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ETHICS IN MEDICAL FUTILITY AT THE END-OF-LIFE: A REVIEW

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Abstract

Ethics in medical futility at the end-of-life concerns when it is morally appropriate to withhold or withdraw treatments that are deemed to have no reasonable chance of providing meaningful benefit to a patient. The authors offer in-depth perspective derived from literature on the ethics of medical futility based on the four standard bioethical principles frame futility debates: beneficence (providing benefit), nonmaleficence (avoiding harm), respect for autonomy (honoring informed choices), and justice (fair use of resources). Clinicians are expected to offer only treatments that are medically appropriate and consistent with professional standards of care. Ethically sound practice requires eliciting patient's values, goals and explaining which interventions can or cannot meet acceptable outcomes, and, when conflict persists, using structured processes such as ethics consultation or institutional policies rather than unilateral bedside decisions.

Keywords: *Autonomy, Beneficence, Ethics, Justice, Medical Futility, Nonmaleficence*

Research Highlights

What is the current knowledge?

- There is still no consensus about who should have final authority when conflicts about medical futility cannot be resolved.
- Current ethical guidance broadly holds that clinicians are not obligated to provide interventions they judge to be non-beneficial or medically inappropriate at the end-of-life.
- End-of-life care planning is ethically grounded in aligning medical decisions with the patient's values, goals, and best interests while minimizing suffering and using resources fairly.

What is new in this study?

- The four standard principles of bioethics may provide a clear structure for understanding the ethics of medical futility at the end-of-life.
- Contemporary approaches stress shared, transparent communication processes rather than unilateral decisions, combining evidence-based prognosis with careful attention to patient values, family perspectives, and institutional policies.
- Integrating palliative care supports symptom control, emotional and spiritual needs, and family caregiving, helping prevent unwanted aggressive treatments in the final days of life.

INTRODUCTION

Medical futility refers to a situation where a medical treatment is unlikely to offer any real benefit to the patient (Temple & Waspe, 2025). In the literature, this concept is typically divided into two main categories: physiological or quantitative futility, and qualitative futility (Rubin et al., 2023). Physiological futility occurs when a treatment will not produce the desired physiological positive outcome or does not realistically offer a chance to restore physiological function. In contrast, qualitative futility occurs when a treatment has some effect, such as maintaining biological life but does not enhance or sustain what many would consider a meaningful quality of life. However, no objective or universally accepted criteria exist to determine when treatment is futile, making decisions inherently difficult and individualized. Cultural and religious perspectives profoundly shape views on medical futility, particularly regarding the sanctity of life, the acceptability of withdrawal of care, and definitions of suffering or dignity (Hamdan Alshehri et al., 2025; Ramazani et al., 2025).

Ethics in medical futility is a complex and evolving field that challenges the boundaries of medicine, intertwining with the values of patients, society, and the duties of healthcare professionals (Huang, 2025). Navigating the concept of medical futility exposes individuals to a range of vulnerabilities and ethical challenges. A key ethical concern is determining whether a treatment will benefit the patient by improving their condition or quality of life (beneficence) or potentially cause more harm than good (nonmaleficence). It is also important that the treatment aligns with the patient's own goals and wishes (autonomy) and supports the interests of the patient, society, and the healthcare system as a whole (justice; Varkey, 2021). The four guiding principles in biomedical ethics often come into tension when considering the withdrawal or withholding of treatments deemed futile. For example, patients or families may wish to continue treatments based on personal, religious, or cultural values, while clinicians may judge such interventions as offering no real benefit or even causing harm. It is vital to recognize that when life-sustaining treatment is unlikely to achieve meaningful benefits, such as symptom improvement, continued care may be discordant with the patient’s goals (Kopar et al., 2022).

Autonomy

Medical futility highlights the tension between a physician's authority and a patient's autonomy, making it a vital issue in ethical decision-making at the end of life (Rubin et al., 2023). The philosophical basis for autonomy in medicine is that every person has intrinsic and unconditional worth, which means all individuals should have the power to make rational decisions and moral choices, and each should be allowed to exercise their capacity for self-determination (Varkey, 2021). The concept of patient autonomy means that patients are directly involved in making decisions about their treatment (Ramazani et al., 2025). Autonomy underpins informed consent and protects individuals from coercion, thus affirming their right to make decisions about their own bodies and care (Varkey, 2021). As patient autonomy has become a central guiding principle, clinicians have faced dilemma when patients or their surrogates insist on treatments that physicians judge to be ineffective or non-beneficial. While a physician may ethically choose to limit treatments that are deemed inappropriate or futile, this raises important questions about who has the authority to define futility. To date, there is no consensus on who should hold the ultimate decision-making authority in matters of medical futility (Huang, 2025). Decisions regarding what is considered futile can lead to conflict between healthcare providers and patients or their families, who may strongly believe that every effort should be made to prolong life regardless of the circumstances (Udwadia et al., 2023). Common reasons for providing futile treatments include requests from patients or families, healthcare professionals’ personal motives, and social or organizational pressures, which can result in patient suffering, financial burdens, moral distress among healthcare workers, and reduced quality of care (Huang, 2025).

Medical futility has become a key element in clinical decision-making, primarily due to the growing emphasis on patient autonomy in healthcare (Huang, 2025). The rise of autonomy has created a need to balance patients’ rights to make decisions with physicians’ professional judgment about what constitutes beneficial treatment, leading to the consideration of futility as a guiding principle in withholding or withdrawing care despite patient requests. While continuing ineffective, aggressive treatment may seem irrational, these decisions are rooted in different values and perspectives on time held by patients and doctors (Huang, 2025). What may appear as a clinically appropriate choice could be ethically questionable if it fails to consider the patient’s personal experiences and outlook on life (Kopar et al., 2022).

Healthcare providers face challenges in end-of-life care planning due to limited knowledge of end-of-life care and legal frameworks, while family conflicts and limited understanding of end-of-life care contribute to delays in decision-making (Kim et al., 2025). Advance care planning, including the development of advance directives and designation of healthcare proxies or surrogates, offers a proactive means to mitigate conflicts related to medical futility (Sedini et al., 2022). When patients express their preferences in advance, it can guide clinicians and family members in making decisions that respect the patient’s values, even when the patient cannot speak for themselves. Shared decision-making models, which emphasize partnership and mutual respect between patients and healthcare professionals, have been beneficial in facilitating conversation about medical futility (Huang, 2025). This approach requires clinicians to provide honest information about prognosis and likely treatment outcomes while supporting patients in expressing and achieving their goals for care. Respecting patient autonomy means that clinicians must disclose important medical information and treatment options. This is essential for patients to make informed choices and upholds the values of informed consent, honesty, and confidentiality. Balancing the autonomy and best interests of the individual at end of life with family wishes and institutional realities remains a significant challenge, necessitating institution-sensitive support and training for providers. End-of-life care planning requires careful navigation of ethical and legal considerations involving the patient, family members, and external factors.

Surrogate decision-making for end-of-life care is a complex and emotionally challenging process for both healthcare providers and families. Decisions are typically made during critical transitional periods, such as facility admission or significant health decline, and involve discussions about treatment options, possible transfers to acute care, and do-not-resuscitate or life-sustaining treatment orders (Kim et al., 2025). Healthcare providers, including physicians, nurses, and social workers, should lead in conveying information, guiding families, and facilitating discussions. Conversations about medical futility should prioritize patient autonomy but are often influenced by family consensus and legal requirements, such as the need for two physicians to confirm imminent death before withdrawing life-sustaining treatments (Kim et al., 2025). Providers are urged to balance their professional duty to avoid non-beneficial interventions with the respect for the wishes of the patient and family during end-of-life care in terminal or declining health states (Temple & Waspe, 2025). This process requires collaborative decision-making that considers ethical, emotional, and legal factors, aiming to provide compassionate care while upholding the patient's values and the best available medical judgment (Huang et al., 2025). Therefore, strong protections for patient autonomy through robust communication, second opinions, and fair review processes, rather than simple refusal at the bedside should be adopted.

Beneficence and Nonmaleficence

Beneficence and nonmaleficence are closely linked ethical concepts in healthcare that play a critical role in considerations of medical futility. Beneficence refers to the physician's duty to act in the best interest of the patient by providing treatments that offer benefit and improve the patient's condition or quality of life (Varkey, 2021). Conversely, nonmaleficence is the ethical principle obligating physicians to avoid causing harm (Varkey, 2021). It requires clinicians to weigh the potential harms and burdens of treatments against their likely benefits, avoiding interventions that are excessively burdensome or likely to cause suffering without meaningful benefit to the patient. In situations of medical futility, continuing aggressive or non-beneficial treatments can lead to increased patient suffering, diminished quality of life, and depleted healthcare resources, which contradicts the principle of nonmaleficence. Decisions about futility must consider the patient's best interest and dignity, typically involving transparent communication and ethical deliberation, including input from ethics committees or legal processes if contested (Kopar et al., 2022). This approach aligns with principles set forth in guidelines like the *American Medical Association Code of Ethics* and Catholic healthcare ethical directives, framing futility decisions as a duty-bound ethical responsibility rather than mere clinical judgment (Huang et al., 2025; Ramazani et al., 2025).

Within a similar framework, deontological (duty-based) ethics in medical futility emphasizes the professional obligations of physicians to act according to established duties, primarily to avoid harm and promote patient well-being, regardless of outcomes (Clark, 2007; McQuoid-Mason, 2017; Vearrier & Henderson, 2021). The physician–patient relationship is a deontological construct in which the physician's primary duty is to the patient. This perspective holds that physicians have a moral obligation to act according to professional and ethical duties, such as preserving patient dignity, avoiding harm, and using healthcare resources responsibly. Under this basis, a physician is justified in refusing to provide interventions that are deemed futile, even if requested by a patient or surrogate, because the duty to avoid harm and promote beneficence overrides obligation to comply with all patient demands.

In the context of medical futility, nonmaleficence supports the withholding or withdrawing of treatments that merely prolong dying, cause pain, or decrease quality of life without a realistic chance of recovery or improvement (Ramazani et al., 2025). Physicians may justify declining an intervention with minimal benefit on the grounds that the risks or burden outweigh the potential benefits (Brown, 2018). Clinicians must carefully weigh the benefits and burdens of interventions, prioritizing treatments that respect the patient's dignity and quality of life and avoiding those that only prolong suffering without meaningful benefit. Physicians' right, and sometimes their duty, is often upheld to refrain from providing interventions that are clearly ineffective, even when such care is requested by patients or families (Brown, 2018).

Patients may undergo care that conflicts with their personal goals, enduring interventions that cause pain and suffering rather than allowing a dignified death (Ibrahim et al., 2024). Families and surrogate decision-makers often face uncertainty about their roles, feel burdened by decisions regarding withholding or withdrawing care, and, if aggressive resuscitation is pursued, risk missing the opportunity to be present with their loved ones during their final moments (Ibrahim et al., 2024). Nonetheless, the legal framework often requires physicians to communicate the rationale for such decisions, engage in discussion, facilitate second opinions, and sometimes arrange transfers of care (Misak et al., 2016).

Effective and compassionate communication is essential throughout this process. Healthcare professionals are encouraged to avoid the term "futility" in discussions with patients, opting instead to frame conversations around the potential benefits and burdens of treatment in relation to specific goals of care (Misak et al., 2016). By actively listening, respecting uncertainty, and engaging in honest dialogue, clinicians can better align medical interventions with patient preferences and values, even as limits are recognized. This ethical stance supports withholding or withdrawing futile treatments while fostering empathetic, patient-centered dialogue to navigate these complex decisions.

Justice

Justice focuses on promoting equality in healthcare (Vearrier & Henderson, 2021). Concerns over limited medical equipment and resources have raised the issue of medical futility, shifting the lens of principlism from deontological to utilitarian views (Heydari et al., 2025; Vearrier & Henderson, 2021). How can we fairly allocate limited healthcare resources while maintaining professional integrity and respecting diverse values of life within reasonable limits of care? The ethics of medical futility extend beyond individual cases to the society level, where the interests of individuals may be overshadowed by those of the population at large through a utilitarian approach that maximizes net benefit for society. Utilitarian (consequence-based) ethics in medical futility emphasizes promoting the greatest good for the greatest number of people, focusing on outcomes such as effective stewardship of medical resources and the collective welfare of society (Vearrier & Henderson, 2021). This ethical approach justifies withholding futile treatments to conserve scarce healthcare resources for patients who are more likely to benefit (Vearrier & Henderson, 2021). The principle assumes particular significance during public health emergencies or in settings with limited intensive care availability. Under utilitarian nonmaleficence, threats to population health may outweigh potential or actual harms to individual patients. Discussions continue over risks of bias (for example, devaluing lives with disability), how to fairly integrate resource stewardship, and how much uncertainty is acceptable before labeling treatment "futile," so the field remains ethically and practically contested even as process-based, dialogical approaches gain prominence.

Debates around expensive diagnostic or therapeutic procedures often address the intersection of medical futility and healthcare rationing (Heydari et al., 2025). Medical futility refers to situations where a treatment just does not work for a patient, regardless of cost or resource allocation (Kopar et al., 2022). On the other hand, rationing recognizes that a treatment could benefit a patient but may not be reasonable or fair to provide due to high costs or competing needs of other patients (Heydari et al., 2025). It is crucial to avoid futile treatments not for economic reasons, but because they do not benefit the individual. Conversely, beneficial but costly treatments might sometimes be withheld if their benefits do not justify the costs. Decisions about futility are made at the bedside for each patient, whereas rationing decisions occur at the community or policy level to ensure equitable resource distribution. Importantly, futility policies should not be misused as cost-cutting measures, as there is a legitimate concern that treatments could be mislabeled futile simply to reduce healthcare expenditures.

A qualitative study conducted by Close et al. (2019) in Australia explored how doctors perceive the relationship between resource limitations and medical futility in end-of-life decision-making. Some clinicians considered resource availability among several factors, usually secondary to patient-centered considerations, while a minority viewed the concept of futility as a means of concealing rationing decisions. Generally, there was more comfort with explicit rather than implicit rationing, and doctors reported distress regarding resource implications when providing potentially futile treatments, especially due to a lack of administrative support for rationing at the bedside. The authors concluded that clearer policies and regulatory support for explicit rationing could help doctors distinguish resource-related rationing from true medical futility, thereby promoting legitimacy and fairness in end-of-life decisions.

Considerations regarding the allocation of scarce medical resources and the question of how much society is prepared to invest in treatments with marginal benefit remains topics to be further explored. Hospitals should evaluate whether providing futile care compromises overall patient care, resource distribution, or institutional integrity. Healthcare providers must approach futility cases with cultural humility and sensitivity, recognizing that their own beliefs and backgrounds may differ from those of patients they serve.

IMPLICATIONS TO CLINICAL PRACTICE

The question of who determines futility at the end-of-life is a central ethical challenge. Historically, physicians' expertise in medicine positioned them as the primary arbiters of what is medical possible. However, modern bioethics emphasizes that assessments of quality of life and the subjective meaning of benefit require incorporating patient and family perspectives. This is especially important in cases where the definition of a meaningful benefit is contested, such as the debate between maintaining biological life at all costs versus prioritizing consciousness, independence, or freedom from suffering. While some clinicians focus on biological indicators, these may not reflect the values and priorities of patients or their families. The debate over quality-of-life judgments raises complex ethical questions. *Would prolonging life in a minimally conscious or persistent vegetative state be desirable or even ethical?* Perspectives vary widely, influenced by religious, cultural, philosophical, and individual beliefs. It is crucial to recognize that patients' and families' notions of dignity, suffering, and meaningful existence may sharply diverge from those held by healthcare professionals. Therefore, ethical decision-making must eschew a "one size fits all" approach.

Aksoy and Ilkilic (2024) examined how Turkish intensive care physicians make ethical decisions about medical futility at the end of life. Their findings indicate that decision-making is largely driven by medical consensus among physicians. Factors such as legal and societal pressures, resource allocation considerations, and hierarchical professional structures influence these decisions. The authors suggest that improving team dynamics, reducing hierarchical barriers, and ensuring active participation from all healthcare members could support more ethically sound decision-making processes.

To minimize subjectivity and conflict, major medical organizations recommend that institutions develop clear futility policies that outline transparent procedures and clarify the roles and rights of all parties involved (Heydari et al., 2025). Such policies should promote shared decision-making, provide mechanisms for dispute resolution through ethics committees or appeals processes, and clarify available options if consensus cannot be reached. Ethics committees serve a vital function as neutral parties who assess medical facts, weigh ethical considerations, and help bridge gaps between clinical judgment and patient or family values (Huang et al., 2025). Their involvement fosters communication, reduces the emotional burden on clinicians and families, and enhances trust in the decision-making process. Nationwide implementation of clinical ethics committees and quality guidelines is recommended to address current shortcomings in managing medical futility. Medical education and clinical training should cultivate physicians' capacities for ethical dialogue, narrative attentiveness, and existential understanding (Huang, 2025).

At the end of life, healthcare providers can advocate for palliative care, which improves the quality of life for patients and families dealing with life-threatening illnesses by preventing and mitigating suffering through early identification, pain assessment and treatment, and addressing multidimensional needs of patients beyond physical symptoms, including emotional, psychosocial, spiritual, and existential distress (Holloway et al., 2014). As a medical philosophy, palliative care focuses on meeting the holistic needs of patients facing serious illnesses through the prevention and relief of suffering, regardless of the diagnosis or prognosis (Aslakson et al., 2017). As a vital part of integrated, holistic, and patient-centered health services, palliative care supports patient autonomy, shared decision-making, and access to essential information (Evangelista et al., 2016; Holloway et al., 2014). Communication about palliative care should be positive and clear, with healthcare providers openly acknowledging the limitations of medical treatments (Kopar et al., 2022).

CONCLUSION

As healthcare continues to evolve, the ethics of futility will grow in importance, demanding wisdom, humility, and partnership at every level of care. The ethics of medical futility at the end of life involves careful consideration of when medical interventions are unlikely to provide benefit or meaningfully improve quality of life, and the moral responsibilities of healthcare providers to act in the patient's best interests. Clinicians are generally regarded as having no ethical obligation to provide treatments they consider futile or non-beneficial, especially when such treatments may cause unnecessary suffering or drain scarce resources. It is crucial for healthcare organizations to establish robust ethical decision-making frameworks and ensure continuous education and training for clinicians and other healthcare professionals to effectively manage the ethical complexities encountered at the end of life. This approach upholds fundamental ethical principles such as autonomy, beneficence, non-maleficence, and justice, while providing compassionate and patient-centered care in challenging situations.

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