SEI Process No. 26.21.000001457-7

Subject: Therapeutic limitations in the intensive care unit and therapeutic futility: representative autonomy and shared deliberation.

Reviewer: Councilor Fabiano Marcio Nagel

SUMMARY: Therapeutic limitations in the intensive care unit. Therapeutic futility. Physiological futility. Potentially inappropriate treatment. Representative autonomy. Shared deliberation. Limits of medical technical authority. Interpretation of article 41 of the Medical Code of Ethics. Distinction between ethical duty and ethical permission. Need for robust justification for unilateral decisions to suspend life support.

CONSULTATION

Consultation forwarded to the Technical Chamber of Medical Ethics and Bioethics of the Regional Council of Medicine of the State of Rio Grande do Sul regarding the ethical scope of medical authority in decisions to limit or suspend life-support treatments in incapacitated patients admitted to intensive care units, especially in situations where there is disagreement between the medical team and the patient's family members or legal representatives.

The central question is whether, when faced with allegations of therapeutic futility or disproportionate treatment, a physician is ethically obligated to unilaterally impose therapeutic limitations, or whether such conduct should be understood as a qualified ethical permission dependent on a structured and shared deliberative process.

BACKGROUND 1.
Problem Definition Decisions
regarding the limitation or suspension of life-sustaining treatments in intensive care units remain among the most complex issues in contemporary clinical bioethics. Such decisions are not limited to the technical assessment of prognosis or therapeutic efficacy, but also involve issues related to the proportionality of treatment, human dignity, professional responsibility, and the autonomy of the patient or their legal representatives.
In situations where the patient is unable to express their will, it is common for family members or legal representatives to participate in the decision-making process. Disagreements often arise between the medical team and the patient's representatives regarding the continuation or discontinuation of certain therapeutic measures.
In these cases, it is necessary to
distinguish between: • the absence of a professional duty to maintain a particular treatment; • and the existence of a positive duty to unilaterally impose its suspension.
This distinction has ethical and legal relevance, since ethical permissions should not be confused with categorical duties.

2. Clinical Decision-Making in the ICU and Shared Deliberation

Although the intensive care unit is a highly complex technical environment, decisions regarding the limitation of life support are not exclusively biomedical in nature.
In addition to probabilistic prognostic assessments, these decisions involve prudential judgments regarding the proportionality between expected benefits, imposed suffering, quality of life, and the existential significance of continuing therapy.
Contemporary bioethics widely recognizes the centrality of shared decision-making as an essential component of good clinical practice, including in critical settings.
Although legal representatives may not possess the same technical expertise as the medical team, family involvement is essential for a proper understanding of the values, beliefs, and preferences of the incapacitated patient.
The legal representative acts not only as a formal substitute for the will of the patient, but also as a participant in the biographical journey of the ill person. Their exclusion from the decision-making process can, in practice, represent the indirect exclusion of the patient themselves.
For this reason, it is understood that decisions regarding therapeutic limitations require: • clear and honest communication; • sharing of prognostic information;
• explicit statement of reasonable alternatives;
• effective listening to the values involved;
• and seeking clinical and ethical consensus whenever possible.

3. Therapeutic Futility and its Ambiguities The expression "therapeutic futility" is often used imprecisely, encompassing conceptually distinct situations.

Generally speaking, three main categories can be identified:
1. Interventions incapable of producing any relevant physiological effect; 2. Interventions capable of producing limited biological effects, but with an extremely low probability of clinically significant benefit; 3. Interventions whose value is the subject of axiological disagreement, especially regarding the meaning of the continuation of life in certain clinical conditions.
The first hypothesis is predominantly technical in nature. The others involve prudential and evaluative judgments that go beyond mere biomedical observation.
Contemporary bioethical literature has recognized this distinction. In particular, international intensive care societies have begun to recommend replacing the term "futility" with the expression "potentially inappropriate treatment," precisely to acknowledge that many conflicts arise not from absolute physiological impossibility, but from reasonable disagreements about the overall appropriateness of the treatment.
In these intermediate situations, the decision cannot be reduced to a unilateral technical imposition.

4. Physiological Futility
The least controversial hypothesis corresponds to what is called physiological futility.
Physiological futility exists when the proposed intervention is unable to produce the intended biological effect or to causally interfere with the progression of the disease.
Under these circumstances:

- **There is no real therapeutic benefit;**

• The intervention does not alter the pathophysiological trajectory; • and the progression to death is inevitable and cannot be modified by the available measures.

The mere presence of transient or localized physiological effects is not sufficient to rule out the characterization of physiological futility, if such effects do not alter the irreversible progression of the disease in a clinically relevant way.

From an ethical and professional standpoint, this Technical Chamber understands that:

• There is no obligation to institute or maintain physiologically futile treatments; • nor is there a subjective right for third parties to demand their implementation.

Medical refusal, provided it is adequately justified, documented, and consistent with good healthcare practices, does not constitute an ethical violation. In these circumstances, all clinically indicated comfort and palliative care measures should be maintained, observing the principles of human dignity, non-maleficence, and comprehensive patient care.

However, the category of physiological futility should be used rigorously and sparingly. A guarded prognosis, low probability of recovery, or high statistical mortality are not, in isolation, sufficient to justify unilateral decisions to limit treatment.

5. Potentially Inappropriate Treatment and Axiological Disagreement A different situation occurs when the treatment is still capable of producing some relevant physiological effect, although its overall adequacy is questionable due to the low probability of significant benefit, the suffering imposed, or the disproportion between burden and expected results.

In these cases, there is no unequivocal technical impossibility, but rather a prudential judgment regarding therapeutic suitability.

Similarly, there are situations in which the conflict arises predominantly from axiological differences regarding: • dignity;

• suffering; • quality of life; • or the value of continued existence under certain clinical conditions.

In these contexts, the decision cannot be presented as a simple, uncontroversial technical finding.

The interpretation of article 41 of the Medical Code of Ethics requires harmonization between:

• the duty to avoid therapeutic obstinacy; • and the duty to respect the wishes of the patient or their legal representatives.

This harmonization should occur through prudent deliberation, and not through automatic decision-making. In these cases, shared deliberation constitutes the preferred path for decision-making. However, the pursuit of consensus does not eliminate the physician's technical responsibility regarding the indication, maintenance, or suspension of therapeutic measures, and any persistent divergence should be addressed through adequate clinical and ethical justification and, whenever possible, through the use of institutional mediation mechanisms.

6. Patient Rights Statute The conclusions above are consistent with the recent Law No. 15.378/2026, which established the Patient Rights Statute.

The aforementioned legal decree consolidated principles such as:

- **autonomy;**
- **informed consent;**
- **active patient participation in therapeutic decisions;**
- **and recognition of the role of the legal representative in situations of incapacity to make decisions.**

The Statute reinforces the understanding that critical clinical decisions cannot be reduced solely to the technical dimension, requiring integration between professional judgment and substantive consideration of the patient's values.

At the same time, recognizing autonomy does not eliminate the need for prudent medical judgment, nor does it convert every family disagreement into a professional obligation to maintain therapy.

CONCLUSÂO

In light of the bioethical, normative, and hermeneutical considerations developed in this opinion, it is understood that:

1. **Therapeutic limitation should, whenever possible, result from a shared deliberative process. In cases of unequivocal physiological futility, there is no ethical duty to institute or maintain the intervention. In other situations, the absence of consensus does not, in itself, imply an obligation to maintain measures considered disproportionate or incompatible with good medical practices, provided that the decision is adequately justified.**
2. **The distinction between physiological futility and potentially inappropriate treatment contributes to the proper delimitation of cases in which therapeutic limitation stems predominantly from technical criteria from those in which prudential or evaluative divergences persist, recommending a deliberative approach proportionate to the nature of the conflict.**
3. **In cases of potentially inappropriate treatment, therapeutic limitation should be understood as qualified ethical permission, recommending a structured and shared deliberative process for decision-making, without prejudice to the physician's technical and ethical responsibility in light of the specific circumstances of the case.**
4. **Shared decision-making, including in intensive care settings, constitutes a component essential to good contemporary medical practice.**
5. **Representative autonomy has significant ethical value in reconstructing the values, preferences, care objectives, and presumed will of the incapacitated patient, and should be considered substantially in the deliberative process, without excluding the physician's technical and ethical responsibility.**
6. **Withdrawing a treatment that has already been established requires particularly robust technical and ethical justification, due to the legitimate expectations created in the patient and their family.**
7. **In situations of persistent conflict, the use of institutional mediation mechanisms is recommended, including second medical opinions, multidisciplinary discussions, and consultation with bioethics or clinical ethics committees.**

8. It is also recommended that medical training in clinical bioethics, communication of bad news, palliative care, and shared decision-making in critical contexts be continuously promoted.

That's the opinion, subject to correction.

Councilor Fabiano Marcio Nagel

Approved and ratified at the Plenary session of July 30, 2026.

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