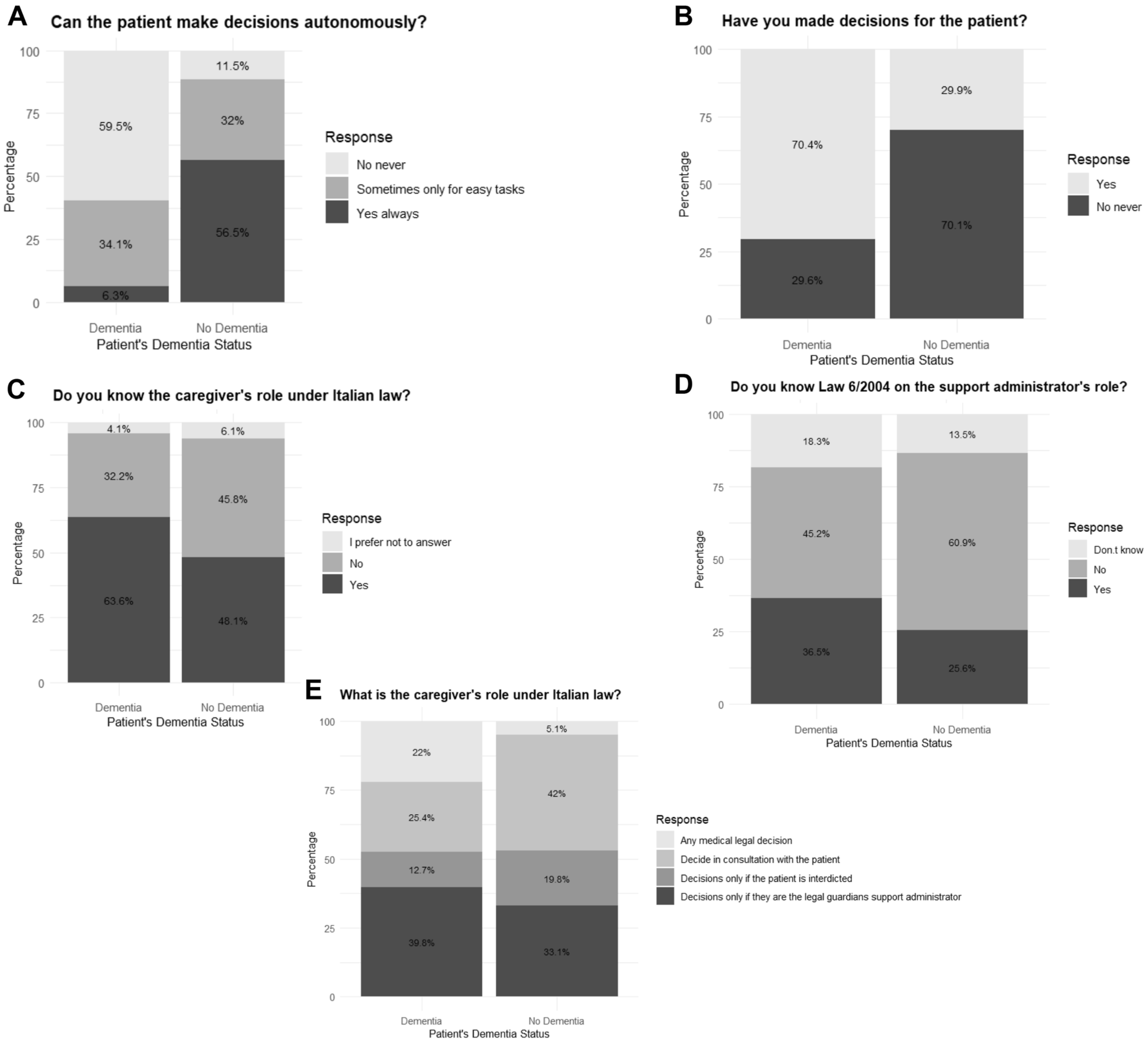

Fig. 1. Caregiver awareness of legal framework and decision making in patient care. All responses in this figure were provided by caregivers, not by patients. Panel A illustrates the patient's perceived ability to make independent decisions, whereas panel B highlights the proportion of caregivers who made decisions on behalf of the patient. Panels C and D assess knowledge of the caregiver's role and familiarity with Italian Law 6/6/2004 regarding guardianship, respectively. Panel E presents the participants' understanding of the legal authority granted to caregivers in medical decision making.

cognitive impairments compromise the patient's ability to make informed decisions.

Considering the ethical dilemma in decision making in clinical practice in case of impaired capacity or limited autonomy and the legal implications regarding the absence or presence of a guardian or the designation of a full guardian in every country,[6] this study holds the potential for future expansion to a broader European and non-European context.[6,8,19] In fact, if on one hand the absence of a guardian may leave the older person unprotected or exposed to neglect, exploitation, or inappropriate medical interventions, on the other hand, the designation of a full guardian may hinder the balance between autonomy and self-determination vs protection. For these reasons, several formal legal roles (eg, guardians, support administrators, legally authorized representatives) have been conceptualized in different countries, but legislations and cultural implications differ across the globe. For example, in France, the "mandataire judiciaire à la protection des majeurs" assists individuals with limited capacity.[15] In Spain, the "tutor legal" serves as a full guardian.[8] Germany's "Betreuer" supports individuals in managing financial and personal matters.[38] The UK's Mental Capacity Act 2005 presumes capacity unless proven otherwise.[39] In the United States[6,16,18] and Canada,[13,14,17] guardianship laws safeguard financial, legal, personal, and health care decisions for adults lacking capacity or those with cognitive impairment. A scoping review from Africa addressing ethics regulations from 14 countries for persons with Alzheimer disease and related dementia (ADRD) underlined how most regulations required the appointment of Legally Authorized Representatives, but only a few countries provided guidance in supporting capacity assessment and advance directives.[19] Interestingly, in China, the Family Support Agreement, based on filial piety, regulates older adult care, leading to challenges different from those experienced by other countries.[12,40] These international comparisons are crucial examples that illustrate how guardianship structures represent not only legal constructs but also mirror heterogeneous and complex cultural perspectives on autonomy, family responsibility, and the physician's role in decision making. Indeed, even in countries with established regulations, certain ethical and legal aspects remain ambiguous, creating potential gaps, and cultural and religious norms play a sensitive and pivotal role in shaping patient beliefs and health care practices. In many Asian and African nations, medical decisions often follow a communal perspective, with family members taking an active role when older adults—with or without cognitive impairment—confront serious health issues.[40-42] In the Italian context, even if the legal framework is nationally uniform, the observed disparities might depend more on different levels of awareness of the law among caregivers and health care professionals and consequent practical applications rather than to structural or different cultural nuances. However, what clearly emerges from our study is a homogeneous and widespread lack of knowledge across the North, the Center, and the South of the country. Nonetheless, as global migration continues to shape patient demographics, cultural differences in ethical medical decision making emerge as crucial health competence and require adaptable frameworks that incorporate cultural values while safeguarding patient needs, autonomy, and dignity.

Beyond legal challenges, ageism presents an additional barrier to equitable health care for older adults, negatively affecting clinical outcomes for older adults. In our study, caregivers of patients with dementia were more prone to perceive themselves as having full medical decision-making authority, whereas fewer reported engaging in decisions in consultation with the patient. Nonetheless, even if low, a percentage of caregivers of older patients without dementia believed they could decide for the patients independently of having consulted with them. Because this might reflect an underlying intrinsic ageist culture and paternalistic attitudes of caregivers, a legally recognized figure advocating for the older person might represent an effective protective measure toward biased care and facilitate the engagement of older adults, ensuring that health care professionals can provide care that considers the patients' preferences.[43] This might be crucial, especially for persons living with dementia who might face a double stigma of dementia-related and age-related discrimination.[44] In this sense, in addition to country legislation, the international Carta of Florence Against Ageism calls on health care professionals to engage comprehensively with older patients, promoting a more inclusive health care system that values the autonomy and dignity of older adults.[45] Addressing existing disparities requires structured, proactive strategies. Shared care planning can reduce decisional distress for patients and families, and clear guardianship arrangements and formalized decision-making processes may help prevent conflicts, delays in care, and misalignment with patient values.[24] In the Italian context, this entails strengthening awareness of the legal framework for consent and guardianship among patients, caregivers, and health care professionals, ensuring that all parties understand their roles, legal responsibilities, and available resources. This support should extend beyond cases of terminal diagnoses such as dementia or cancer (which require comprehensive care planning), involving also individuals with multiple chronic conditions that may worsen unpredictably or follow uncertain trajectories.[32,46] Coordinated action between health care institutions, legal professionals, and social services is essential, including regular training, accessible informational resources, and—where possible—integrated legal advisory services to support ethically and legally sound, patient-centered decisions.[47,48]

At the end of life, challenges in assessing the proportionality of medical interventions often intensify. The absence of clear legal guardianship can increase the risk of moral distress among health care providers, who may struggle to balance medical ethics, legal constraints, and patient autonomy.[49] Addressing these concerns requires a proactive approach, fostering interdisciplinary collaboration between medical, legal, and ethical experts to guide decision-making processes effectively. By strengthening guardianship systems, raising awareness among caregivers, and integrating legal and health care services, we can move toward a more inclusive and ethically grounded approach that presumes capacity, prioritizes supported decision making, and reserves guardianship for least-reactive and proportionate circumstances aligned with the person's values and advance directives. This holistic framework, attentive to dementia stage and comorbidities, would ensure legal compliance and upholds dignity, autonomy, and compassionate care.

Strength and Limitations

This study innovatively combines ethical inquiry with epidemiologic methods to quantify guardianship issues among older inpatients, offering a comprehensive view of the problem. Its nationwide design, spanning multiple regions and hospital departments, strengthens the generalizability of findings within Italy. The analysis reveals poor guardianship use and significant gaps in caregivers' knowledge and perceptions of guardianship, underscoring areas for improvement. By addressing both legal and ethical aspects, it highlights the complex challenges caregivers and health care providers face in caring for cognitively impaired older adults. The findings support the need for further research and targeted interventions. However, limitations include its cross-sectional design, limited statistical power for predictive modeling to detect associations, and potential bias from self-reported data. Excluding patients with dementia who lacked caregivers or legal guardians may have underestimated guardianship needs, omitting some of the most vulnerable individuals. Furthermore, as the study was conducted in tertiary hospitals, results may not fully reflect experiences in community or long-term care settings. Finally, the generalizability of the results may be limited by country-specific regulations and laws. However, the ethical issues and challenges raised are common in various health care settings and across different countries. Future research should involve larger, more diverse cohorts and longitudinal approaches to expand on these insights in other clinical and assistive settings and at an international level.

Conclusion and Implications

These findings highlight a substantial gap in awareness and understanding of guardianship laws among patients and caregivers, emphasizing the need for targeted educational interventions. The discrepancy in perceived decision-making capacity and caregiver authority suggests potential ethical concerns regarding autonomy and informed consent in the care of older adults, especially in the presence of cognitive impairment. Future research should focus on the effectiveness of interventions aimed at enhancing legal literacy among patients, caregivers, and health care professionals. These interventions could ensure not only that patients easily advocate for themselves but also that caregivers are adequately equipped to support patient-centered decision making as well as health care professionals. Therefore, increasing the knowledge of the legal framework might contribute to safeguarding the rights of vulnerable older adults, promoting shared care planning, and reducing ethical conflicts that may arise in the absence of clear decision-making structures.

Data Availability Statement

Data is available upon written request to the corresponding author.

CRediT authorship contribution statement

Study concept and design: Chukwuma Okoye, Caterina Trevisan, Maria Beatrice Zazzara; *Acquisition of data*: All authors; *Analyses and Interpretations of data*: Chukwuma Okoye, Susanna Gentili, Chiara Ceolin, Maria Beatrice Zazzara; *Drafting of the manuscript*: Chukwuma Okoye, Susanna Gentili, Chiara Ceolin, Maria Beatrice Zazzara; *Critical revision of the manuscript*: All authors.

Ethics Approval Statement

This study was conducted in accordance with the Declaration of Helsinki and approved by the Ethics Committee of the coordinating center and by the local Ethics Committees of the participating centers.

Consent Statement

All human subjects provided informed consent.

Disclosure

The authors declare no conflicts of interest.

Supplementary Data

Supplementary data related to this article can be found online at https://doi.org/10.1016/j.jamda.2025.105979.

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