



“Beyond Life Support: Ethical Dilemmas, Compassionate Practice, and the Critical Care Nurse at the End of Life”

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Abstract: End-of-life care in the intensive care unit (ICU) represents one of the most ethically complex areas of contemporary healthcare. Advances in life-sustaining technologies have increased the ability to support failing organs, but they have also created difficult decisions concerning treatment limitations, patient autonomy, medical futility, surrogate decision-making and the appropriate transition from curative treatment to comfort-focused care. Critical care nurses occupy a central position in these situations because of their continuous bedside presence, close relationships with patients and families, and responsibility for symptom assessment, communication, advocacy and the implementation of care plans. This narrative review examines the principal ethical challenges encountered during ICU end-of-life care and explores the professional responsibilities of critical care nurses in promoting dignity, comfort and ethically defensible decision-making. The discussion addresses autonomy, beneficence, non-maleficence, justice, withholding and withdrawal of life-sustaining treatment, advance care planning, informed consent, family conflict, cultural and spiritual diversity, palliative sedation, resource allocation and moral distress among nurses. Evidence from professional guidelines, systematic reviews, consensus statements and relevant ethical literature published through 2025 was considered to develop an integrated overview of clinical practice. The literature emphasises the importance of shared decision-making, transparent communication, interdisciplinary collaboration, timely palliative care, appropriate symptom management and respect for patients' values. Critical care nurses can facilitate these processes by recognising unmet palliative needs, supporting patients and families, documenting concerns, participating in ethical discussions and advocating for patient-centred care. Nevertheless, their effectiveness may be limited by hierarchical decision-making, inadequate training, staffing constraints and emotional exhaustion. Strengthening ethics education, communication skills, institutional policies and staff-support systems is essential to improving the quality of end-of-life care in critical care environments.

Keywords: end-of-life care; intensive care unit; critical care nursing; ethical dilemmas; patient autonomy; shared decision-making; palliative care; life-sustaining treatment; moral distress; patient advocacy; withdrawal of treatment; dignity in dying.

1. Introduction

The intensive care unit is a specialised healthcare environment where critically ill patients receive continuous monitoring, advanced organ support and urgent interventions intended to prevent death or restore physiological stability. Mechanical ventilation, vasopressor therapy, renal replacement therapy and other life-sustaining interventions have transformed the management of severe illness. However, these technologies cannot guarantee recovery, and some patients continue to deteriorate despite maximal treatment. In such circumstances,

healthcare professionals and families must consider whether continued intervention remains consistent with the patient's values, prognosis and achievable treatment goals.

End-of-life care refers to the comprehensive care provided when a person is approaching death or when the principal goals of treatment shift towards comfort, dignity and relief of suffering. In the ICU, this transition can be particularly challenging because patients may be unconscious, sedated, mechanically ventilated or otherwise unable to communicate their wishes. Decisions may therefore involve advance directives, previously expressed



preferences, legally recognised representatives and discussions between families and healthcare professionals. Clinical uncertainty, emotional distress and disagreement about appropriate treatment can further complicate the process [1,2]. End-of-life care should not be understood as abandonment of the patient or the termination of professional responsibility. Rather, it represents a change in the objectives of care when interventions intended to prolong life are no longer appropriate, are inconsistent with the patient's informed preferences, or are unlikely to achieve the agreed goals. Comfort, dignity, communication, emotional support and relief of suffering remain essential responsibilities of the healthcare team [1,3].

Critical care nurses have a distinctive role in this process because they remain closely involved in the patient's daily care, observe changes in comfort and clinical condition, and frequently communicate with distressed family members. Their responsibilities extend beyond technical procedures to include ethical reflection, advocacy, communication, symptom management and coordination of multidisciplinary care. Understanding the ethical principles and practical challenges of ICU end-of-life care is therefore fundamental to professional critical care nursing practice.

2. Review Objective and Approach

This narrative review aims to examine major ethical challenges associated with end-of-life care in the ICU and analyse the role of critical care nurses in promoting ethical, compassionate and patient-centred practice. The discussion focuses on established ethical principles, decision-making concerning life-sustaining treatment, communication with patients and families, symptom management, professional responsibilities and organisational support.

The review draws on relevant clinical guidelines, consensus statements, systematic reviews, professional policy documents and peer-reviewed literature published up to December 2025. Literature concerning ICU end-of-life decision-making, critical care nursing, palliative care, patient autonomy, family communication and moral distress informed the discussion. The review is narrative rather than systematic; it does not claim to have exhaustively searched all available databases or to have applied a formal risk-of-bias assessment. Its purpose is to synthesise established concepts and evidence into a clinically relevant discussion for nursing education and practice.

3. Ethical Foundations of End-of-Life Care

Ethical practice in the ICU requires healthcare professionals to balance respect for individual preferences, clinical responsibilities,

professional standards and the interests of patients who may be unable to communicate. Four widely recognised principles—autonomy, beneficence, non-maleficence and justice—provide a foundation for analysing these decisions. Nevertheless, ethical principles may conflict in practice, and no single principle automatically resolves every dilemma [4,5].

3.1 Respect for patient autonomy

Autonomy refers to the right of a competent individual to make informed decisions about personal healthcare. In the ICU, autonomy requires clinicians to explain the patient's condition, available treatment options, expected benefits, risks and uncertainties in a way the patient can understand. A capable patient may accept or refuse treatment, including life-sustaining interventions, subject to applicable law and the circumstances of the decision.

Autonomy becomes complicated when critical illness prevents communication because of sedation, delirium, neurological impairment or mechanical ventilation. In such situations, nurses should help the healthcare team identify advance directives, previously expressed preferences and legally recognised representatives. Family members can provide valuable information about the patient's values, but their personal preferences should not automatically replace the patient's known wishes. Critical care nurses protect autonomy by advocating for communication aids when appropriate, encouraging the inclusion of the patient whenever possible and ensuring that concerns about the patient's preferences are communicated to the treating team [2,6].

3.2 Beneficence and non-maleficence

Beneficence requires healthcare professionals to act in the patient's interests, while non-maleficence requires them to avoid causing unnecessary harm. These principles can become difficult to reconcile when life-sustaining treatment prolongs biological functioning without offering a realistic prospect of achieving the patient's goals. Invasive procedures, repeated resuscitation, prolonged mechanical ventilation and other interventions may impose substantial burdens, including pain, discomfort and loss of dignity.

The ethical question is not simply whether treatment can extend life, but whether its anticipated benefits justify its burdens in the context of the patient's preferences and clinical condition. Nurses contribute by observing suffering, monitoring treatment tolerance and communicating changes in the patient's condition. Their bedside observations may help the multidisciplinary team reassess whether the current plan remains appropriate. A transition to comfort-focused care should preserve active treatment of pain,



breathlessness, anxiety and other distressing symptoms rather than interpreting treatment limitation as an absence of care [1,3].

3.3 Justice and fairness

Justice concerns fairness in the distribution of healthcare resources and the equitable treatment of individuals. ICU resources, including beds, ventilators, staffing and specialised therapies, may be limited. Decisions about access to these resources should follow transparent, clinically relevant and ethically defensible policies rather than discrimination based on social status, disability, ethnicity, financial circumstances or perceived social worth.

Critical care nurses can promote justice by identifying unequal treatment, advocating for consistent application of institutional policies and raising concerns when decisions appear to be influenced by prejudice. Resource allocation decisions should be made through appropriate clinical and organisational processes, not by individual nurses acting independently. Ethical practice also requires that decisions about treatment limitation remain distinct from assumptions about a patient's personal value or quality of life [5,7].

4. Ethical Challenges in Decisions About Life-Sustaining Treatment

4.1 Withholding and withdrawing life-sustaining treatment

Withholding treatment means deciding not to initiate a particular intervention, whereas withdrawing treatment involves discontinuing an intervention that has already been started. Examples include not initiating dialysis, not escalating vasopressor support, or withdrawing mechanical ventilation following an appropriate decision-making process.

These decisions can be emotionally difficult for families and clinicians because withdrawing an established treatment may feel different from deciding not to start it. Nevertheless, many established ethical frameworks regard withholding and withdrawing treatment as ethically equivalent when the same clinical and patient-centred justification applies. The decision should be based on medical appropriateness, the patient's informed preferences or best interests, and applicable legal and institutional requirements [1,8].

Critical care nurses may experience distress when asked to implement a treatment-limitation plan, particularly when they have developed a close relationship with the patient. They should have opportunities to clarify the rationale for the decision, communicate concerns and participate in multidisciplinary discussions. Once an appropriate decision has been reached, nursing care should focus

on comfort, dignity, family support and the prevention of avoidable suffering.

4.2 Medical futility and potentially inappropriate treatment

The term medical futility is often used when treatment is unlikely to achieve a particular clinical objective. However, the term can be problematic because clinicians and families may disagree about what constitutes a meaningful outcome. A treatment may be physiologically effective—for example, maintaining circulation without achieving recovery or a patient-valued goal.

The American Thoracic Society and collaborating critical care organisations have emphasised the importance of structured responses to requests for potentially inappropriate treatments, including communication, conflict resolution, ethics consultation and institutional procedures [7]. Nurses should avoid using the term futile as a substitute for a clear explanation of the patient's condition and the likely effects of proposed interventions.

When disagreements arise, the critical care nurse can help clarify the patient's goals, identify misunderstandings and request further discussion with the responsible physician. If disagreement persists, the nurse should support escalation through the institution's ethics consultation or conflict-resolution process rather than making unilateral decisions about treatment.

4.3 Do-not-resuscitate decisions and treatment limitations

A do-not-resuscitate (DNR), or do-not-attempt-resuscitation, order generally specifies that cardiopulmonary resuscitation will not be attempted if cardiac or respiratory arrest occurs. It does not automatically mean that all other treatments should be stopped. Patients with such an order may continue to receive antibiotics, oxygen, symptom relief, nutrition, nursing care and other treatments consistent with their goals.

A major ethical challenge occurs when families interpret a DNR decision as abandonment or when staff mistakenly assume that it means withholding all active treatment. Nurses should explain the scope of the order within their professional role and seek clarification whenever documentation is ambiguous. Decisions about resuscitation should be communicated clearly, documented accurately and reviewed when the patient's condition or preferences change [8].

4.4 Advance directives and surrogate decision-making

Advance directives allow individuals to record treatment preferences for circumstances in which they may later lose decision-making capacity. A legally recognised healthcare representative may also be appointed according to applicable law. In critical illness, these documents and previously expressed



wishes can help guide decisions concerning resuscitation, ventilation and other life-sustaining interventions.

When a patient lacks capacity, surrogate decision-making should generally prioritise the patient's known preferences and values. Where these are unknown, the appropriate standard may involve determining the patient's best interests, depending on the jurisdiction. Family members should receive adequate information and support rather than being left to make complex decisions without clinical guidance [2,6].

Critical care nurses can help locate relevant documents, identify the appropriate representative, communicate the patient's previously expressed wishes and ensure that information reaches the treating team. They should also recognise that family members may disagree with one another or experience guilt when asked to participate in decisions. In these circumstances, repeated discussions, social work involvement, palliative care and ethics consultation may help reduce conflict.

5. Communication and Shared Decision-Making

Communication is one of the most important components of ethical end-of-life care. ICU conversations often involve uncertain prognoses, emotionally difficult choices and unfamiliar medical terminology. Poor communication can create unrealistic expectations, mistrust and conflict, while clear and compassionate communication can help patients and families understand the clinical situation and participate meaningfully in decisions.

Shared decision-making is a collaborative process in which clinicians and patients, or their appropriate surrogates, consider the available evidence alongside the patient's values, goals and preferences. A joint policy statement from the American College of Critical Care Medicine and the American Thoracic Society recommends shared decision-making for major ICU treatment decisions that are influenced by personal values, including decisions to limit life-prolonging interventions [2].

Critical care nurses support shared decision-making by preparing families for meetings, identifying questions, explaining routine care within their scope of practice and communicating concerns to the medical team. They can use active listening, open-ended questions and clear language to understand what the family has heard and what remains uncertain. For example, asking, "What have you understood about the likely outcome of the treatment?" may reveal misunderstandings that require further explanation by the responsible clinician.

Family meetings should provide opportunities to discuss prognosis, treatment options, uncertainty, the patient's wishes and the goals of care. Nurses can contribute valuable information about

the patient's comfort, behaviour, responses to treatment and previously expressed concerns. Communication should be culturally sensitive and adapted to language needs, health literacy and the family's preferred level of involvement. Professional interpreters should be used when necessary rather than relying exclusively on family members for complex medical discussions [2,9].

6. The Role of Critical Care Nurses in End-of-Life Care

6.1 Patient advocacy and protection of dignity

Patient advocacy involves protecting the patient's rights, preferences, comfort and interests, particularly when the patient is unable to speak independently. Critical care nurses are often well placed to recognise discrepancies between the documented care plan and the patient's expressed wishes or observed needs.

A qualitative systematic review by Vanderspank-Wright and colleagues synthesised thirteen studies of critical care nurses' experiences of treatment withdrawal and identified four themes: navigating complexity and conflict, focusing on the patient, working with families, and dealing with emotions related to treatment withdrawal [10]. These findings demonstrate that nursing involvement extends beyond implementing medical decisions.

Advocacy may include requesting clarification about an unclear treatment plan, communicating signs of distress, raising concerns about unnecessary interventions and ensuring that the patient's previously expressed preferences are considered. Nurses must exercise this responsibility within their professional scope, applicable law and institutional policy while maintaining respectful collaboration with the multidisciplinary team.

6.2 Assessment and relief of physical symptoms

Symptom management is a central nursing responsibility during end-of-life care. Patients may experience pain, breathlessness, agitation, anxiety, secretions, nausea or other distressing symptoms. Critical illness, sedation and impaired consciousness can make assessment difficult, requiring nurses to combine patient reports when available with validated behavioural or observational assessment tools.

Nurses should assess symptoms regularly, administer prescribed medications safely, evaluate responses and promptly report uncontrolled distress. Analgesics and other symptom-relieving medications should be used according to clinical indication, prescription, monitoring requirements and institutional protocols. The aim is effective relief of suffering, not the intentional hastening of death.

When life-sustaining treatment is withdrawn, preparation is essential. The care team should anticipate likely symptoms,



establish an appropriate medication plan, explain the process to the family and ensure that the necessary resources are available. Nursing responsibilities include monitoring comfort before, during and after treatment withdrawal and promptly addressing any signs of distress [1,3].

6.3 Psychological and emotional support for families

Families of critically ill patients frequently experience fear, uncertainty, grief, helplessness and decisional conflict. The ICU environment can intensify these feelings through alarms, unfamiliar equipment, restricted visiting and rapid changes in clinical condition.

Critical care nurses can provide emotional support by listening without judgement, acknowledging distress, offering clear explanations within their scope and facilitating communication with the treating team. Families may need information repeated because emotional distress can affect their ability to process complex explanations. Nurses should allow time for questions and avoid pressuring relatives to reach immediate decisions when the clinical circumstances permit further discussion.

Family support should continue after the patient's death. Nurses may facilitate culturally appropriate opportunities for farewell, explain immediate post-death procedures and connect relatives with bereavement support when available. Such practices help preserve dignity and acknowledge the continuing emotional needs of the family.

6.4 Facilitating cultural and spiritual care

Beliefs about dying, suffering, family responsibility, treatment limitations and death vary among individuals and communities. Religious practices, cultural traditions and family expectations may influence how people understand end-of-life decisions. However, nurses should not assume that all members of a cultural or religious group hold identical beliefs.

Culturally responsive care involves asking patients and families about their preferences, facilitating appropriate spiritual support and respecting meaningful rituals whenever clinically and organisationally feasible. Nurses can collaborate with chaplains, religious representatives, social workers and community support persons when requested.

In multicultural healthcare settings, professional interpreters may be essential for ensuring that patients and families understand treatment options. Respect for culture does not require clinicians to provide every requested intervention regardless of medical appropriateness, but disagreements should be approached through respectful dialogue, transparent explanation and appropriate ethics consultation [1,7].

6.5 Documentation and continuity of care

Accurate documentation supports ethical accountability and continuity of care. Relevant records include the patient's decision-making capacity when assessed by the responsible team, advance directives, the identity and authority of the appropriate representative, goals-of-care discussions, treatment decisions, resuscitation status, symptom assessments and responses to interventions.

Nurses should document their own assessments, observations, communications and actions objectively. Concerns about inconsistency between the patient's preferences and the current plan should be communicated through appropriate channels. Documentation must follow institutional policy and applicable privacy requirements.

Clear records are particularly important during shift changes, transfers between units and transitions from active treatment to comfort-focused care. They reduce the risk of contradictory messages, unnecessary interventions and confusion among staff and family members.

7. Palliative Care and the Transition to Comfort-Focused Treatment

Palliative care focuses on improving quality of life by preventing and relieving suffering through assessment and management of physical, psychological, social and spiritual needs. It can be provided alongside disease-directed treatment and should not be reserved exclusively for the final hours of life. In the ICU, early attention to palliative needs may improve communication and help align treatment with the patient's goals [1,11].

The transition to comfort-focused treatment does not mean that the healthcare team stops caring for the patient. Instead, the priorities shift towards symptom relief, emotional support and dignity. Depending on the patient's circumstances and agreed plan, interventions may include discontinuation of burdensome monitoring, adjustment of medications, withdrawal of organ support and facilitation of family presence.

Palliative sedation requires particular ethical care. It may be considered by appropriately qualified clinicians for refractory suffering when indicated, following applicable guidance, careful assessment, proportionality and informed discussion wherever possible. Its clinical purpose is relief of otherwise intolerable suffering, not the intentional causing of death. Decisions about sedation should be distinguished from practices intended to end life, and local law and professional standards must be followed [1,12].



Critical care nurses contribute by assessing symptom burden, implementing prescribed interventions, monitoring comfort and helping families understand what to expect. A coordinated plan is especially important when mechanical ventilation or other life-sustaining therapies are withdrawn because distress may occur during the transition.

8. Ethical Challenges and Moral Distress Among Critical Care Nurses

Moral distress may arise when nurses believe that a particular action would be ethically appropriate but feel unable to act because of institutional restrictions, hierarchical decision-making, family conflict or disagreement within the healthcare team. Examples include continuing interventions perceived as excessively burdensome, observing uncontrolled symptoms, or feeling excluded from discussions about a patient's goals of care.

Repeated exposure to dying patients, distressed families and ethically challenging decisions can also contribute to emotional exhaustion, grief and burnout. These effects should not be interpreted as personal weakness. They may reflect the emotional demands of critical care and the limitations of the organisational environment.

The systematic review by Vanderspank-Wright and colleagues describes the process of treatment withdrawal as complex and challenging for critical care nurses, who must navigate conflict while managing their own emotional responses [10]. Education, supportive leadership, opportunities for reflective discussion and access to ethics consultation can help nurses respond more constructively.

Structured debriefing after particularly difficult deaths may allow staff to discuss concerns, identify lessons and receive emotional support. Confidential counselling and employee assistance services may also be useful. Institutions should encourage nurses to raise ethical concerns without fear of retaliation and establish clear processes for escalating disagreements.

9. Legal and Professional Considerations in End-of-Life Care

Ethical decisions in the ICU must be consistent with applicable legislation, professional standards and institutional policy. The legal framework governing consent, advance directives, surrogate authority, resuscitation decisions, treatment withdrawal and palliative sedation differs among jurisdictions. Consequently, guidance developed in one country should not automatically be assumed to apply in another.

Critical care nurses should understand their scope of practice, maintain professional competence and seek clarification when legal or ethical uncertainty arises. They should not independently

initiate treatment withdrawal or make decisions beyond their authority. Instead, they should participate in the multidisciplinary process, advocate for the patient's interests and follow authorised care plans.

In India, the legal and professional context is particularly important because end-of-life decisions must be interpreted in light of applicable Supreme Court judgments, current legal requirements and institutional procedures. Professional consensus statements can support clinical practice, but they do not replace the need to verify the current legal position [8,13].

Confidentiality also remains important. Information should be shared with authorised individuals according to applicable law and professional standards. At the same time, relevant information must be communicated to the care team to support safe and ethically appropriate treatment.

10. Education and Organisational Strategies for Better Practice

Effective end-of-life care requires more than individual compassion. It also depends on staff competence, institutional culture and accessible support systems. Nursing education should include ethical principles, communication skills, advance care planning, symptom assessment, palliative care, cultural humility, bereavement support and management of moral distress.

Simulation-based education can help nurses practise difficult conversations, respond to family conflict and recognise situations requiring ethics consultation. Case discussions can help learners distinguish between withholding treatment, withdrawing treatment, DNR decisions and comfort-focused care. A 2025 scoping review of educational programmes for critical care nurses highlighted the relevance of structured end-of-life education and the need to strengthen preparation for these clinical responsibilities [14].

Hospitals can further improve care by developing standardised protocols for goals-of-care discussions, documentation, symptom management and treatment withdrawal. Multidisciplinary family meetings, early palliative care involvement when appropriate, access to ethics consultation and clear escalation pathways can support consistent practice.

Organisational leaders should also ensure adequate staffing, access to interpreters, opportunities for continuing education and staff-support mechanisms. Policies should recognise nursing contributions to decision-making and establish processes for reviewing ethical concerns. Quality improvement initiatives may evaluate symptom control, family communication, documented preferences, staff training and family experiences while respecting confidentiality.



11. Implications for Nursing Practice and Research

For clinical practice, the central implication is that end-of-life care should be integrated into critical care rather than treated as a separate responsibility that begins only after treatment has failed. Nurses should recognise when goals of care require reassessment, communicate concerns promptly and help ensure that comfort and dignity remain priorities throughout the patient's ICU stay.

For nursing education, curricula should provide opportunities to develop ethical reasoning and communication skills in addition to technical competence. Students and practising nurses need supervised experience in discussing uncertainty, responding to family distress and understanding the boundaries of their professional authority.

For nursing administration, supportive leadership and clear institutional protocols are necessary to reduce avoidable conflict and moral distress. Nurse participation in multidisciplinary meetings and ethics committees can strengthen the integration of bedside observations into care planning.

Future research should investigate which educational interventions improve nurses' confidence and competence, how nurse participation affects family experiences and treatment decisions, and which organisational strategies effectively reduce moral distress. Further research is also needed to evaluate culturally appropriate approaches to end-of-life care in diverse healthcare systems, including resource-constrained settings.

12. Conclusion

End-of-life care in the ICU requires healthcare professionals to balance the possibilities of modern life-sustaining technology with ethical obligations to respect patient autonomy, promote benefit, avoid unnecessary harm and provide fair care. Decisions about resuscitation, treatment limitation, withdrawal of organ support and transition to comfort-focused care are often emotionally difficult because they involve clinical uncertainty, family expectations and deeply held personal values.

Critical care nurses play a central role in addressing these challenges. Through patient advocacy, symptom management, compassionate communication, family support, cultural sensitivity, documentation and multidisciplinary collaboration, they help ensure that end-of-life care remains patient-centred. Their bedside observations and sustained relationships with families can contribute significantly to identifying suffering, clarifying preferences and improving the implementation of agreed care plans.

However, nurses cannot fulfil these responsibilities effectively without appropriate education, supportive leadership, clear institutional policies and access to ethics and palliative care expertise. Reducing moral distress and strengthening nurses' participation in decision-making are therefore important organisational priorities.

Ultimately, high-quality ICU end-of-life care is not measured solely by the ability to prolong biological life. It is also reflected in the relief of suffering, respect for individual values, preservation of dignity and compassionate support offered to patients and families during the final stage of life.

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