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Dignity in Intimate Assistance at the End of Life: A Normative Framework for Negotiating Privacy, Dependence, and Patient Preferences during Toileting and Personal Nursing Care

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Abstract

Intimate assistance with toileting, continence, washing, dressing, and related personal care is often unavoidable as serious illness progresses, yet the ethical significance of these encounters is easily obscured when they are treated as routine nursing tasks. Dependence can increase bodily exposure, reduce control over timing and personnel, and intensify vulnerability, while the same assistance may also relieve distress, preserve comfort, and enable patients to remain involved in their own care. This normative analysis examines how dignity should be protected when privacy, physical dependence, patient preference, safety, and professional responsibility cannot all be maximized simultaneously. Drawing on contemporary palliative-care, nursing, dignity, continence, relational-autonomy, and clinical-ethics scholarship, the analysis distinguishes necessary assistance from avoidable exposure and rejects the assumption that dependence itself extinguishes agency. It argues that dignity-preserving intimate care requires attention to the form of authorization under which assistance occurs, the minimum exposure reasonably necessary for care, the opportunities patients retain to influence how assistance is provided, the possibility that preferences change during illness, and the responsibility to explain and review constraints imposed for safety or feasibility. The proposed normative direction therefore treats dignity as relational and context-sensitive while maintaining the patient as the primary locus of authorization. This approach provides a basis for negotiating intimate nursing care without romanticizing independence, treating privacy as an absolute value, or allowing routine and benevolent intention to substitute for patient-specific ethical justification.

Keywords: Dignity, End-of-life care, Intimate nursing care, Relational autonomy, Patient preferences, Bodily privacy

Introduction

Dependence on another person for toileting, continence care, washing, dressing, or cleaning the body is among the most intimate changes that can accompany advanced illness. Such assistance can conserve comfort and bodily integrity, yet it can also make patients acutely aware that actions previously performed privately now require another person's presence, touch, observation, and judgment. Qualitative evidence from palliative and long-term-care settings shows that these encounters are experienced through questions of control, dignity, adaptation, and relationship, rather than as purely functional tasks [1–3]. The ethical problem therefore begins before any obvious disagreement occurs. It is already present in deciding how assistance is offered, how much of the body is exposed, who remains in the room, whether a patient is asked what is preferred, and how nursing routines respond when a person can still influence some aspects of care despite being unable to perform the activity independently.

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Dignity is especially difficult to protect through standardized assumptions because patients do not experience it in a uniform way. A recent meta-synthesis of hospitalized patients' experiences describes dignity as subjective and shaped by interpersonal conduct, environment, vulnerability, recognition, and the degree to which patients continue to be treated as persons whose perspectives matter [4]. This variability is important at the end of life. A patient may attach great importance to covering the body during washing but be relatively unconcerned about the use of a continence device. Another may prefer rapid assistance from whichever nurse is immediately available because waiting is more distressing than exposure. The ethical objective cannot therefore be reduced to maximizing privacy independently of the patient's circumstances. It requires identifying which aspects of privacy, control, comfort, and participation matter to the particular person in the particular encounter.

Bodily proximity can also carry meanings that are not exhausted by ordinary accounts of confidentiality or physical safety. Work on sexual dignity discomfort in healthcare identifies insufficient preparation, unwanted exposure, objectification, shame, vulnerability, and loss of control as ethically relevant features of bodily care [5]. These concerns do not imply that necessary intimate touch is inherently degrading. They show why the manner in which necessary touch occurs is ethically significant. A technically competent procedure may still be experienced as exposing or depersonalizing when it is performed without adequate explanation, without an opportunity to express a preference, or with more observers or bodily exposure than the task reasonably requires.

This article develops a normative framework for that space between unavoidable dependence and avoidable intrusion. Its focus is adult end-of-life nursing in which the patient requires assistance with toileting or closely related personal care but may retain varying capacities to communicate wishes, choose among feasible options, accept help selectively, or revise earlier preferences. The central question is not whether dependence should be eliminated; for many dying patients that is impossible. The question is how necessary assistance can be ethically justified and delivered while preserving meaningful agency, privacy, bodily integrity, and protection from harm. The analysis therefore examines the clinical conditions under which intimate dependence arises, the normative principles that remain applicable within dependence, the conflicts that occur when those principles compete, and the form of practical reasoning nurses need when no single value can determine the encounter.

Ethical and clinical background

End-of-life bodily care makes the relationship between dependence and dignity unusually visible. Ethnographic research in nursing-home end-of-life care shows that bodily dependence can heighten vulnerability when residents must wait, adapt to institutional routines, or relinquish aspects of privacy, while sensitive interpersonal conduct can protect dignity within the same dependence [6]. The ethically relevant distinction is therefore not between independence and assistance in the abstract. It is between forms of assistance that preserve as much personhood and control as circumstances permit and forms that add avoidable indignity to an already dependent situation.

Continence care illustrates this distinction particularly clearly. Nursing-home staff have described dignity as central to good continence care, linking it with privacy, timely assistance, individualized treatment, and sensitive communication [7]. Conceptual work on dignity-protective continence care similarly extends the meaning of quality beyond successful containment or cleansing [8]. A pad may be changed correctly and promptly while the encounter still leaves the patient feeling ignored or unnecessarily exposed. Conversely, needing substantial assistance need not by itself produce indignity when the interaction preserves recognition, control where possible, and discretion around the body.

These observations place toileting and personal hygiene within the broader literature on fundamental nursing care. A systematic qualitative synthesis of patient and nurse experiences found that fundamental care depends on more than completion of physical tasks; relational engagement and the organizational conditions in which nurses work shape how such care is experienced [9]. Direct observation in nursing homes likewise indicates that physical, psychosocial, and relational dimensions of nursing practice are intertwined rather than neatly separable [10]. For intimate assistance, this means that competent technique and ethical quality cannot be assumed to coincide automatically. A nurse may meet the physical requirement of the task while failing to establish whether the patient wants assistance now, prefers a different method, is distressed by the number of people present, or wishes to retain one achievable part of the activity.

Organizational pressures complicate this picture. Evidence on missed fundamental nursing care shows that care omissions can occur when nurses face resource limitations and competing demands [11]. Comparative work on the quality of fundamental care also suggests that apparently routine aspects of nursing remain sensitive to prioritization and service conditions [12]. In intimate care, such pressures may encourage standardization: using the quickest continence strategy, assisting according to staff workflow rather than patient timing, or treating repeated preference checking as impractical. Resource constraints may explain why options are limited, but they do not make the patient's preferences ethically irrelevant. A distinction must therefore be maintained between what a service cannot reasonably provide and what staff have ceased to ask because a routine has become normalized.

The patient's preferences also arise in a relational environment. Research with nursing-home residents and care partners shows that priorities for care may be developed and expressed through relationships involving identity,

advocacy, mutual adjustment, and practical support [13]. Relationality is especially important at the end of life, where family members may know longstanding preferences or help interpret subtle expressions of discomfort. Yet relational involvement does not convert a patient's body into a shared decision-making object. Family participation can aid understanding without becoming automatic authorization for exposure, presence during toileting, or decisions about how assistance should be given.

Cultural and spiritual contexts further complicate any assumption that dignity has one universal expression. In palliative-care research, family and faith have been described as important sources through which some patients experience dignity and support [14]. At the same time, serious-illness research suggests that dignity has individual, relational, and social dimensions whose importance differs across life circumstances [15]. A patient who wants a daughter present during personal care may therefore experience privacy differently from a patient who finds family presence deeply embarrassing. Respect for culture cannot be achieved by assigning a culturally expected preference to an individual. It requires making room for the person's own interpretation of family, modesty, exposure, gender, assistance, and acceptable dependence.

The practical consequence is that intimate end-of-life care contains several ethically distinct conditions that can coexist in one encounter. Physical assistance may be necessary while the amount of exposure remains negotiable. A nursing routine may be clinically efficient while its timing conflicts with a patient's expressed preference. Family presence may be supportive in one circumstance and intrusive in another. A patient may require near-total physical assistance yet still retain meaningful control over pace, personnel, positioning, covering, communication, or whether a particular step occurs immediately.

These distinctions organize the ethical terrain summarized in **Table 1**.

Table 1. Ethically relevant distinctions between necessary dependence and avoidable intrusion during intimate end-of-life nursing assistance

Intimate-care condition	Patient interest that remains ethically active	What dependence may genuinely require	What can become avoidable intrusion	Nursing obligation in the encounter	Important contextual modifier
Loss of independent toileting ability	Control over how assistance occurs	Physical support, transfer, cleansing, continence management	Assuming that inability to toilet independently removes the need to ask preferences	Preserve feasible choices in timing, method, positioning, pace, and personnel	Fatigue, mobility, urgency, symptom burden
Necessary bodily exposure	Privacy and bodily integrity	Exposure sufficient to complete safe care	Exposing more of the body, for longer, or to more people than reasonably necessary	Limit exposure and restore covering promptly where feasible	Procedure, environment, available equipment, emergency
Repeated intimate contact	Predictability and psychological security	Recurring touch and close bodily proximity	Unexplained contact, abrupt handling, or treating familiarity as ongoing permission	Explain what will happen and remain attentive to withdrawal or discomfort	Cognitive state, communication ability, prior experience
Institutional timing and routine	Temporal control and dignity	Coordination with staffing and clinical demands	Treating workflow convenience as sufficient reason to disregard a stated preference	Negotiate timing where feasible and explain genuine constraints	Staffing, competing urgent care, service setting
Continence-management strategy	Comfort, dignity, participation in choice	Use of products, equipment, or hands-on assistance when clinically appropriate	Defaulting to a method without considering the person's priorities	Elicit preferences and revisit them when circumstances change	Pain, urgency, mobility, fatigue, symptom relief
Family or caregiver involvement	Control over who witnesses or participates in intimate care	Assistance from trusted others when desired or practically necessary	Presuming family presence is welcome because relatives are closely involved in care	Clarify the patient's preference for presence and role	Culture, family relationship, communication support

Declining strength with retained decision-making ability	Agency within physical dependence	Increasing hands-on support	Equating physical dependence with diminished authority over personal care	Separate assistance needs from decision-making authority	Capacity, delirium, sedation, fluctuating consciousness
Safety or safeguarding concern	Respect, explanation, and proportionality	Additional supervision or limitation when a serious risk requires it	Using generalized risk language to justify unnecessary restriction or exposure	Identify the specific risk, use the least intrusive feasible response, and remain accountable for the constraint	Urgency, legal duties, capacity, environmental risk

The clinical background therefore yields an important distinction for the normative analysis that follows. Dependence describes what a patient cannot safely or comfortably do without assistance. It does not by itself determine what the patient may decide, what exposure is justified, how assistance should be offered, or when professional obligations permit a preference to be constrained.

Normative foundations

The first normative foundation is respect for persons understood within dependence rather than only within independence. End-of-life ethics has increasingly challenged models of autonomy that imagine decision-makers as socially detached individuals. Relational accounts instead recognize that choices are made within relationships, illness trajectories, material constraints, and networks of care, while feminist work on vulnerability emphasizes that dependence and vulnerability do not automatically eliminate agency [16, 17]. This is especially important in intimate nursing care. A patient who cannot transfer to a toilet alone may remain entirely capable of deciding whether assistance is acceptable, who should provide it, whether a door should remain closed, which parts of the body should stay covered, or whether a few minutes of delay are preferable to immediate assistance.

Relational autonomy also changes what nursing support should accomplish. Nursing responsibility does not consist only in leaving a person to choose without influence. Studies of home-care nursing show that autonomy can be supported through relational practices in which nurses remain attentive to the person, the context, and the practical conditions required for meaningful choice [18]. In intimate care, such support may involve presenting feasible alternatives, helping a fatigued patient communicate, slowing the encounter long enough for hesitation to be expressed, or enabling the patient to perform one small component of care independently. These practices preserve agency without pretending that the patient is physically independent.

Professional autonomy and institutional organization matter because nurses themselves require sufficient discretion to respond ethically. Philosophical analysis of institutional moral agency has argued that healthcare organizations can strengthen or weaken nurses' capacity to support patient autonomy [19]. A service that gives nurses no time to respond to individual toileting preferences, provides no means to protect privacy, or organizes intimate care entirely around rigid routines shifts the ethical burden onto the bedside while limiting the conditions required for ethically responsive practice. Accountability for dignity therefore extends beyond interpersonal manners to the systems that structure available choices.

Relational autonomy nonetheless has an important limit: relationships can constrain as well as support. A meta-synthesis of relational autonomy in medical decision-making identifies interpersonal support, information, and respectful relationships as potentially autonomy-enhancing, while dominant voices, pressure, and unequal relationships can undermine autonomous participation [20]. This distinction prevents "relational" care from becoming a rationale for family or professional substitution. A nurse or relative may know the patient well and still misunderstand what the person wants in an intimate encounter. Familiarity can improve interpretation, but it does not create permanent permission.

The temporal character of serious illness adds another layer. Philosophical work on the transformative experience of disease highlights how illness can change values, expectations, and the standpoint from which choices are made [21]. End-of-life preferences about intimate care should therefore not be treated as permanently fixed because a patient previously accepted a particular arrangement. A continence product that initially felt humiliating may later be preferred because transfers have become painful. A patient who once insisted on toileting without assistance may later welcome help while still wanting control over who provides it. Conversely, increasing dependence does not authorize clinicians to assume that previously important modesty preferences have ceased to matter.

A further normative distinction is required between care and paternalism. Palliative-care ethics has emphasized that caring action cannot be defined merely by beneficial intention; the relationship between professional action and the patient's will remains ethically significant [22]. This is particularly relevant when nurses believe an option is safer, quicker, cleaner, or less exhausting. Benefit may justify recommending an approach and, under some conditions, may support limiting a choice that creates serious risk. It does not automatically convert the preferred

professional option into authorized care. The ethical question concerns both the reason for intervention and the manner in which the person's will is recognized when professional judgment and patient preference differ.

Moral competence in nursing consequently requires more than knowing ethical principles. International qualitative research with nurses and patient representatives has characterized the morally competent nurse through person-centred knowledge, relational abilities, ethical sensitivity, and attitudes that enable morally responsive practice [23]. In intimate assistance, competence includes recognizing the significance of seemingly small decisions: whether to ask before uncovering the body, whether a second person truly needs to be present, whether silence reflects agreement or fatigue, and whether a standard care routine can be altered without compromising safety.

Taken together, these normative foundations support a dignity-preserving account of intimate assistance built around five distinctions. First, permission concerns whether and how the patient authorizes assistance in the specific encounter; dependence itself cannot supply that authorization. Second, exposure minimization concerns the difference between bodily access genuinely required for care and additional exposure that serves no sufficient care purpose. Third, negotiated assistance concerns the forms of agency that remain available even when physical independence is greatly reduced. Fourth, ongoing preference checking recognizes that preferences can change across symptoms, time, relationships, and illness progression. Fifth, accountability concerns the reasons nurses and organizations must be able to give when safety, safeguarding, urgency, or feasibility restricts what the patient would otherwise prefer.

The interaction among these foundations is represented in **Figure 1**.

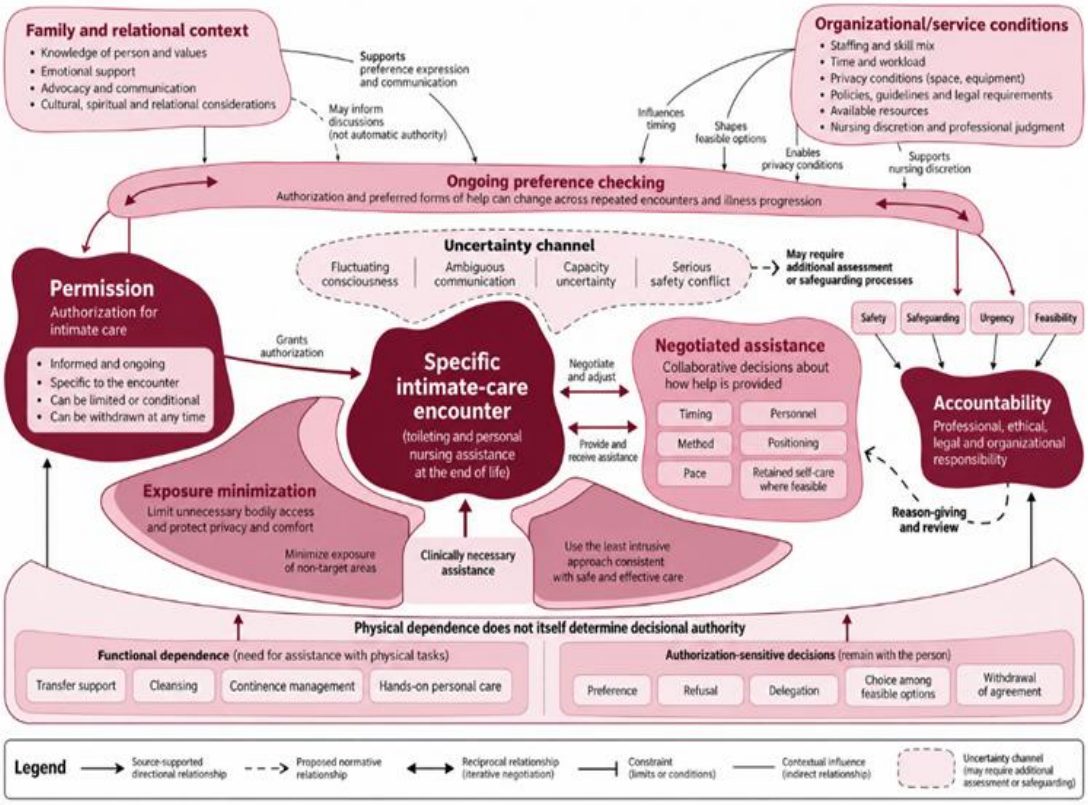


Figure 1. Dignity-preserving negotiation of intimate nursing assistance under conditions of end-of-life dependence

Competing ethical requirements

The most difficult intimate-care encounters are rarely conflicts between dignity and an obviously unethical alternative. More often, several legitimate obligations point in different directions. End-of-life nurses report difficulties around participation, professional responsibility, and shared decision-making when clinical circumstances narrow the range of acceptable options [24]. From the patient perspective, desired participation is also variable: some people want extensive involvement, whereas others prefer clinicians to carry more of the decisional burden when illness, fatigue, or uncertainty intensifies [25]. Ethical nursing therefore requires neither maximal independence nor maximal professional control. It requires attention to what form of participation the patient wants and can meaningfully exercise in the particular encounter.

Safety provides the clearest example. A patient may prefer to toilet without assistance even when weakness creates a substantial risk of falling, or may resist a continence strategy that nursing staff consider safer. Comparable palliative-care research shows that nurses frequently confront genuine conflicts among autonomy, comfort, family wishes, and professional duties rather than situations in which one principle straightforwardly determines action [26]. Safety can therefore justify limiting a preferred option, but it does not make the preference ethically invisible. The relevant question becomes whether the restriction addresses a sufficiently serious risk, is proportionate to that risk, and leaves intact whatever control can reasonably be preserved.

Influence must also be distinguished from authorization. Qualitative work on nudging in nursing homes shows that apparently gentle attempts to steer behavior can raise autonomy concerns when professionals structure choices toward a preferred outcome [27]. Intimate assistance is particularly susceptible to this problem because patients may be tired, embarrassed, hurried, or dependent on the very person presenting the options. A suggestion such as "we will use the pad tonight because it is easier" can function differently from "would you prefer the commode, bedpan, or pad, given how tired you are?" The ethical difference lies partly in whether the patient is given a genuine opportunity to participate.

These bedside conflicts are reinforced by organizational conditions. Systematic evidence on end-of-life nursing identifies recurring tensions involving autonomy, beneficence, communication, family involvement, and professional obligations [28]. Moral-distress research further shows that ethical difficulty arises at interpersonal, organizational, and structural levels rather than exclusively from individual nurses' judgment [29]. Staffing, room configuration, time pressure, availability of lifting equipment, and institutional routines can all limit feasible options. Such constraints may be unavoidable, but they should be recognized as constraints rather than transformed into claims about what the patient ought to prefer.

Table 2 distinguishes several recurrent forms of conflict and the ethically defensible nursing response each requires.

Table 2. Patient preference and nursing obligation when intimate-care values conflict

Encounter conflict	Patient preference at stake	Legitimate nursing concern	Ethically insufficient response	Required form of negotiation	Residual accountability question
Patient wants unassisted toileting despite instability	Independence and privacy	Fall prevention and injury avoidance	Automatically prohibiting all self-participation	Identify which elements can remain patient-controlled while assistance addresses specific risk	Was the restriction proportionate to the actual risk?
Patient refuses a continence product preferred by staff	Bodily control and comfort	Hygiene, skin protection, workload and timely care	Treating staff convenience as clinical necessity	Explain realistic alternatives and consequences without coercive presentation	Were less intrusive alternatives genuinely considered?
Patient wants delayed assistance	Control over timing	Urgency, symptoms, workload or deterioration	Ignoring the request because a routine schedule has begun	Clarify urgency and negotiate timing where clinically feasible	If delay was refused, was the reason explained?
Patient requests a particular caregiver	Modesty, trust or cultural preference	Staff availability and service continuity	Dismissing the request as irrelevant because all staff are competent	Explore whether accommodation is feasible and what alternative would be acceptable	Was non-accommodation necessary or merely convenient?
Family requests involvement the patient has not endorsed	Relational support	Communication or practical care support	Assuming closeness equals permission	Establish the patient's preference for family presence whenever possible	Whose preference is actually guiding the encounter?
Patient accepts help but resists one component	Selective authorization	Completion of necessary care	Treating agreement to the overall task as agreement to every step	Pause, explain the disputed step and seek renewed agreement or an alternative	Was the disputed component genuinely necessary?
Safeguarding concern limits the preferred option	Agency and dignity	Prevention of serious harm	Invoking "safety" without specifying the risk	Use the least intrusive feasible restriction and preserve unaffected choices	Can the restriction be justified, documented and revisited?

Proposed normative framework

The resulting Normative Dignity-Preserving Care Framework treats intimate assistance as a sequence of ethically revisable judgments rather than a one-time consent event. Its first requirement is permission. Permission concerns authorization for this assistance, in this form, at this time. It may be explicit, communicated through behavior, or supported through appropriate decision-making processes when communication is limited, but it cannot be inferred merely from physical dependence.

Second, the framework requires exposure minimization. The ethical objective is not zero exposure, which would make many forms of personal care impossible. It is avoidance of exposure that serves no sufficient care purpose. Covering unaffected parts of the body, limiting unnecessary observers, explaining impending touch, and restoring privacy promptly are therefore ethically relevant features of care rather than cosmetic courtesies.

Third, assistance should be negotiated wherever options remain. Palliative nurses describe dignity-preserving care as involving individualized attention, practical competence, sensitivity, and presence [30]. Negotiation operationalizes those qualities by asking what the patient can still control: timing, pace, position, caregiver, continence method, sequence, or participation in one part of the task. Negotiation can also result in willing delegation; dignity does not require forcing decision-making activity on someone who prefers staff to take the lead.

Fourth, preferences require ongoing checking. Confidential and meaningful conversations in palliative nursing often emerge during ordinary care rather than only in scheduled decision meetings [31]. Nursing communication is therefore constitutive of care itself, not simply information transfer [32]. A brief question during washing or toileting may reveal that a previously acceptable arrangement has become painful, embarrassing, or unnecessarily tiring. Cultural research on sensitive clinical preferences reinforces the importance of elicitation rather than assumption [33].

Fifth, the framework requires accountability for constraint. When safety, safeguarding, urgency, or feasibility prevents the patient's preferred option, the ethical task does not end with the restriction. The reason should be specific, proportionate, and open to reconsideration. Accountability distinguishes an ethically justified limit from a routine override: the nurse or service should be able to explain what risk or constraint required the departure from preference, why a less intrusive option was insufficient, and what elements of patient control remain available.

These five requirements operate together. Permission without feasible alternatives can become nominal choice; exposure minimization without attention to patient preference can become impersonal modesty management; negotiation without safety judgment can become neglect; and safeguarding without accountability can become paternalism. The framework therefore protects dignity by preserving the patient as the primary locus of authorization while recognizing that professional obligations can sometimes constrain the range of feasible choices.

Results and Discussion

The framework rejects two symmetrical errors. The first is to romanticize independence so strongly that nurses fail to provide needed assistance for fear of appearing intrusive. Vulnerability can make abandonment or delayed assistance as harmful to dignity as unnecessary control. The second is to interpret dependence as permission for routine substitution of professional judgment. Beneficent intentions matter, but they cannot make patient authorization irrelevant.

Family involvement illustrates the importance of this middle position. Family caregivers may themselves experience significant dignity-related burdens during home end-of-life care [34]. Their needs deserve attention, particularly where they provide intimate assistance. Yet caregiver burden does not automatically authorize practices the patient rejects. Family participation is best understood as a contextual resource or potential constraint whose ethical legitimacy depends on the patient's wishes, the caregiver's own limits, and the seriousness of competing care needs.

Implementation will also vary by setting. Home care may permit continuity with a preferred caregiver but provide fewer practical resources. Institutional settings may offer equipment and rapid assistance while increasing exposure to unfamiliar staff or rigid routines. Cultural expectations concerning family presence, gender, bodily modesty, and professional authority can alter the meaning of the same nursing action. The framework therefore specifies questions that require attention rather than producing one universal answer.

Its evidence base also has limits. Much of the most directly relevant literature is qualitative, setting-specific, or focused on broader dignity and continence phenomena rather than testing a unified intimate-care intervention. Measurement is another limitation. A systematic COSMIN review of dignity-related patient-reported measures found important gaps in the evidence supporting several measurement properties [35]. Future validation should therefore combine patient interviews and observational research with carefully selected quantitative instruments rather than assuming that a single dignity score captures whether intimate assistance was ethically appropriate.

Table 3 translates the framework into normative guidance while preserving these limits.

Table 3. Normative guidance for evaluating intimate end-of-life care encounters

Question for evaluation	Dignity-preserving interpretation	Warning sign	Context that may justify limitation	Required follow-through
Was assistance authorized?	The patient had a meaningful opportunity to accept, refuse, modify or delegate assistance	Dependence was treated as sufficient permission	Immediate danger or inability to communicate may narrow ordinary authorization processes	Reassess authorization when circumstances permit
Was exposure necessary?	Bodily access was limited to what the task reasonably required	Routine exposure exceeded the care need	Emergency access may temporarily increase exposure	Restore privacy promptly and review avoidable exposure
What control remained possible?	The patient influenced feasible aspects of timing, pace, method or personnel	Physical dependence was equated with total passivity	Severe symptom burden may reduce desired participation	Offer participation without imposing it
Were preferences current?	Staff remained attentive to changing wishes	Earlier acceptance was treated as permanent consent	Stable preferences may permit less repetitive questioning	Continue proportionate checking for change
Was family involvement patient-aligned?	Family support reflected the patient's wishes where these could be established	Family preference replaced patient preference without justification	Capacity loss or communication failure may require formal surrogate roles	Distinguish supportive involvement from decisional authority
Was a restriction proportionate?	Safety or safeguarding limits addressed a specific serious concern	"Safety" was used as an unexplained blanket rationale	Serious and immediate risk can justify narrower options	Preserve unaffected choices and reconsider when risk changes
Can the decision be explained?	Staff can state why the chosen assistance was necessary and why less intrusive options were insufficient	Routine or convenience is the only rationale	Resource scarcity may genuinely constrain feasible care	Document and escalate recurrent system constraints where appropriate

The framework should therefore be tested empirically before it is treated as a clinical standard. Useful research would examine how patients interpret permission and avoidable exposure, whether nurses can operationalize negotiated assistance under real staffing conditions, how cultural and family contexts alter acceptable forms of intimacy, and whether repeated preference checking improves the experience of care without becoming burdensome. Such work should also distinguish patient-reported dignity from clinician assessments, because the very problem addressed here arises when professionally reasonable care and personally acceptable care do not fully coincide.

Conclusion

Intimate assistance at the end of life is ethically significant because necessary dependence places bodily privacy, comfort, safety, professional responsibility, and patient agency in direct contact. Dependence does not itself extinguish authority over how the body is approached or how assistance is delivered. Dignity-preserving care therefore requires permission for the encounter, limitation of avoidable exposure, negotiation of whatever aspects of assistance remain open to choice, ongoing attention to changing preferences, and accountability when safety or feasibility constrains what the patient wants. These requirements do not guarantee that every value can be simultaneously satisfied. They provide a disciplined way to distinguish justified assistance from unnecessary intrusion and safeguarding from unexamined paternalism. The ethical quality of intimate end-of-life nursing consequently depends not on preserving independence at all costs, but on preserving meaningful agency within dependence.

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