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Nurses ethical dilemmas in responding to requests to withdraw life-sustaining treatment: A qualitative study from bioethical and Maqashid Al-Shariah perspectives

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Abstract

Background: Ethical dilemmas surrounding the limitation of life-sustaining treatment in patients experiencing medical futility remain complex because they involve clinical, ethical, legal, and religious considerations. Nurses frequently encounter these situations because of their close involvement with patients and families during end-of-life care.
Purpose: This study aimed to explore nurses' ethical dilemmas in responding to the limitation of life-sustaining treatment from bioethical and maqashid al-Shari'ah perspectives.
Methods: This descriptive qualitative study used purposive sampling. Eleven participants, comprising seven nursing professionals and four religious leaders from Sumedang and Bandung, Indonesia, were recruited. Data were collected through in-depth, semi-structured interviews and analyzed using the Miles and Huberman interactive analysis model.
Results: Four major themes emerged: (1) limitations of nurses' authority in decision-making; (2) nurses' roles as patient advocates and communication mediators; (3) integration of bioethical principles and maqashid al-Shari'ah in treatment limitation under conditions of medical futility; and (4) transformation of nursing care toward palliative and spiritual approaches. Participants emphasized that nurses do not have independent authority to discontinue life-sustaining treatment but play essential roles in advocacy, communication, comfort care, and spiritual support. Treatment-limitation decisions were understood as multidisciplinary clinical decisions guided by bioethical principles and the concept of hifz al-nafs.
Conclusions: Ethical dilemmas related to treatment limitation in medical futility require an integrative approach combining clinical, ethical, legal, and spiritual considerations. The findings highlight the importance of collaboration among healthcare professionals, families, and religious leaders in supporting ethical, patient-centered end-of-life care.

Background

Advances in medical technology and intensive care aim to optimize survival among critically ill patients through the use of life-support modalities such as mechanical ventilation, vasopressors, and other organ-support interventions (Marzuki & Mulyawan, 2025). Despite their intended benefits, these technologies frequently generate complex ethical and moral dilemmas when patients experience medical futility or no longer demonstrate a realistic prospect of clinical improvement (Azizah et al., 2025; Suhaemi et al., 2025). The absence of clear, standardized criteria for limiting life-sustaining treatment (LST), together with the uneven availability of clinical ethics teams across healthcare facilities, complicates decision-making and may create conflict among healthcare professionals, families, and institutions (Rahmawati & Zafi, 2020). These circumstances may also impose psychological burdens on patients' families and create uncertainty regarding the legal accountability of healthcare professionals (Kusumo & Ash-shidiqqi, 2023). Therefore, decisions to withhold or withdraw LST are not exclusively clinical matters; they are multidisciplinary issues involving medical, ethical, legal, and spiritual dimensions.

Within this complexity, nurses occupy a structurally close position to patients and their families. Although nurses do not usually hold primary authority to determine whether life-sustaining treatment remains effective, they serve as patient advocates and communication mediators between families and the healthcare team. This dual role can create substantial ethical pressure, particularly when nurses must balance obligations to protect patient safety and well-being, respect family values, and uphold holistic standards of professional nursing practice (Marzuki & Mulyawan, 2025; Suhaemi et al., 2025). Such tensions become more pronounced in

cases of medical futility, in which no available option is entirely free from moral consequences.

Medical bioethical principles and religious values provide important frameworks for navigating this complexity. Beauchamp and Childress describe autonomy, beneficence, non-maleficence, and justice as core principles for evaluating benefits, risks, safety, and fairness in healthcare. However, this approach may not fully capture the values and spiritual dimensions embedded in societies with strong religious orientations. The maqashid al-Shari'ah perspective, particularly hifz al-nafs (preservation of life), recognizes life as a trust that must be protected while also allowing consideration of treatment limitation when an intervention no longer provides meaningful benefit (Rahmawati & Zafi, 2020). Integrating these frameworks is important for producing a comprehensive and culturally relevant analysis of end-of-life clinical decisions. Previous studies have examined the limitation of LST from legal, ethical, medical, and religious perspectives (Azizah et al., 2025; Kusumo & Ash-shidiqqi, 2023; Marzuki & Mulyawan, 2025; Rahmawati & Zafi, 2020; Suhaemi et al., 2025). Nevertheless, most have focused on normative reviews and document analyses, leaving the experiences and perspectives of practitioners insufficiently explored.

This gap formed the basis of the present study. Existing literature demonstrates a lack of empirical research specifically exploring ethical dilemmas from the perspective of nurses as clinical practitioners while also involving religious leaders as representatives of community religious values. In contrast to previous research, this study integrates medical bioethical and maqashid al-Shari'ah perspectives based on the views of nursing professionals and religious leaders. This multidisciplinary approach is expected to provide a more comprehensive and applicable understanding of nurses' roles and the ethical dilemmas they experience in end-of-life decision-making.

This study therefore aimed to analyze the ethical dilemmas experienced by nurses caring for patients with medical futility through the perspectives of medical bioethics and maqashid al-Shari'ah, based on the views of nursing professionals and religious leaders. The findings are expected to strengthen ethically grounded nursing practice aligned with religious values and contribute to the development of clinical policies that are more responsive to communities with strong cultural and spiritual backgrounds.

Methods

Study Design

This study employed a descriptive qualitative design using a field-research approach. This approach was selected to explore and understand nurses' subjective experiences, perspectives, and ethical dilemmas concerning the limitation of life-sustaining treatment. The design also enabled the researchers to obtain a contextual account of the ethical, religious, and professional considerations arising in everyday clinical practice. The study was intended to provide a comprehensive understanding of the phenomenon based on participants' lived professional and religious experiences.

Participants

Participants were selected through purposive sampling based on their knowledge, experience, and involvement in the research topic. The study included 11 participants: four religious leaders representing Islamic organizations, including Muhammadiyah, Nahdlatul Ulama (NU), and Persatuan Islam (PERSIS), who contributed maqashid al-Shari'ah perspectives on the withdrawal of life-sustaining treatment; and seven nursing professionals, comprising clinical nurses and nursing lecturers with direct clinical or academic experience in caring for critically ill or terminally ill patients and expertise in nursing ethics or bioethics. These participants were considered able to provide comprehensive perspectives on the ethical dilemmas surrounding the limitation of life-sustaining treatment. The inclusion criteria were: (1) willingness to participate; (2) experience with or understanding of issues related to the limitation of life-sustaining treatment; (3) knowledge of Islamic law or maqashid al-Shari'ah; and (4) ability to provide in-depth information relevant to the study.

Data Collection

Data were collected through in-depth interviews using a semi-structured interview guide and through document review. The interviews were conducted by the principal researcher, a nursing student who had received supervision and training in qualitative interviewing from an academic supervisor. The researcher had no prior personal relationships with the participants.

Interviews were conducted face-to-face or online according to participants' preferences. Most interviews took place in private, conducive settings to protect participants' comfort and confidentiality. Each participant was interviewed once for approximately 30–50 minutes. All interviews were audio-recorded after informed consent had been obtained. The recordings were transcribed verbatim and supplemented with field notes to provide contextual information. The interview guide was reviewed and pilot-tested with individuals who had characteristics similar to those of the study participants to ensure the clarity and relevance of the questions. In addition to interviews, the researchers reviewed scientific publications, nursing codes of ethics, and fatwas issued by Islamic organizations as supporting documents.

The study was conducted at several healthcare facilities and religious institutions in Sumedang and Bandung, selected according to participants' workplaces or organizational activities. The settings included hospitals, clinics, educational institutions, and religious organizations. These locations were selected because the participants had professional or religious experience relevant to the study focus. The principal interview questions addressed: (1) religious leaders' views of passive euthanasia from a maqashid al-Shari'ah perspective; (2) healthcare professionals' experiences of ethical dilemmas related to the limitation of life-sustaining treatment; and (3) nurses' roles in decision-making, communication with families, and spiritual support for terminally ill patients.

Data Analysis

Data were analyzed using the Miles and Huberman interactive analysis model, which consists of data reduction, data display, conclusion drawing, and verification. The analysis began with repeated reading of the interview transcripts to develop a comprehensive understanding of participants' experiences and perspectives. The researchers then selected relevant data, assigned codes, and grouped the codes into categories and themes corresponding to the study focus, including nurses' ethical dilemmas, advocacy roles, communication in decision-making, and bioethical and maqashid al-Shari'ah perspectives. The categorized data were organized into thematic narratives to illustrate relationships among themes and compare perspectives across participants. Throughout the analysis, the researchers continuously verified interpretations against the original data, interview transcripts, and information provided by participants. The final analysis was then integrated with concepts from medical bioethics and maqashid al-Shari'ah to develop a comprehensive understanding of nurses' ethical dilemmas concerning the limitation of life-sustaining treatment.

Trustworthiness

Trustworthiness was maintained according to four criteria: credibility, dependability, confirmability, and transferability. Credibility was established through source and method triangulation by comparing information across participants and examining interview data alongside supporting documents. Member checking was also conducted to confirm that the researchers' interpretations were consistent with the participants' accounts. Dependability was supported through an audit trail documenting all stages of the study, from data collection and transcription to analysis. Confirmability was strengthened by grounding the findings in audio recordings, verbatim transcripts, field notes, and research documentation. Transferability was supported by providing descriptions of participant characteristics, the research context, and the study process to enable readers to assess applicability to similar settings.

Ethical Consideration

The study was conducted after approval had been obtained from the relevant educational institution and permission had been granted by the research sites. Before the interviews, all participants received information about the study purpose, procedures, potential benefits, and their right to refuse or withdraw at any time without consequences. Participants who agreed to take part provided informed consent. The researchers protected participants' identities by using codes or initials in the study findings. All research data, including interview recordings and transcripts, were stored securely and used solely for research purposes.

Results

The findings are presented in two sections: a brief description of participant characteristics and the qualitative findings. The study involved 11

participants, comprising four religious leaders and seven nursing professionals, including clinical nurses and nursing lecturers. Participant characteristics are presented in Table 1.

Table 1. Participant Characteristics

Participant	Affiliation/Institutional Category	Interview Method
RL1	Religious leader/Representative of Nahdlatul Ulama (NU)	Online interview
RL2	Religious leader/Representative of Muhammadiyah	In-depth interview
RL3	Religious leader/Representative of Persatuan Islam (PERSIS)	In-depth interview
RL4	Religious leader/Leader of Tiryaaqul Aghyaar Islamic Boarding School	In-depth interview
P1	Nursing professional	In-depth interview
P2	Nursing professional	In-depth interview
P3	Nursing professional	In-depth interview
P4	Nursing professional	In-depth interview
P5	Nursing professional	In-depth interview
P6	Nursing professional	Online interview
P7	Nursing professional	Online interview

Table 2. Themes and Subthemes

Major Theme	Subthemes
Theme 1. Limitations of Nurses' Authority in Decision-Making	1. Boundaries of nurses' authority in limiting life-sustaining treatment 2. The importance of multidisciplinary decisions and medical documentation
Theme 2. Nurses' Roles as Patient Advocates and Communication Mediators	1. Advocacy for patients' rights and values 2. Therapeutic communication with families
Theme 3. Integration of Bioethical Principles and Maqashid al-Shari'ah in Treatment Limitation under Conditions of Medical Futility	1. Bioethical principles in medical futility 2. *Hifz al-nafs and the limits of therapeutic endeavor*
Theme 4. Transformation of Nursing Care toward Palliative and Spiritual Approaches	1. Comfort care 2. Spiritual support for patients and families 3. Caring as an act of worship

Theme 1: Limitations of Nurses' Authority in Decision-Making

Subtheme 1.1: Boundaries of nurses' authority in limiting life-sustaining treatment

The findings revealed clear boundaries on nurses' authority within the healthcare system regarding decisions to limit life-sustaining treatment. All nursing participants emphasized that nurses do not have independent authority or a legal right to decide whether life-support measures should be withdrawn from terminally ill patients. This authority rests with the medical team, particularly the responsible physician, following clinical evaluation and consent from the patient's family. In these circumstances, nurses primarily implement clinical decisions while continuing to accompany and care for the patient throughout the treatment process.

Subtheme 1.2: The importance of multidisciplinary decisions and medical documentation

Participants explained that decisions to limit treatment are not made individually but through multidisciplinary evaluation and discussion involving physicians, nurses, and other relevant healthcare professionals. In clinical practice, the terms withdrawal or withholding of life support are used more frequently than passive euthanasia because they are considered more appropriate to the healthcare context. These terms describe the discontinuation or non-initiation of medical interventions that no longer provide meaningful therapeutic benefit. Legal protection for

healthcare professionals also depends on adherence to standard operating procedures (SOPs) and the maintenance of accurate, accountable medical records.

"The issue of withdrawing or withholding life support arises in almost every case involving an end-stage patient. In Indonesia, however, we rarely call it 'passive euthanasia' because the term has sensitive connotations. We more often refer to it as 'treatment limitation.' This issue usually emerges when a multidisciplinary team—including physicians, nurses, and intensivists—concludes that our interventions are no longer prolonging life but are instead prolonging the dying process." (P5)

Theme 2: Nurses' Roles as Patient Advocates and Communication Mediators

Subtheme 2.1: Advocacy for patients' rights and values

Nurses play an important role as patient advocates despite their limited authority in treatment-limitation decisions. They are responsible for ensuring that patients' autonomy, personal values, and preferences are considered by both the healthcare team and the family during decision-making. This advocacy role helps balance medical considerations with the patient's interests in emotionally demanding situations. Participants emphasized that respect for patient rights must be maintained even when the patient has entered the terminal phase of illness.

Subtheme 2.2: Therapeutic communication with patients' families

In addition to serving as advocates, nurses mediate communication between families and the medical team and help explain the patient's condition in clear, accessible language. Communication is delivered honestly and therapeutically so that families can understand medical futility and the available options without misunderstanding. Open and empathetic communication is considered essential for helping families accept the patient's condition and understand realistic goals of care at the end of life.

"What is the nurse's role at this point? A nurse's role is to support the patient's life. We also educate, advocate, and bridge communication between the family and the medical team. We explain the situation as honestly as possible—not because we are giving up, but because the patient's quality of life will not improve with the device. We use language that the family can easily understand." (P7)

Theme 3: Integration of Bioethical Principles and Maqashid al-Shari'ah in Treatment Limitation under Conditions of Medical Futility

Subtheme 3.1: Bioethical principles in medical futility

The findings demonstrated alignment between modern bioethical principles and the practice of treatment limitation under conditions of medical futility. Decisions to discontinue treatment were considered in relation to beneficence, non-maleficence, autonomy, and justice. Participants regarded the term treatment limitation as more appropriate because it describes the discontinuation of interventions that no longer provide therapeutic benefit. They emphasized that such decisions are not intended to end the patient's life but to avoid medical interventions that no longer offer clinical benefit and may increase suffering.

Subtheme 3.2: Hifz al-nafs and the limits of therapeutic endeavor

From the perspective of religious leaders, the obligation to preserve life is an expression of hifz al-nafs and requires the pursuit of appropriate therapeutic efforts. However, this obligation has limits when medical interventions no longer provide benefit and merely maintain biological functions mechanically. Religious leaders clearly distinguished active euthanasia, which is prohibited because it violates hifz al-nafs, from passive euthanasia in the form of treatment limitation under conditions of medical futility. The latter may be considered acceptable according to the Islamic legal maxim la darar wa la dirar, which seeks to prevent greater harm. The patient's overall welfare therefore becomes an important consideration in deciding whether a medical intervention should be continued.

"Neither nurses nor physicians determine whether a person lives or dies; that authority belongs to Almighty God. To maintain inner peace and professional integrity, every action should follow the applicable standard operating procedures and codes of ethics. As long as we act with the intention to help, remain honest, respect the patient's autonomy, and follow hospital procedures, God

willing, we are protected professionally, legally, and religiously." (RL4)

Theme 4: Transformation of Nursing Care toward Palliative and Spiritual Approaches

Subtheme 4.1: Comfort care

Once a treatment-limitation decision has been reached through multidisciplinary discussion and deliberation with the family, the focus of nursing care shifts from a curative approach to palliative care or comfort care. During this phase, nurses continue to provide fundamental nursing care, maintain patient comfort, and administer prescribed analgesia to reduce physical suffering. Care is no longer directed primarily toward prolonging life but toward meeting the patient's needs comprehensively and preserving dignity.

Subtheme 4.2: Spiritual support for patients and families

Spiritual support is an integral component of end-of-life care. Nurses facilitate spiritual needs according to the patient's beliefs. For Muslim patients, nurses may guide talqin or play Qur'anic recitations, whereas for non-Muslim patients they coordinate access to the hospital's designated spiritual care provider. Families are also given space and privacy to accompany patients during the final moments of life. Spiritual support is perceived to help patients and families attain calmness, acceptance, and strength while confronting the end-of-life process.

"When the decision to remove the device is finally implemented, the nursing role reaches its most meaningful point. We transition from curative care to comfort care. We ensure that the patient is clean, well-groomed, and positioned comfortably. Spiritually, we provide full privacy. For Muslim patients, we help guide talqin or play Qur'anic recitations; for patients of other faiths, we facilitate access to their religious leader. We also accompany the family so that they can touch the patient and whisper their final words. At that moment, our focus is no longer the electrocardiogram monitor but the patient's dignity at the end of life." (P5)

Subtheme 4.3: Caring as an act of worship

Participants viewed nursing practice in situations of medical futility not only as a professional responsibility but also as a form of spiritual service. The philosophy of care as a service to God reflects the belief that life and death are under God's authority, whereas the nurse's responsibility is to provide the best possible care in accordance with humanitarian, ethical, professional, and religious values. From this perspective, treatment limitation is not regarded as an act of ending life but as respect for the natural process of living and dying. This view gives spiritual meaning to nursing practice and helps nurses perform their roles professionally and compassionately in end-of-life situations.

Discussion

Limitations of Nurses' Authority and Their Advocacy Role in Decision-Making

The findings showed that nurses do not have authority to decide independently whether life-sustaining treatment should be withdrawn, but they serve as patient advocates and communication mediators between the medical team and the family. This role places nurses in a complex position because they must protect the patient's interests while supporting a clinically determined decision-making process. The findings are consistent with Elmiyanti and Sallang (2022), who identified advocacy as a central nursing role in protecting patient rights. Effective therapeutic communication also helps families understand the patient's condition and supports more appropriate decision-making (Prihatini & Juwita, 2023).

The importance of advocacy is further supported by Nesime and Belgin (2022), who found that advocacy education can improve nurses' ethical sensitivity and capacity to defend patient rights. Nurses may nevertheless experience ethical challenges because they remain at the forefront of care without holding full authority over final decisions (Palmryd et al., 2025). Clear, honest, and empathetic communication is therefore essential to help families understand the patient's condition, prognosis, and goals of care at the end of life (Norouzadeh, 2022). Although the nurses in this study did not have primary authority to decide on the withdrawal of life-support measures, their roles as patient advocates and communication links between the healthcare team and families were indispensable. Effective collaboration among physicians, nurses, and families is required to ensure that decisions to withdraw life support are based on clear and valid consent, thereby reducing

future legal risk for the healthcare team (Ramadhani & Prabarini, 2021).

Medical Futility and Treatment Limitation from a Bioethical Perspective

The findings indicated that treatment limitation is a more acceptable term than passive euthanasia because it describes the discontinuation of interventions that no longer provide clinical benefit. Under conditions of medical futility, the goals of care shift from cure toward preventing unnecessary suffering. This interpretation is consistent with the principles of beneficence, non-maleficence, autonomy, and justice that guide ethical decision-making in healthcare (Holijah et al., 2023). Punia (2024) and Lukito et al. (2025) similarly emphasized that treatment-limitation decisions should consider clinical benefit, quality of life, and patient well-being. Damps et al. (2022) further noted that treatments without meaningful benefit may prolong suffering, whereas Lissak and Young (2024) distinguished treatment limitation from euthanasia on both ethical and legal grounds.

Maqashid al-Shari'ah, Hifz al-Nafs, and the Limits of Therapeutic Endeavor

The findings showed that hifz al-nafs provides a foundation for preserving human life, although therapeutic efforts are not unlimited. When treatment no longer provides benefit and only prolongs suffering, its limitation may be understood as an effort to prevent greater harm. This finding is consistent with Rahmawati and Zafi (2020), Roslan and Zainuri (2023), and Kusumo and Ash-shidiqqi (2023), who emphasized that preserving life must remain attentive to the patient's welfare. The findings therefore demonstrate compatibility between medical bioethics and maqashid al-Shari'ah in situations of medical futility. Treatment limitation may consequently be understood as respect for the patient's welfare rather than an active attempt to end life (Lissak & Young, 2024).

Transformation of Nursing Care toward Palliative and Spiritual Approaches

The findings showed that once treatment limitation is established, the focus of nursing care shifts from curative treatment toward palliative and spiritual care. Nurses address not only patients' physical needs but also the emotional and spiritual needs of patients and their families. This finding supports Yusefa et al. (2024), who emphasized the importance of spiritual support and family involvement in end-of-life care. Care for terminally ill patients should therefore be holistic and address physical, psychological, social, and spiritual dimensions. This conclusion is consistent with Best et al. (2023) and Bulut et al. (2023), who reported that spiritual care contributes to spiritual well-being, hope, and quality of life.

Implications for Nursing Education and the Development of End-of-Life Care SOPs

The findings indicate a need to strengthen nurses' competencies in crisis communication, ethical decision-making, and spiritual support. The risks of burnout and compassion fatigue also demonstrate the importance of psychological support and continuing professional development. These findings are consistent with Yusefa et al. (2024) and Rizkianti et al. (2025), who emphasized the need to strengthen bioethics education and develop end-of-life care SOPs to support ethical, patient-centered care. Other studies have shown that structured education on patient advocacy, end-of-life communication, and ethical decision-making can improve nursing students' moral sensitivity and preparedness for complex clinical situations (Cao et al., 2022; Nesime & Belgin, 2022). Shaban et al. (2025) further demonstrated that critical care nurses are at high risk of burnout and therefore require psychological support and stronger emotional competencies.

Study Limitations

This study was limited by its relatively small number of participants and its concentration in specific geographical areas, which restrict the broad generalizability of the findings. The religious perspective was also dominated by Muslim religious leaders, physician involvement was limited, and patients' family members were not included as participants.

Practical Implications

The findings emphasize the importance of collaboration among healthcare professionals, families, and religious leaders in decision-making under conditions of medical futility. The integration of medical bioethics and maqashid al-Shari'ah may provide a foundation for developing policies, SOPs, and nursing practices that are more ethical, humane, and patient-centered.

Conclusion and Recommendation

This study showed that nurses do not have independent authority to make treatment-limitation decisions but serve as patient advocates, communication mediators, and care providers in end-of-life situations. The findings demonstrate compatibility between medical bioethical principles and maqashid al-Shari'ah in addressing medical futility, in which treatment limitation is understood as an effort to prevent harm when medical interventions no longer provide meaningful benefit. This study offers empirical insight into the integration of healthcare professionals' and religious leaders' perspectives in understanding nurses' ethical dilemmas during end-of-life decision-making. Nursing educational institutions and healthcare facilities should strengthen education in bioethics, therapeutic communication, spiritual support, and the development of end-of-life care SOPs. Future research should involve physicians, patients' families, and participants from more diverse religious backgrounds to obtain a more comprehensive understanding.

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