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# Older Spouses' Decision-Making on Intubation for Older Patients: A Qualitative Study

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## ABSTRACT

**Introduction:** When older patients are intubated, their older spouses often play an important role in making difficult decisions to assist them. Therefore, this study was conducted to understand how older spouses experienced making decisions on intubation for older patients.

**Design:** A descriptive qualitative design.

**Methods:** Fifteen participants were recruited using purposive sampling. Face-to-face semi-structured interviews were employed to interview participants. Data were analysed using the content analysis method.

**Findings:** Four themes identified were as follows: (1) Reasons for making decisions—believing in doctors' recommendation, enhancing the survival of older patients without suffering and performing intubation because of their love for, and attachment to, their spouse; (2) Consequences of decision-making—worry about the survival of older patients and effects of prolonged intubation, fear of signs of deterioration and complication, but happiness to see spouses' survival; (3) Requiring assistance—they required assistance from physicians, nurses and family members in decision-making for spouses with regards to intubation; and (4) Selected treatment—they selected treatments for older patients with utmost treatment, symptomatic treatment and avoidance of suffering.

**Conclusions:** Spouses of older patients were often eager to help choose treatments, including intubation, for them. However, they faced both positive and negative consequences in decision-making, which highlighted their need for assistance from healthcare professionals. These challenges resulted from a lack of knowledge and experience.

**Implications for Practice:** To address these challenges, basic information can be utilised to create a decision-making program that supports spouses of older patients in their choices in managing intubation for them.

## 1 | Introduction

Older patients are treated with intubation because of respiratory failure. The causes of respiratory failure requiring intubation are pneumonia, airway obstruction, hypoventilation, cardiogenic pulmonary oedema, chronic obstructive pulmonary disease and surgery (Cheng et al. 2020). Additionally, lung function in ageing is changed. For instance, elastic recoil of the lung parenchyma reduces, 1-s forced expiratory volume (FEV1) and forced vital capacity (FVC) decreases with age, and ventilation/perfusion imbalance may occur (Lee et al. 2016). These changes may make older patients have difficulty breathing because they lower oxygen levels in the blood and impair removal of carbon dioxide. That is, low oxygen can result in hypoxemia or hypoxia, thus intubation is performed to assist their breathing due to hypoventilation (Cheng et al. 2020) and cardiac arrest (Idzwan Zakaria et al. 2023).

Most patients who are intubated are older patients and most are male (Idzwan Zakaria et al. 2023). Similarly, Chongthanadon

**Summary**

**What does this research add to existing knowledge in gerontology?**

- Older spouses faced positive and negative consequences in decision-making (e.g., happiness, worry and fear), highlighting their need for assistance from nurses, physicians and relatives.
- Decision-making to select effective treatments (e.g., utmost treatment, symptomatic treatment and avoidance of suffering) for intubated older patients was conducted out of love and attachment to saving the lives of their loved ones.

**What are the implications of this new knowledge for nursing care for and with older adults?**

- Older spouses felt worried and afraid about complications, prolonged intubation and older patients' survival. Therefore, psychosocial support should be provided by healthcare providers.
- Older spouses face making difficult decisions. Thus, information support from physicians and nurses is essential, and having relatives to help them in decision-making is also the preference of older spouses.

**How could the findings be used to influence practice, education, research and policy?**

- Understanding the older spouses' perspectives on decision-making regarding intubation for older patients is essential to design educational programs that support them in making these difficult decisions.
- Researchers can use this basic information when conducting further research relevant to this topic regarding decision-making for intubated older patients.

et al. (2023) showed that 56.2% of Thai males were diagnosed with pneumonia and their mean age was 71.2 years. Of these, 69.8% were older patients and they were treated with intubation and mechanical ventilation. While older patients who are intubated are treated for their condition, they may have physical and psychological impacts from intubation. For example, prolonged intubation is associated with a prevalence of laryngeal injury, dysphonia, pain, hoarseness and dysphagia. In addition, anxiety and depression can occur during treatments (Wallace and McGrath 2021). Intubation at an older age is associated with poor survival and high mortality (Smolin et al. 2022). Therefore, intubated older patients need to be assisted by physicians and nurses regarding airway management. At the same time, they also need family involvement in providing care and so collaboration between healthcare professionals and family members during hospitalisation is important (Brunker et al. 2023; Tabootwong and Kiwanuka 2020).

Apart from family participation in the provision of physical and psychological care to older patients admitted to the hospital, family members have a responsibility regarding decision-making to assist their loved ones because these older patients have symptoms of disease and cognitive impairment. Therefore, they are involved as surrogate decision-makers about life-saving treatment options, and the decision to transfer older patients for such treatments is conducted (Lee et al. 2020). In Thai culture, the eldest brothers or male members of the family are the surrogate decision-makers of older patients. The primary caregivers are the youngest daughter or female members (Supaporn et al. 2022). In addition, Thailand has a hierarchy of surrogate decision-makers for elderly patients who lack the capacity to make their own decisions. That is, the law prioritises family members as potential guardians, with the spouses, parents and adult children being the first in line (Tsoh et al. 2015). The attending physician plays a crucial role in communicating with family members about prognosis and treatment options. When family members receive adequate information, decisions are made based on the patient's preferences and the families' requests (Ketchaikosol et al. 2024). However, family members often find decision-making. To help family members by making this process less difficult, healthcare professionals should share more information about treatment options, symptoms and caring activities (Tabootwong et al. 2022). Effective communication between healthcare professionals and family members can help them make good decisions (Sharkiya 2023).

Moreover, family members are important caregivers for Thai older patients, especially spousal caregivers. Caregiving by spouses may be a committed role of both wife and husband, who care for their spouses for the rest of their lives (Thanapet and Pradubmook-Sherer 2024). While hospitalised older patients are treated, spouses may play a role as surrogate decision-makers because older patients lack the capacity to make medical decisions (Lee et al. 2020) due to impaired cognition, confusion, sudden desaturation and general deterioration in health. Their decision-making is about life-sustaining therapy decisions, procedures and discharge planning (Torke et al. 2014). Regarding spouses' roles in decision-making, their involvement reflects the qualities of a devoted caregiver who provides care to older patients with love and sincerity (Tabootwong et al. 2022). During emergencies, their surrogate decision-making role becomes stressful because of the limited time for decision-making in understanding the older patient's clinical situation. But these complex decisions for older family members who are intubated are facilitated by adequate communication between physicians and family members (Lee et al. 2020).

Concerning surrogate decision-makers for older patients, previous studies are presented concerning the scope of surrogate decision-making and outcomes for hospitalised older patients (Torke et al. 2014), family surrogate decision-making for patients with chronic critical illness (Moss et al. 2019), decision-making difficulties in end-of-life care for older adults (Batteux et al. 2020; Shinada et al. 2022), as well as difficult decisions of the family caregivers of patients on prolonged mechanical ventilation (Lee et al. 2020). However, current knowledge of older spouses' experiences in making intubation decisions for hospitalised older patients is limited. Therefore, this qualitative study was conducted to study older spouses' decision-making on intubation for older patients. Additionally, basic information from this study will be essential and used to improve quality care for intubated older patients and to support their older spouses as family surrogate decision-makers for them.

## 2 | Methods

### 2.1 | Design

The study adopted descriptive qualitative research to understand how older spouses experienced making decisions on intubation for older patients in medical and surgical wards of one hospital, Chonburi province, Thailand.

### 2.2 | Participants

Fifteen participants were recruited through purposive sampling. Participants were older spouses who had attained a certain age, particularly for older spouses aged 60 years and over (United Nation 2017). Older spouses were consulted by their attending physician and nurse to adopt the responsibility of making healthcare decisions on behalf of intubated older patients. The inclusion criteria were: (1) spouse aged 60 and over by registering a marriage with older patients (60 years and over) with intubation; (2) surrogate decision-makers for an older patient with intubation; (3) no cognitive impairment. The Six Item Cognitive Impairment Test (6 CIT) was used to assess cognitive impairment (Scoring less than 7); (4) ability to communicate in Thai; and (5) willingness to participate in this study. Participants were interviewed until data saturation; that is, when participants' answers no longer yielded new data or ideas.

### 2.3 | Ethical Considerations

The research proposal was approved by the human research ethics committee of one hospital in Thailand for permission to carry out the research. Participants were informed about the aim of the study, the process of doing the research, the benefits and how to withdraw from this study anytime without conditions. Their older family member's treatment and supervision by healthcare professionals would remain unaffected by their participation in or withdrawal from the study. Meanwhile, an information sheet was given in the Thai language, and the informed consent was signed by each participant and a witness before collecting data.

### 2.4 | Data Collection

Data collection was conducted between February and June 2024. To recruit participants, the researcher contacted nurses in the hospital to help with providing information about conducting the research, and they asked each participant to meet the researcher. After each participant expressed willingness to participate in this study, they would be asked to confirm this. Participants would be screened to meet inclusion criteria and the researcher would then start to collect data based on demographics and semi-structured interview guidelines. Semi-structured interviews were developed by the research team from the literature review and three experts who were experienced in qualitative research and caring for older patients. The semi-structured interviews were as follows:

1. Could you tell me about your experiences in making decisions on intubation for your husband/wife?
2. How did you think about intubated older patients?
3. How did you feel when you were a surrogate decision-maker?
4. What was difficult decision-making, and how did you manage it?
5. What support did you need if you had problems concerning decision-making?

With each interview, the researcher ensured there was enough time to engage and discuss with them, allowing about 45 min. The voice recorder was used to record what each participant narrated. After each interview, field notes were written about what the researcher faced while collecting data, such as gestures, expressions and the researcher's feelings while interviewing.

### 2.5 | Data Analysis

Transcribed data were analysed using the content analysis methods (Vaismoradi et al. 2013). There were three steps as follows: (1) Data preparation—the researcher read and reread transcribed data to understand what participants needed to communicate and how they felt about decision-making on intubation for older patients; (2) Data organisation—coding was conducted by finding words or phrases extracted from each interview. Thirty codes were reviewed to sort different or similar codes. After that, those reviewed codes were grouped to define categories and themes; and (3) Report—to present data and published results, the methodology of doing this qualitative research and the findings of decision-making on intubation (reasons for decision-making, feelings of decision-making, needs of family to be supported and selected treatment) were explained clearly so that basic information can be identified to be beneficial for readers. Additionally, presented data were checked and confirmed with codes and meaning units from participants.

### 2.6 | Trustworthiness of Findings

To ensure the findings were trustworthy, four methods were used: (1) Credibility—prolonged engagement was considered as 5 months of data collection to select each participant. Also, the first author was trained in qualitative research. The research team also had experience in doing qualitative research and caring for older patients; (2) Dependability—semi-structured interviews were suggested by two experts in qualitative research and one expert about caring for intubated patients. The recommended semi-structured interviews were tested with two participants to ensure that questions were appropriate and could be used for interviewing in a real situation; (3) Confirmability—coding in this qualitative research involved the process of searching, reviewing and organising data to identify themes and patterns. This process of coding was conducted by the first author, and the research team also helped in checking for the accuracy and possibility to generate themes. Additionally, member checking was performed by

returning summarised findings to five participants to review and confirm the findings; and (4) Transferability—consolidated criteria for reporting qualitative studies (COREQ) developed by Tong et al. (2007) was used to confirm that this study aligned with qualitative research methodology. In other words, this report can be used with confidence by readers using the findings to develop the relevant research.

## 3 | Findings

The 15 participants included 12 older females (80%) and three older males (20%). The majority (80%) were the young–old group (60–69 years). About half of the participants graduated from primary school (53%). About one-third (40%) had annual incomes of 10,000 Thai baht or less. The length of intubation was between three and 7 days. Characteristics of participants are displayed in Table 1. Older spouses' perspectives in decision-making for intubated older patients is presented in Table 2. Participants explained their reasons for making decisions, the consequences of decision-making, the requiring of assistance and selected treatment. The four themes are as follows:

**TABLE 1** | Characteristics of participants ($N = 15$).

| Demographic data | Frequency | Percentage |
|---|---|---|
| *Sex* | | |
| Male | 3 | 20 |
| Female | 12 | 80 |
| *Age (years)* | | |
| 60–69 | 12 | 80 |
| 70–79 | 3 | 20 |
| *Occupation* | | |
| Merchant | 3 | 20 |
| Housewife | 3 | 20 |
| Retired government official | 3 | 20 |
| Unemployed | 6 | 40 |
| *Education* | | |
| Primary school | 8 | 53.3 |
| Secondary school | 4 | 26.7 |
| Bachelor degree | 3 | 20 |
| *Income (Baht/year)* | | |
| < 10,000 | 6 | 40 |
| 10,000–15,000 | 5 | 33.3 |
| 15,001–20,000 | 4 | 26.7 |
| *Experience of caregiving for the older patient* | | |
| Yes | 3 | 20 |
| No | 12 | 80 |

### 3.1 | Reasons for Decision-Making

Participants explained their reasons for making decisions about intubation for older patients as being comprised of believing in doctors' recommendations, enhancing the survival of older patients without suffering and performing intubation out of love for, and attachment to, their loved ones. With respect to believing in doctors' recommendations, older spouses believed that doctors had superior knowledge of intubation and, therefore, that they recommended inserting an endotracheal tube to assist the breathing of older patients with dyspnoea. If intubation was not performed, older patients might suffer unnecessarily and die prematurely. We had to assist them.

> It depends on the doctor's consideration. His life is crucial, and I can easily decide to assist him because intubation was crucial for him at that time.
>
> (P9)

> Doctor told me that if he was not intubated, he might experience difficult breathing, which could result in death. I need to decide to make intubation before he dies. The doctor said that it will be difficult if he cannot breathe on his own.
>
> (P13)

Enhancing the survival of older patients without suffering was a reason for deciding to assist because older patients suffered from dyspnoea as uncomfortable breathing. Therefore, intubation could reduce suffering and save their older patients' lives.

> At first time, I think that he could not breathe out. He lies down and looks like he is dying. His body is cold and sweaty; thus, I need a doctor to assist him with intubation. I do not know how to assist his life.
>
> (P1)

> If I don't decide to assist him with intubation, I think that he might suffer from difficulty breathing. His breathing looks unfulfilled and looks like he is dying.
>
> (P3)

Performing intubation out of love and attachment was one of the reasons why participants needed to assist their loved ones. Because of the love and attachment between wife and husband, they had to decide with doctors to perform intubations as they hoped to see their loved one's safety.

> It is our love. I do not know what I can do to him. I think this is a good decision to assist him.
>
> (P6)

> We live together as an attachment. She is my wife, and I have to take care of her. That is what I can do in

**TABLE 2** | Older spouses' perspectives in decision-making for intubated older patients.

| Themes | Subthemes | The number of participants |
|---|---|---|
| Reasons for decision-making | • Believing in doctors' recommendations | 5 |
| | • Enhancing the survival of older patients without suffering | 4 |
| | • Performing intubation out of love and attachment | 6 |
| Consequences of decision-making | • Positive consequence | 4 |
| | • Negative consequences | 11 |
| Requiring assistance | • Assistance from physicians | 7 |
| | • Assistance from family members | 8 |
| Selected treatment | • Utmost treatment | 6 |
| | • Symptomatic treatment | 4 |
| | • Avoidance of suffering | 5 |

> her life. I am a surrogate to help her when she cannot make decisions by herself.
>
> (P7)

### 3.2 | Consequences of Decision-Making

Regarding responsibility for decision-making, participants explained that decision-making to assist their intubated older patients could have positive and negative consequences. Regarding positive consequences, 14 participants' older patients could survive after intubation, and they felt happy to see the survival of their loved ones as a result.

> I am happy when I decided to assist him with intubation. I hope to see his recovery.
>
> (P3)

> It is good (intubation). I feel happy when he can breathe easily after inserting a tube. If he is not intubated, he may die.
>
> (P10)

With respect to negative consequences, participants felt worried about the survival of older patients and the effects of prolonged intubation. Meanwhile, they were afraid of signs of deterioration and complications when their older patients had to be intubated for a long time.

> I used to see intubated patients, and they cannot recover. I feel afraid that his symptoms will worsen. He may suffer when they are intubated through his mouth.
>
> (P5)

> I worried as I do not know my decision is wrong or true because intubated patients cannot survive. Meanwhile, the patient may be intubated for many days.
>
> (P8)

### 3.3 | Requiring Assistance

Participants required assistance from physicians, nurses and their family members in decision-making, especially older spouses who lacked experience. They needed information support regarding the process of inserting an endotracheal tube and the subsequent care required for older patients, especially if a decision had to be made about intubation. Additionally, assistance from physicians was required from older spouses. They required physicians' advice to understand the type of endotracheal tube, chance of recovery and complications.

> I didn't know who can rely on in the hospital except the doctor who could give me advice.
>
> (P9)

> The doctor explained to us that intubation is not as dangerous as we thought. We wanted him to explain what would happen after the intubation, what the intubation looks like.
>
> (P13)

Requiring assistance from family members (e.g., children and relatives) was essential to help them listen to and understand physicians' explanations about intubation and mechanical ventilation. This assistance could help them with decision-making because they lack knowledge and experience.

> I would like to talk to children how to decide intubation for his father. Is intubation good or bad? That is his father, and I need his help to listen and think about assistance for his father.
>
> (P2)

> I would like to have relatives and children to listen to what doctors said about decision-making for our patient.
>
> (P8)

### 3.4 | Selected Treatment

Participants decided to select medical treatments for their intubated older patients. Selected treatment included utmost treatment, symptomatic treatment and avoidance of suffering. Regarding utmost treatment, it was the intention of older spouses to provide the utmost treatment with the assistance of physicians for intubated older patients. Their intubated loved ones should not die, as they can survive after intubation.

> I am going to help him and do my best. I think about how to support him in surviving because I do not want him to die.
>
> (P9)

> Doctors can treat him better than I can. I hope that he will be able to go back home.
>
> (P14)

In addition, symptomatic treatment was performed when intubated older patients were unresponsive to medical treatments. Therefore, the purpose of treatment depended on how physicians would treat their intubated older patients' symptoms.

> Symptomatic treatment is fine. A doctor said that his kidneys are failing, and he should undergo hemodialysis. We need to observe him on daily basis.
>
> (P6)

> Doctors are treating him based on his symptoms because he is unresponsive. If he cannot recover, we will continue to treat him according to his symptoms.
>
> (P11)

Apart from utmost treatment and symptomatic treatment, participants explained that natural death was a choice made to avoid unnecessary suffering for older intubated patients. They preferred their loved ones to have a good death and without pain from intubation.

> Let him go his own way. He is suffering.
>
> (P14)

> No need to do anything more. He is enduring so much suffering from pain. He is old. He can't recover like a child. It's best to let him go.
>
> (P15)

## 4 | Discussion

Participants explained their reasons for decision-making, the consequences of decision-making, requiring treatments and selected treatments. The first reason for decision-making, believing in doctors' recommendations, can be described as older spouses who played a role in decision-making for older patients with intubation not having enough previous experience in this type of care. Moreover, they also lacked knowledge, thus knowledgeable physicians could advise them on how to assist their older patients with dyspnoea and respiratory failure and when intubation should be performed. Giving adequate information to relatives by physicians is essential because relatives believed that physicians were well-positioned to support them. Park et al. (2023) indicated that physicians agreed to be primary care providers and were responsible for identifying relatives' needs. Likewise, Kumar et al. (2017) showed that decision-making was a complex issue and physicians were held in awe and seen as the main deciding authority. Therefore, this finding suggests that physicians should have compassionate and communicative competence.

The relationship between husband and wife fosters love and attachment, which is one of the reasons for wanting to enhance the survival of older intubated patients and minimise their suffering. The finding indicated that spouses always share a deep emotional expression, and love may be a key motivator to care for their loved ones (Kahana et al. 2021). In other words, human attachment is an evolutionary-based system designed to ensure proximity to loved ones during times of threat throughout the lifespan (Monin et al. 2014). Additionally, compassionate love and attachment can create a sense of responsibility and willingness to support their loved ones (Sabey and Rauer 2018). Older patients' spouses can be surrogates and involved and informed about responsibility in decision-making for their loved ones (Moss et al. 2019). This finding is consistent with results of previous studies that older patients lacked decisional capacity, thus surrogates commonly face a broad range of decisions about comfort-focused care and life-sustaining treatment (Comer et al. 2020; Torke et al. 2014). Spousal caregivers often assisted with life-sustaining treatment decisions by discussing with adult–child caregivers and relatives when curative treatment was no longer effective for the elderly patient (Zhu et al. 2023). That is, providing care for older partners indicated the fondness and strength of the relationship between husband and wife, as well as love and attachment, which were qualities of a good caregiver (Tabootwong et al. 2022).

One interesting finding concerns the consequences of decision-making. Worry about older patients' survival and the effects of prolonged intubation, as well as the fear of signs of deterioration and complications, were negative consequences of decision-making for intubated older patients. Worry and fear were the psychological impacts of decision-making because family members had to make decisions about critical conditions, such as the patient collapsing, sudden dyspnoea or an overall deteriorated condition, all of which can confuse and shock family members (Lee et al. 2020). In accordance with this finding, a study indicated the difficulty of being a surrogate decision-maker comes from the uncertainty of not knowing what problems may afflict older patients. Moreover, the decision process can be iterative, necessitating constant assessment and reconsideration (Moss et al. 2019). The positive consequences of decision-making, however, include happiness in seeing the survival of older patients, which may be related to the positive psychological effects from caregiving (Schulz et al. 2020). That is, decision-makers who give their loved ones care and support find satisfaction in feeling needed and observing that older patients are happy and comfortable (Pysklywec et al. 2020).

The finding also demonstrated that the spouses required assistance from physicians, nurses and family members in decision-making for older patients with intubation. With assistance from healthcare professionals (e.g., physicians and nurses), older spouses can overcome their lack of knowledge. They required support through information about disease processes and formal care services to help them in decision-making for their older patients (Hall et al. 2022). Meanwhile, physicians and nurses were identified as communicators, care coordinators, conflict mediators and advocates for caregivers (Parmar et al. 2024). In contrast to a previous study, this discovery shows that caregivers encounter difficulties in obtaining and communicating with healthcare providers to help them with decision-making (Rajanala et al. 2020). In addition, older spouses required family members to aid them in listening and problem-solving, with a focus on helping older loved ones with decision-making to prevent conflicts in the family during this process (Parks et al. 2011).

Another finding is that older spouses selected treatments for older patients with attention to utmost treatment, symptomatic treatment and avoidance of suffering. This finding can be explained by the fact that older spouses chose the therapeutic intensity level in accordance with the conditions and chances of long-term survival of older patients, and where a clinical decision must be made (Guidet et al. 2018). Spouses chose life-saving treatments for older adults because they wanted to give their loved ones the best possible chance of survival at the end of life (Batteux et al. 2020). Vincent and Creteur (2022) explained that physicians were usually responsible for end-of-life decisions. The older patients will often have lost the capacity for decision-making because of the illness itself or the treatment. Consequently, decisions about the appropriateness of intensive care, life-sustaining treatment, withdrawing life support and terminal sedation are more frequent among older patients and will likely be discussed by their physicians and relatives. Based on these findings, we can suggest that healthcare professionals should prioritise providing information support and effective communication to assist older spouses in their decision-making. This is important because ageing often leads to increased frailty, a decline in daily living activities and cognitive impairment. These changes may affect delayed decision-making regarding care for older patients who are intubated.

### 4.1 | Strengths and Limitations

This study was conducted in one hospital, which may be a limitation of the context studied. Informational diversity is insufficient because guidelines in supporting families of each hospital may be different. Thus, large sample size and various settings from other hospitals should be considered to obtain diversified data concerning decision-making for intubated older patients among older spousal caregivers. In addition, the first author collected data and interviewed participants by herself as her master's thesis. To prevent researcher bias, investigator triangulation may be used in qualitative research. In addition, findings came from young–older people and female caregivers. That is, there were limitations in explaining the real experiences between gender and age. Therefore, selecting participants may be reconsidered if we would like to do similar research again. Moreover, further research may be warranted targeting male caregivers of older people requiring intubation. However, basic information from this study will be essential to conduct quantitative research and experimental design regarding decision-making for intubated older patients and older spousal caregivers.

## 5 | Conclusions

The findings of this qualitative study indicated older spouses faced making difficult decisions because of the lack of knowledge and experience. However, they were surrogates in decision-making in order to assist their intubated loved ones by considering what physicians and nurses advised. Decision-making to select effective treatments (e.g., utmost treatment, symptomatic treatment and avoidance of suffering) for intubated older patients was performed out of love and attachment to saving the lives of their loved ones. With decision-making often a lonely task, information support from physicians and nurses was essential, and having relatives to help them in decision-making was also the preference of older spouses. Regarding decision-makers, older spouses were happy in taking this responsibility. On the other hand, they felt worried and afraid about complications, prolonged intubation and older patients' survival. Therefore, information and psychosocial support should be provided by healthcare professionals. Moreover, educational programs should be designed to enhance knowledge for older spouses on how to manage older patients with intubation during hospitalisation.


#### Author Contributions

Study design: J.J., W.T., W.K. Data collection: J.J. Data analysis: J.J., W.T. Manuscript preparation: J.J., W.T., W.K.

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The authors have nothing to report.


#### Ethics Statement

The Human Research Ethics Committee, Burapha University (G-HS089/2566).

#### Conflicts of Interest

The authors declare no conflicts of interest.

#### Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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