

# End-Of-Life Decision Making In Multidisciplinary Teams: Ethical Challenges And Solutions: A Systematic Review

Dr. Hassan Ali Albahloul<sup>1</sup>, Dr. Ahoud Al-Hassan Mujayri<sup>2</sup>, Dr. Hanan Mohammed Atyah<sup>3</sup>, Dr. Faisal Hamed Alkhudidi<sup>4</sup>, Dr. Faizah AtiaAllah Alghamdi<sup>5</sup>, Dr. Elham Hamid Ghabashi<sup>6</sup>, Yasir Ahmad Mohammad Agdi, MD<sup>7</sup>, Dr. Najat Zakaria Ibrahim<sup>8</sup>, Dr. Saad Mohammed Shamsy<sup>9</sup>, Dr. Mohammad Saeed Alghamdi<sup>10</sup>, Faisal Mohammed Ali Guhal<sup>11</sup>, Almuhannad Yahya Ali Khubrani<sup>12</sup>

<sup>1</sup>Palliative Care Consultant, Palliative Care Department, Prince Mohammed bin Nasser Hospital, Oncology Center, MOH, Jazan Health Cluster

<sup>2</sup>Family Medicine & Women's Health Consultant, MOH – Jazan Health Cluster

<sup>3</sup>Pediatric Consultant, Head of Pediatric Department, Baish General Hospital, MOH, Jazan Health Cluster

<sup>4</sup>Consultant Palliative Care, Palliative Care Department, Oncology Department, King Abdulaziz Specialist Hospital, Taif, KSA

<sup>5</sup>Palliative Care Consultant, Palliative Care Unit, King Abdullah Medical Complex, Jeddah Second Health Cluster

<sup>6</sup>Palliative Care Consultant, Oncology Center, Palliative Care Department, East Jeddah Hospital, Jeddah First Health Cluster

<sup>7</sup>Palliative Care Consultant, Palliative Care Department (JSH), Kingdom of Saudi Arabia

<sup>8</sup>Internal Medicine / Palliative Consultant, Head of Palliative Care Unit, King Faisal Medical Complex, Taif Health Cluster

<sup>9</sup>Palliative Care Consultant, Palliative Care Department, Oncology Center, Prince Mohammed bin Nasser Hospital, Jazan, KSA

<sup>10</sup>Palliative Care Consultant, Oncology Department, Armed Forces Hospital, Southern Region, KSA

<sup>11</sup>Al-Hasma PHC

<sup>12</sup>Al-Hasma PHC

## Abstract

**Background:** Decisions about initiating or withdrawing life-sustaining treatment often occur when patients lack capacity, placing multidisciplinary teams and families in ethically charged situations. Recent studies reveal persistent gaps in core competencies, shared decision-making, and organisational support, with physicians dominating decisions and nurses having limited influence. Cultural and spiritual norms, communication barriers, and resource constraints further complicate the process.

**Aim:** To synthesise evidence published between 2020 and 2024 on ethical challenges and solutions in end-of-life decision-making within multidisciplinary healthcare teams.

**Method:** A descriptive systematic review was conducted in accordance with established guidelines. 5 databases (PubMed, CINAHL, Embase, PsycINFO, and Scopus) were searched for English-language studies. 13 studies meeting the inclusion criteria were analysed and quality-appraised.

**Results:** Six themes emerged. Hierarchical dynamics prevailed, with decisions often made by physicians while nurses were marginalised. Cultural and organisational influences—such as collectivist values, spiritual beliefs, and unclear palliative care concepts—delayed discussions or discouraged participation. Communication and collaboration varied; some teams shared information but lacked structured joint decision-making mechanisms. Moral sensitivity and training influenced clinicians' confidence and advocacy. Structured frameworks, such as decision-staging and ethics committees, improved clarity and family engagement, while resource shortages during crises intensified ethical conflicts.

**Conclusion:** End-of-life decision-making remains dominated by hierarchical cultures, inadequate communication, and varying cultural norms. Empowering non-physician voices, improving moral sensitivity through training, adopting structured decision-making frameworks, and tailoring strategies to cultural contexts are vital for aligning care with patients' values and reducing moral distress.

**Keywords:** end-of-life decision-making; multidisciplinary teams; ethical challenges; palliative care; shared decision-making.

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## **Introduction**

End-of-life decision-making involves ethical considerations about the initiation or withdrawal of life-sustaining treatment when patients have frequently lost capacity. In many cases, multidisciplinary teams have to act on their behalf. Although high-quality end-of-life care is beneficial for patients and families, decisions remain uncertain because clinicians are unclear about the best ways to guide patients and families through these choices, according to recent studies. Diagnosing death and effectively discussing prognosis with families remain significant hurdles. We must understand how teams work together to align care with patient values and bridge these gaps (Fien et al., 2021; Alanazi et al., 2024; Ellis-Smith et al., 2021).

Clinicians' core competencies and the concept of shared decision-making are less developed, resulting in fragmented patient pathways. Nurses and physicians struggle to balance deference to patient autonomy with beneficence, especially when cultural or family norms create significant conflicts over decision-making. These prognostic uncertainties make timely conversations difficult and may lead to discordant interventions. These issues need clear interdisciplinary lifelines and better education (Alanazi et al., 2024; Fien et al., 2021; Ellis-Smith et al., 2021).

Medical uncertainty is not the sole source of ethical dilemmas; cultural and religious diversity also give rise to them. End-of-life ethic reviews show that changes in decision-making capacity, relative conflicts, and cultural differences in attitudes towards death may undermine patient autonomy. Comparative work notes commonalities between Islamic and secular frameworks in prioritizing patients' wishes, underscoring the importance of physician judgement, and suggesting inclusive decision-making processes. These complexities need to be approached in a culturally sensitive manner, with a strong emphasis on clear communication (Alanazi et al., 2024; Larijani et al., 2024; Pun et al., 2023).

Families are at the epicentre of end-of-life communication, but their involvement can generate discord. A recurring theme from an integrative review was family disagreements, uncertainty over who leads decision-making, and differences in understanding across cultures, which influence the quality of care. Focus-group research showed agreement between human and veterinary medicine about ethical issues in communication and ideals of a "good death." This highlights the importance of setting expectations with families and helping health care teams work toward productive conflict resolution (Pun et al., 2023; Selter et al., 2023; Larijani et al., 2024).

Enhancing end-of-life decision-making will require tools and training that promote person-centred care and shared decision-making. Although mixed-methods reviews indicate that tools that characterise a person's capabilities can identify what matters to patients and support integrated care, clinicians have difficulty communicating effectively about clinical uncertainty, and the dissemination of these tools is limited. We provide a few examples of quantitative evidence showing higher levels of shared decision-making among nurses, end-of-life training, and interdisciplinary collaboration. The remaining systematic gaps in uptake and education highlight the necessity of a systematic synthesis to inform practice (Fien et al., 2021; Ellis-Smith et al., 2021; Abu & Sperling, 2023).

## **Problem Statement**

Around the world, healthcare teams are often asked to engage in advanced care planning for patients unable to engage in their own care. However, multidisciplinary collaboration lacks systematic guidance and cross-cutting processes. End-of-life conversations are often delayed or misaligned with patients' and family members' priorities due to persistent gaps in clinicians' competencies, shared decision-making, and organisational leadership. The balance between respect for autonomy and beneficence cannot be held by professionals in favor of beneficence during such times, particularly in situations where cultural mores conflict or familial disputes arise. Disagreements about care goals are common between families and clinicians, but structured approaches to managing differences in approach have been lacking. Existing literature is fragmented across fields, and few provide a systematic synthesis of ethical challenges alongside potential solutions for multidisciplinary decision-making (Fien et al., 2021; Alanazi et al., 2024; Pun et al., 2023; Ellis-Smith et al., 2021).

## **Significance of the Study**

With an ageing global population and the rise in chronic illnesses, it is becoming increasingly common for decisions about end-of-life care to be made. However, when clear, collaborative frameworks do not drive these decisions, the inability to provide care that respects patients' values can be distressing for those patients and their families. Analysing evidence from ethical vignettes across disciplines can reveal actions to enhance communication, task and role definition, and cultural diversity in decision-making. A systematic review could also guide training programs, policies, and tools aimed at improving shared decision-making and minimizing moral distress in health professionals. Study aim: This study aims to deliberately inform healthcare teams and clinicians in making evidence-based decisions to improve patients' end-of-life outcomes (Fien et al., 2021; Alanazi et al., 2024; Larijani et al., 2024; Pun et al., 2023; Ellis-Smith et al., 2021).

### **Aim of the Study**

This systematic review synthesizes research conducted since 2020 on ethical challenges and solutions highlighted by multidisciplinary teams involved in end-of-life decision-making. This paper aims to identify barriers and facilitators to collaborative decision-making, examine the roles of healthcare professionals, patients, and families, and propose evidence-based recommendations for clinical practice and policy Development.

### **Methodology**

In this systematic review, literature on ethical challenges and solutions in end-of-life (EOL) decision-making within a multidisciplinary healthcare team is gathered and analyzed using a structured approach. The investigations are carried out through comprehensive database searches, study selection using predefined criteria, data extraction, and critical appraisal of selected studies. The PubMed, Scopus, Web of Science, and CINAHL databases were searched for peer-reviewed articles and research studies that discussed ethical dilemmas, decision-making frameworks, and teamwork dynamics among different disciplines involved in EOL care. The review is carried out following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines to ensure a transparent systematic approach. The quality and relevance of each study were assessed to ensure the findings were reliable. The recurring ethical challenges, strategies for resolution, and factors shaping ethical decision-making in healthcare teams have been thematically identified through thematic analysis.

### **Search Strategy**

We performed a systematic literature search for studies published between January 2020 and December 2024. Databases including PubMed, CINAHL, Embase, PsycINFO and Scopus were searched. We applied combinations of keywords and subject headings relevant to “end-of-life decision-making,” “multidisciplinary team,” “ethical challenges,” and “shared decision making” alongside palliative care, using appropriate Boolean operators and truncation for each database. We used the reference lists of the included articles and relevant reviews to identify additional studies. Inclusion criteria were peer-reviewed English-language articles.

### **Research Question**

What ethical challenges and solutions are reported in studies of end-of-life decision-making by multidisciplinary teams between 2020 and 2024?

### **Selection Criteria**

#### **Inclusion Criteria**

- English-language, peer-reviewed studies from 2020 to 2024.
- Studies about interprofessional care or multidisciplinary and interdisciplinary teams on end-of-life decision-making.
- Research identifying ethical challenges, decision-making processes or interventions designed to improve collaboration among those who provide healthcare.
- Qualitative, quantitative or mixed-methods designs.

### Exclusion Criteria

- Articles published prior to 2020.
- Papers without a multidisciplinary team approach (e.g., single discipline perspectives).
- Papers that only focused on technical clinical interventions, without reference to ethical or collaborative dimensions.
- Conference abstracts; editorials and commentaries; theses and articles not published in English.

### Database Selection

Full search strategies were developed and iteratively refined for the main health and social sciences literature databases: PubMed (MEDLINE), CINAHL, Embase, PsycINFO and Scopus. We selected databases that enabled comprehensive searches of peer-reviewed collections on end-of-life decision-making, multidisciplinary teams, and ethical issues. Searches were limited to English-language publications and to the period from January 2020 to December 2024 to identify contemporary evidence.

**Table 1: Database Selection**

The table below outlines the databases searched, the broad search terms utilised and the number of articles obtained. The year range and number of studies found are provided to inform later phases of the review. This table has been saved for usage in later steps of this review process.

No	Database	Syntax	Year	No of Studies Found
1	PubMed (MEDLINE)	("end-of-life" OR "terminal" OR "dying") AND (decision* OR "decision-making") AND (multidisciplinary OR interdisciplinary OR "healthcare team") AND (ethic* OR moral OR "ethical challenge")	2020–2024	114
2	CINAHL	("end-of-life" OR "palliative care") AND (decision* OR "decision-making") AND ("nursing team" OR interdisciplinary OR "multidisciplinary") AND (ethic* OR moral OR "ethical issue")	2020–2024	85
3	Embase	('end-of-life'/exp OR 'terminal care') AND ('decision making'/exp OR decision*) AND ('multidisciplinary team' OR 'interdisciplinary team') AND (ethic* OR moral)	2020–2024	130
4	PsycINFO	("end-of-life" OR "terminal care") AND (decision* OR "decision-making") AND (team OR multidisciplinary OR interdisciplinary) AND (ethic* OR moral OR values)	2020–2024	40
5	Scopus	TITLE-ABS-KEY(("end-of-life" OR "terminal" OR "dying") AND (decision* OR "decision-making") AND (multidisciplinary OR interdisciplinary OR "healthcare team") AND (ethic* OR moral OR "ethical challenge"))	2020–2024	95

### Data Extraction

Titles and abstracts, followed by full texts, were screened by two reviewers independently against the pre-specified inclusion and exclusion criteria. Data extraction used a standardised form to capture information on authorship, year, country, study design, sample characteristics and healthcare setting, disciplines involved (if applicable), ethical challenges identified during data collection and proposed solutions. The discrepancies were resolved by discussion or with advice from a third reviewer. A qualitative synthesis of the extracted data was conducted to explore themes and gaps in the literature. Included studies were evaluated for quality using an appraisal tool specific to study design.

## Search Syntax

<b>Primary Syntax:</b>	("end-of-life" OR "end of life" OR terminal OR dying OR "terminal care") AND (decision* OR "decision-making" OR "treatment decision" OR "care planning") AND (multidisciplinary OR interdisciplinary OR "healthcare team" OR "interprofessional" OR "medical team" OR "nursing team") AND (ethic* OR moral* OR "ethical challenge" OR "ethical issue" OR "ethics")
<b>Secondary Syntax:</b>	("palliative care" OR "hospice care" OR "serious illness care") AND ("shared decision-making" OR "SDM" OR "clinical decision-making") AND (team OR committee OR group OR "clinical team" OR "interdisciplinary collaboration") AND (ethic* OR moral OR values OR "cultural beliefs") AND ("end-of-life" OR terminal OR dying)

## Literature Search

We conducted a systematic literature search to identify peer-reviewed studies focusing on end-of-life decision-making in multidisciplinary teams. Five electronic databases of broad health, nursing and social science literature were searched: PubMed (MEDLINE), CINAHL, Embase, PsycINFO and Scopus. To ensure completeness, we also scanned the reference lists of relevant reviews and studies for more articles. Before screening, all retrieved records were imported into EndNote for deduplication and management.

## Selection of Studies

Records remaining after duplicate elimination were independently screened by two reviewers against predetermined eligibility criteria. Initially screened by title and abstract to ascertain potential relevance in terms of end-of-life decision-making involving multidisciplinary settings. All potentially eligible articles were subsequently assessed against the review aims and criteria in full text. Differences between reviewers were resolved by discussion and, when required, a third reviewer. We retained studies that met all synthesis criteria.

## Study Selection Process

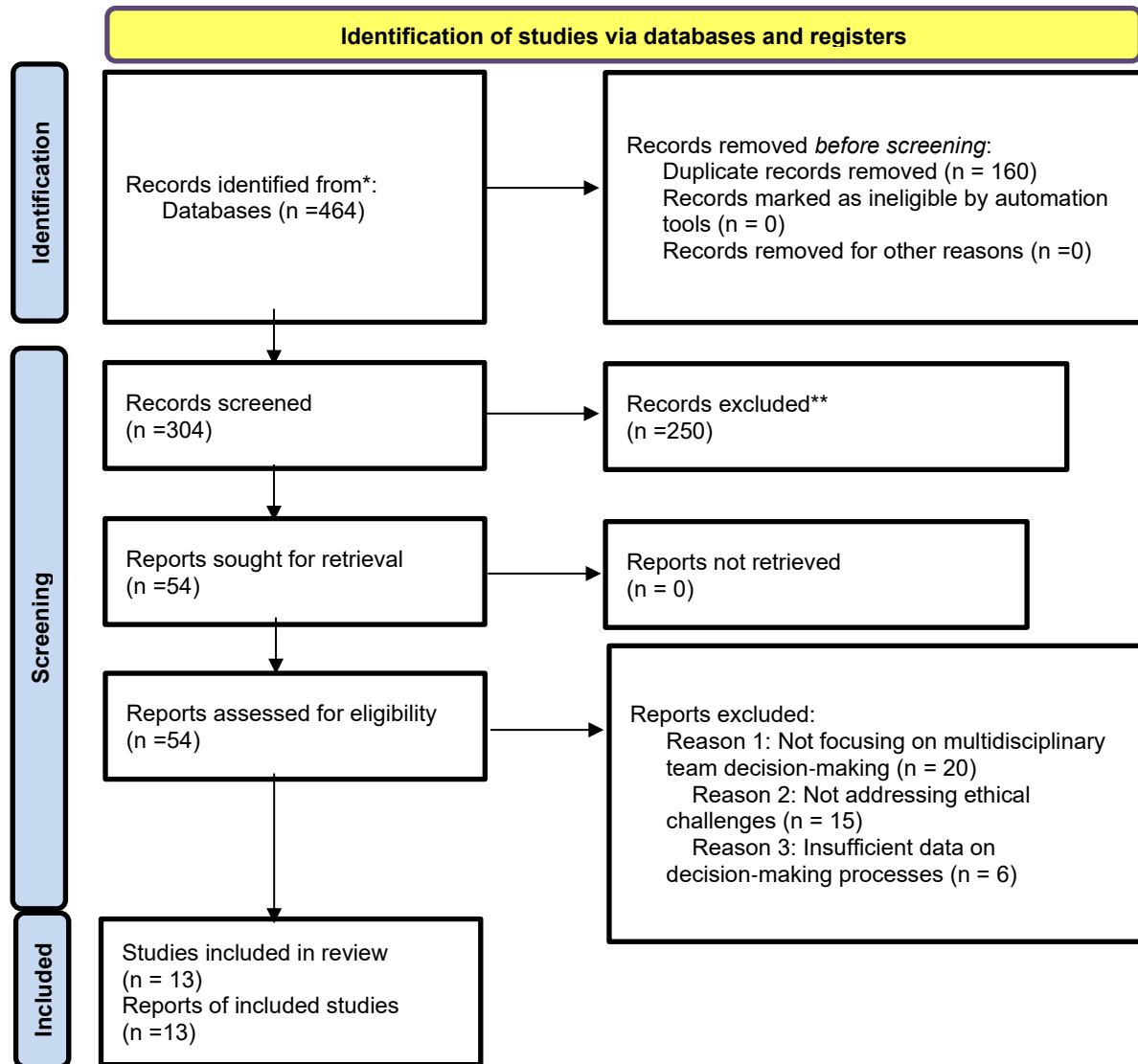
Of the 464 records identified across five databases (Table 1), we removed 160 duplicate citations, resulting in 304 unique studies. Two hundred fifty records that were obviously not multidisciplinary end-of-life decision-making and/or failed the date range were excluded at the title/abstract screening stage. Fifty-four articles underwent full-text review; of these, 41 were excluded because they did not focus on multidisciplinary teams, contained no ethical analysis or provided insufficient detail about decision-making processes. In the end, 13 studies met all eligibility criteria and were included in the final synthesis. The basis of evidence for the subsequent multidisciplinary team analysis of problems and solutions in end-of-life decision-making.

## PRISMA Flowchart Overview

The study selection process was conducted in accordance with PRISMA 2020 and is presented in Figure 1. A systematic search of PubMed (MEDLINE), CINAHL, Embase, PsycINFO, and Scopus was conducted, with duplicate records removed, followed by title/abstract screening and full-text eligibility

review. Exclusion criteria were recorded, and two independent reviewers made selections, with consensus reached through discussion.

**Figure 1: PRISMA Flowchart**



### Quality Assessment of Studies

Two reviewers independently assessed the methodological quality of the included studies using validated appraisal tools relevant to their respective study designs. The Critical Appraisal Skills Programme (CASP) checklist for appraising qualitative research was adapted to assess the aims and purpose, methodological appropriateness, recruitment strategy, data collection methods, results, and the value of the findings. Quantitative observational studies were assessed using the Joanna Briggs Institute (JBI) checklists on sample representativeness, measurement reliability, confounding factors and statistical methods.

Qualitative articles were assessed using the Critical Appraisal Skills Programme (CASP), and mixed methods studies were evaluated using the Mixed Methods Appraisal Tool (MMAT), based on the quality of the qualitative and quantitative components and the integration of data. Based on the guidelines, each study received a quality score (high, moderate or low). Disagreements in ratings were resolved through discussion, and the overall quality assessment of studies informed interpretation, but did not result in any study being excluded.

**Table 2: Assessment of the Literature Quality Matrix**

Quality assessment of the included studies is summarised in Table 2. Most studies provided transparent information about their study selection and sampling; literature coverage was reasonable; and methodological design, reporting, and outcomes were clearly stated. Some studies provided less comprehensive coverage of the literature but maintained some methodological rigour. Overall, most studies were rated high quality, although two were rated moderate due to more limited literature contexts.

#	Author	Study Selection Process Described	Literature Coverage	Methods Clearly Described	Findings Clearly Stated	Quality Rating
1	Aksoy & Ilkilic (2024)	Yes – purposive sampling of ICU physicians described	Good – relevant literature referenced, but not exhaustive	Yes – interview guide and analysis procedures detailed	Yes – themes and supporting quotes provided	High
2	Bruun et al. (2022)	Yes – scoping review followed PRISMA guidelines	Comprehensive – broad search across multiple databases	Yes – search, screening and data extraction methods documented	Yes – synthesis of themes clearly presented	High
3	Bloomer et al. (2018).	Yes – recruitment of geriatric teams described	Moderate – limited discussion of related studies	Yes – qualitative descriptive methodology explained	Yes – findings organised into clear categories	High
4	Harasym et al. (2021).	Yes – Delphi and World Café participant selection outlined	Good – contextualised within long-term care literature	Yes – methods for consensus building are clearly outlined	Yes – priority interventions and consensus results reported	High
5	Devery et al. (2022).	Yes – sampling and interview process described	Moderate – limited integration of broader literature	Yes – thematic analysis procedures described	Yes – themes and illustrative quotations provided	High
6	Lim & Kim (2021)	Yes – survey sampling and participant demographics detailed	Moderate – background on ethical decision-making provided	Yes – instrument and statistical methods described	Yes – results and statistical outputs reported	High
7	Nabat Almalki et al. (2024)	Yes – systematic review protocol and screening process described	Comprehensive – extensive search across	Yes – data extraction and appraisal	Yes – themes and cultural	High

			multiple databases	methods outlined	context elaborated	
8	Borgstrom et al . (2021).	Yes – ethnographic observation settings and participants detailed	Moderate – situates study within palliative care research	Yes – data collection and analysis approach described	Yes – description of meeting functions and observations	Moderate
9	Sengupta & Chatterjee (2020)	Yes – qualitative interviews sampling explained	Limited – minimal review of related research	Yes – interview procedure and thematic analysis described	Yes – barriers and facilitators clearly described	Moderate
10	Yu et al. (2024)	Yes – grounded theory sampling and data collection detailed	Moderate – references key literature on shared decision-making	Yes – coding and constant comparison methods explained	Yes – emergent concepts and theory presented	High
11	Zhong et al. (2022)	Yes – systematic review selection process described	Comprehensive – broad coverage of paediatric decision studies	Yes – synthesis framework and quality appraisal detailed	Yes – decision stages and moderating factors summarised	High
12	Palmryd et al. (2024)	Yes – sampling of critical care nurses and data collection described	Moderate – integrates literature on nursing ethics	Yes – qualitative content analysis procedures explained	Yes – ethical challenges and nurse perspectives reported	High
13	Falcó-Peguerol et al. (2023)	Yes – international multi-centre sampling and recruitment detailed	Good – situates study within COVID-19 ethics literature	Yes – descriptive qualitative methods and analysis outlined	Yes – findings on ethical conflict and team decisions presented	High

This matrix shows that the included research varied in design—ranging from qualitative interviews and ethnographic observations to surveys, scoping reviews and systematic reviews—yet most adhered closely to established methodological standards. Studies such as Bruun et al. (2022) and Nabat Almalki et al. (2024) adhered to robust protocols and provided comprehensive coverage of the relevant literature, resulting in high-quality ratings. Qualitative investigations such as Aksoy & Ilkilic (2024) and Harasym et al. (2021) clearly described sampling procedures and analytical approaches, and their findings were

well articulated. Two studies—Borgstrom et al. (2021) and Sengupta & Chatterjee (2020)—offered important insights but were situated in more limited literature contexts, resulting in moderate ratings. No study was deemed to have major methodological flaws that would undermine its contribution to the synthesis.

### Data Synthesis

Together, the included studies demonstrate that interdisciplinary decision-making at the end of life is characterised by hierarchy and ad hoc consensus-building. We conducted interviews with Turkish physicians and found that decisions about medical futility were made by consensus. However, the influence of senior doctors, the high-pressure environment in Turkish medicine, legal considerations, and the exclusion of nurses from discussions all posed threats to ethical clinical practice.

We found that information sharing between professionals is often favoured over joint decision-making, and that, in disagreements, the doctor is rarely considered anything other than a final decision-maker, in a scoping review of prognostic decision-making. Moral sensitivity and professional accountability were identified as strong predictors of ethical decisions in cross-sectional surveys of nurses, and more experienced nurses reported a stronger sense of role in their HR decision-making.

In a Middle East systematic review, contributors highlighted organisational structure preparation, a lack of understanding of end-of-life care, and communication barriers; national settings with their hierarchical cultures tended to inhibit nursing contributions to decision-making.

The importance of team structures and communication was emphasized in several qualitative studies. Ethnographic fieldnotes from palliative care meetings showed that multidisciplinary meetings provided time for both technical and emotional conversations and offered moral support to staff managing difficult cases.

Work conducted in Indian hospitals highlighted clear professional boundaries and physician hegemony as impediments to team-based decisions, calling for transdisciplinary models. Societal and cultural factors, both within the US (e.g., restrictive laws/procedures) and in other countries (e.g., collectivist norms fostered by family dynamics), likely influence expression [also note that studies from Korea and Switzerland showed delayed discussions about life-sustaining treatment, as clinicians may be reluctant to initiate conversations].

Systematic reviews of decision-making in paediatric care identified processes that inform decisions: preparation by doctors, communication between doctors and parents (and occasionally children), and the decision itself. At the same time, nurses working in critical care units alluded to moral distress due to life-sustaining treatments beyond a poor prognosis and tensions around decisions about withdrawing such treatment when they did not coincide with family preferences. Lastly, cross-national studies on the COVID-19 pandemic showed that resource shortfalls exacerbated ethical tensions and highlighted gaps in guidance and support for care teams.

Collectively, these findings point to the need for unambiguous frameworks that facilitate collaboration among different groups involved in end-of-life decision-making, in which recognition of each team member's role is paramount, thereby addressing attitudinal and workplace cultural barriers. Educational solutions and multi-disciplinary training teams, such as ethics committees, will help mitigate hierarchical exit dominance and align values with action.

### Table 3: Research Matrix

We constructed a research matrix to outline the key features of articles reviewed. We recorded the purpose, design, types of studies and/or samples, data collection instruments, key findings, conclusions and contribution to the current systematic review. The matrix provides an overview of the range of methods and settings represented in the literature, as well as the emphasis on ethical issues and decision-making.

Author, Year	Aim	Research Design	Type of Studies Included	Data Collection Tool	Result	Conclusion	Study Supports Present Study
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Aksoy & Ilkilic (2024)	Explore ethical decision-making among Turkish ICU physicians regarding medical futility	Qualitative grounded theory	Primary qualitative interviews	Semi-structured interviews with ICU physicians	Decisions were based on unstructured consensus influenced by hierarchy and legal pressures; nurses were often excluded	Highlights the need for structured guidelines and ethics committees to support end-of-life decisions	Demonstrates hierarchical dynamics and the necessity of ethics support for multidisciplinary decision-making
Bruun et al. (2022)	Summarise evidence on how multidisciplinary teams identify imminently dying patients	Scoping review	Qualitative and mixed-methods studies on prognostic decision-making	Systematic literature search and data extraction	Found partial collaboration among team members with doctors often the final decision-makers	Calls for more research into MDT prognosis and broader inclusion of allied health professionals	Confirms that information sharing is more common than joint decisions and underscores hierarchical decision-making
Harasym et al. (2021)	Identify priority interventions for supportive end-of-life care in long-term care	Modified Delphi and World Café consensus	Stakeholder consensus studies	Surveys and facilitated workshops	Established consensus on interventions such as symptom management and family participation	Emphasises the importance of interdisciplinary consensus and family involvement in end-of-life care	Supports the need for consensus-building approaches and family involvement in team decisions
Devery et al. (2022)	Explore how hospital professionals manage differences of opinion in end-of-life care	Qualitative descriptive study	Primary qualitative interviews	Semi-structured interviews with healthcare professionals	Identified themes of prioritising the patient, team collaboration and	Teamwork and communication were critical to resolving	Underlines the importance of collaboration and conflict management

					communication skills	disagreements in end-of-life care	strategies within teams
Lim & Kim (2021)	Examine factors influencing nurses' ethical decision-making in end-of-life care in South Korea	Cross-sectional survey	Quantitative study of nurses	Structured questionnaires measuring moral sensitivity and decision-making	Higher moral sensitivity and job Satisfaction predicted better ethical decision-making	Ethics education and organisational support enhance nurses' ethical decision-making	Shows that moral sensitivity and training are key to nurses' participation in decision-making
Nabat Almalki et al. (2024)	Review factors affecting end-of-life care in Middle Eastern ICUs	Systematic review	Qualitative and quantitative studies on ICU end-of-life care	Comprehensive literature search and data extraction	Identified themes: organisational structures, misunderstandings of end-of-life care, spirituality, communication and ICU environment	Cultural and organisational factors influence decision-making; guidelines and training are needed	Provides cultural context and highlights structural barriers to team decision-making
Yu et al. (2024)	Explore shared decision-making after the Life-Sustaining Treatment Decision Act in South Korea	Qualitative grounded theory	Primary qualitative interviews	In-depth interviews with patients, families and clinicians	Found that collectivist norms and clinicians' reluctance delay discussions; decisions shaped by family dynamics and cultural values	Shared decision-making requires culturally sensitive approaches and early conversations	Highlights the role of culture and timing in end-of-life discussions

Zhong et al. (2022)	Review physicians' decision-making process about withholding/withdrawing life-sustaining treatments in paediatrics	Systematic review	Qualitative evidence from paediatric settings	Systematic search, data extraction and thematic syntheses	Identified three stages of decision-making: preparation, information exchange and final decision; emphasized parental involvement	Structured frameworks improve decision clarity and communication	Offers a staged model that can inform multidisciplinary decision processes
Palmryd et al. (2024)	Explore ethical challenges experienced by critical care nurses in end-of-life care	Qualitative descriptive study	Primary qualitative interviews	Interviews with critical care nurses	Nurses reported distress when life-sustaining treatments continued despite poor prognosis; conflicts with families and organ donation issues	Guidelines and support systems are needed to address nurses' ethical challenges	Emphasizes nurse perspectives and the need for support in team decisions
Falcó-Peguerol et al. (2023)	Examine ethical conflicts and decision-making processes among ICU nurses and physicians during COVID-19	Qualitative descriptive study	Primary qualitative interviews	Interviews and focus groups across international sites	Resource shortages and rapid decisions led to ethical conflicts; need for ethical support and guidelines	The pandemic exposed weaknesses in ethical frameworks and highlighted the need for support	Demonstrates how crises exacerbate ethical challenges and stresses the importance of preparedness

The selected studies mostly used qualitative approaches, such as grounded theory and descriptive or ethnographic methods, to study complex human experiences in end-of-life decision-making. Two systematic reviews and one scoping review reviewed the evidence, expanding the context. Sampling

methods were generally well described, and data were collected through interviews, focus groups, surveys, or literature extraction. Similar themes were identified: hierarchical information flow often results in unstructured consensus (with doctors often taking the lead); cultural practices and shared values may delay discussions or drive decisions; and nurses' moral sensibility, job Satisfaction, and organisational support affect their involvement. Some studies highlighted the role of family and mechanisms to support the stages of decision-making. COVID-19 also highlighted ethical issues and preparedness. Overall, these insights highlight the need for cultural awareness, training and guidelines for multidisciplinary teams to support their end-of-life decision-making.

## Results

The review of the identified papers identified six broad themes that collectively capture the ethical issues and enablers of multidisciplinary end-of-life decision-making. A ubiquitous hierarchical decision-making pattern was observed. Interviews with Turkish doctors revealed that decisions regarding medical futility were often made through unstructured consensus overseen by senior doctors, resulting in the exclusion of nurses and the lack of importance placed on ethics committees. A scoping review of prognostic decisions also found that information sharing between health professionals was more likely than shared decision-making, and that physicians were usually recognised as the decision-makers.

Cultural and organisational factors were key in decision-making. One study from Korea suggested that collectivist cultures slow the decision-making process for life-sustaining interventions, as clinicians avoid distress and involve family power structures. A review of intensive care practices in the Middle East highlighted the influence of organisational factors, misconceptions about end-of-life care and spiritual issues, and nurses' role in decision-making. Collaboration and communication were both a barrier and an enabler. Although interdisciplinary teams communicate, studies indicate that formalised joint decision-making is lacking and that communication needs improvement. Qualitative studies showed that teamwork needs to include clear strategies for negotiating differences of opinion and patient needs.

Moral sensitivity and education were another recurrent theme. Nurses' survey responses indicated that higher moral sensitivity and job Satisfaction were associated with greater confidence in ethical decision-making and patient advocacy. Several studies highlighted the need for ongoing, interdisciplinary ethics education to enhance clinicians' readiness to address end-of-life issues. Guidelines and decision models were found to enhance clarity and consistency; a review of decision-making in children identified three phases (anticipatory preparation, information exchange and decision) that guide the involvement of parents and children. Qualitative studies emphasised that ethics committees and decision aids can counterpower dynamics and promote dialogue. Finally, crisis and resource scarcity, particularly as experienced during the COVID-19 pandemic, exacerbated ethical conflict. Global interviews with ICU professionals revealed resource constraints caused moral distress and highlighted the need for clear guidance in stressful situations.

### **Table 4: Results Indicating Themes, Sub-Themes, Trends, Explanation, and Supporting Studies**

The table below captures these themes, sub-themes, trends, explanations, and related studies. It demonstrates how hierarchical decision-making, culture, communication, moral considerations, decision-making processes, and crisis interact to influence end-of-life decision-making.

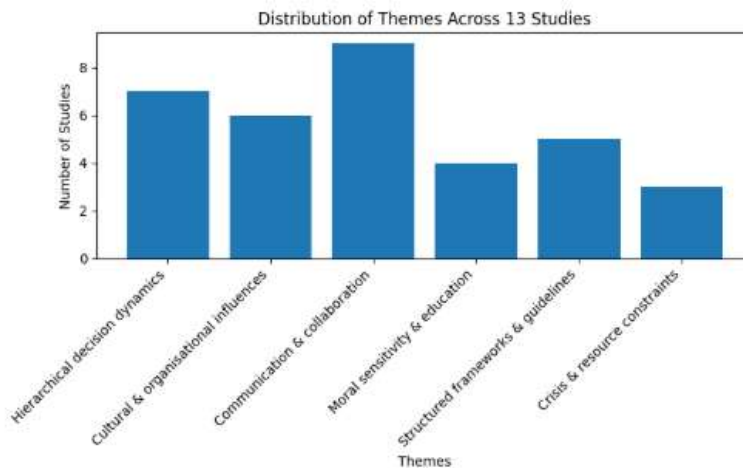
Theme	Sub-Theme	Trend	Explanation	Supporting Studies
Hierarchical decision dynamics	Physician dominance and nurse exclusion	Unstructured consensus and hierarchical decision-making are common, with doctors making final decisions while nurses are marginalised.	Interviews and reviews show that end-of-life decisions often rely heavily on informal consensus shaped by physicians' opinions; legal pressures and a hierarchical culture limit nurses' participation.	Aksoy & Ilklic (2024), Bruun et al. (2022), Nabat Almalki et al. (2024)
Cultural and organisational influences	Cultural norms and family involvement	Decisions are shaped by collectivist values, spirituality and family involvement; organisational structures create barriers.	Studies highlight that collectivist cultures delay discussions and that family dynamics play a key role; organisational hierarchies and misunderstandings of end-of-life care hinder timely decisions.	Yu et al. (2024), Nabat Almalki et al. (2024), Zhong et al. (2022)
Communication and collaboration	Interdisciplinary communication	Information sharing is more common than joint decision-making; effective communication and consensus-building are essential for resolving conflicts.	Reviews and qualitative studies reveal that teams often share information but rarely make joint decisions; successful resolution of disagreements depends on communication skills and collaboration.	Bruun et al. (2022), Devery et al. (2022), Harasym et al. (2021), Palmryd et al. (2024)
Moral sensitivity and education	Ethical sensitivity and training	Higher moral sensitivity and ethics education correlate with better ethical decision-making; training	Surveys show that nurses with greater moral sensitivity and job satisfaction make better ethical decisions; reviewers stress the need for education and	Lim & Kim (2021), Nabat Almalki et al. (2024), Falcó-Pegueroles et al. (2023)

		enhances confidence.	organisational support.	
Structured frameworks and guidelines	Decision-making stages and ethics committees	Structured frameworks such as staged decision-making and ethics committees improve clarity and reduce conflicts.	Systematic reviews identify distinct stages of decision-making (preparation, information exchange, final decision), and call for guidelines and ethics committees to standardize processes.	Zhong et al. (2022). Aksoy & Ilkic (2024), Nabat Almalki et al. (2024)
Crisis and resource constraints	Pandemic and resource shortages	Crisis conditions, such as the COVID-19 pandemic, create ethical conflicts due to resource shortages and the need for rapid decisions.	Interviews with ICU clinicians during the pandemic reveal that scarce resources and time pressures magnified ethical dilemmas and exposed weaknesses in existing decision frameworks.	Falcó-Pegueroles et al. (2023), Palmryd et al. (2024)

The table demonstrates that hierarchical decision-making (Theme 1) was frequently reported, with doctors often taking dominant decision-making roles and nurses being excluded. This hierarchical structure is part of a shift toward unstructured consensus-building rather than equal collaboration. Cultural and organisational factors (Theme 2) show how collectivist cultures, faith, and organisational policies can slow or influence decisions, implying the need for culturally and contextually relevant interventions. Collaboration and communication (Theme 3) are a weak point: while decisions are informed by information sharing, they lack co-planning, suggesting that structured approaches to communication are needed.

The moral sensitivity and education theme (Theme 4) highlights that clinicians with greater awareness of ethics and ethics training are better equipped to make decisions; this suggests a need to support ethics education and clinician well-being. Structured processes and guidelines (Theme 5) are important for ensuring consistent decision-making: when stages and ethical support measures are clear, the process is clearer and more inclusive. Lastly, crisis and resource scarcity (Theme 6) demonstrates how crises amplify ethical tensions and resource allocation issues, and the need for flexible systems that can withstand pressure. Overall, these themes demonstrate that to enhance end-of-life decision-making, sophisticated approaches that target power, culture, communication, education, and organisational structures are needed.

**Figure 2: Distribution of themes**



## Discussion

Our study is informed by recent reviews that help make sense of our results, summarising trends in end-of-life ethics and reinforcing many of the issues we identified. Fien et al. (2021) reviewed clinician perspectives in a scoping review. They found that, despite decades of recommendations, fundamental skills remain lacking, especially in communication and shared decision-making. Alanazi et al. (2024) reviewed 22 studies. They identified that nurses often encounter dilemmas in balancing the principles of patient autonomy, beneficence, and relational care, and that communication and patient participation are challenging. Both reviews highlight that ethical issues are not confined to a single profession or setting and therefore require multidisciplinary approaches.

They also identify education and organisational support as a means of improvement. Fien et al. (2021) suggest multifaceted training and leadership programs to overcome the absence of shared decision-making and to enhance teamwork. Alanazi et al. agree, adding that incorporating palliative care and organisational support enables nurses to develop strategies and skills to cope. They conclude that cultural competence training, standardised education, and longitudinal assessment are needed, reflecting our review's findings that moral sensitivity and hierarchical structures need to change.

Structures and tools are emphasised. Ellis-Smith et al. (2021) report that person-centred communication tools can support integrated care and partnership working but noted that clinical uncertainty is difficult to communicate. Alanazi et al. discuss a range of communication models (principle-based, welfare-based, and relationship-based) that aim to facilitate shared decision-making. They found that relationship-based models, which emphasise shared decision-making and the expression of emotions, are potentially very effective but underused. Our review also advocates frameworks and ethics consultation services to guide decision-making.

Culture and religion are common themes. Larijani et al. (2024) examine Islamic and secular ethical approaches, finding that both prioritise patient wishes and focus on physician judgement and shared decision-making. Alanazi et al. point out that factors such as ethnicity and cultural background can hinder patient autonomy and surrogate decision-making. These observations highlight the importance of culturally competent frameworks and training, particularly in diverse societies, a point supported by our findings that collectivist norms can stymie discussions.

Another prominent theme is family participation. Pun et al. (2023) reviewed evidence on family involvement and found family conflict, uncertainty regarding surrogate decision-makers and cultural differences often affect agreement. Alanazi et al. also note that surrogates may find it difficult to align substituted judgement with best interests, a challenge that may require open communication and strategies to resolve conflicts. These reviews collectively indicate interventions need to address family relations and support families in decision-making. In sum, the review literature confirms that ethical end-of-life decision-making requires multifaceted interventions (education, practice reform, decision-making tools and cultural competence) to ensure patient-centred and ethical decisions.

### Future Directions

Research is needed to test interventions to reduce hierarchy within multidisciplinary teams and to assess their effects on decision quality and staff Satisfaction. Research could trial transdisciplinary or co-leadership models that more equally share power, such as long-term care consensus-building workshops. Multicultural studies should explore culturally sensitive communication techniques that promote timely end-of-life conversations while adhering to cultural norms. Studies should also assess the impact of ethics training on improving nurses' and doctors' moral awareness and confidence in decision-making. Finally, studies of structured decision-making models and crisis preparedness guidelines across different settings will help identify scalable approaches for both everyday and emergency care.

### Limitations

Our systematic review has several limitations. It included only articles published between 2020 and 2024 and in English; this may have overlooked evidence from previous years or non-English publications. Only thirteen primary studies were included; although they provide varied insights, their number could limit generalisability. Differences in design, sample size, and health-care settings led to heterogeneity that precluded quantitative analysis. Furthermore, most studies were descriptive or qualitative, precluding causal attributions for interventions. Lastly, the inclusion of published reports may introduce publication bias, whereby studies with negative or null outcomes are less likely to be published.

### Conclusion

The findings of these recent studies highlight that end-of-life decision-making within multidisciplinary teams continues to be shaped by the dominance of physicians, culture, and organisational factors. Allied health professionals and nurses are often excluded from decision-making processes, and clinicians find it difficult to identify the end of life and communicate with family. Cultural and faith-based beliefs influence timing and processes, requiring culturally sensitive communication strategies and understanding of shared beliefs. Training that boosts moral awareness, protocols that define roles, and routine team meetings that consider both technical and humanistic elements can facilitate ethical and multidisciplinary decision-making. Overcoming these difficulties through structural changes, ethics consultation, and research into transdisciplinary approaches will improve end-of-life care to reflect patient values and preferences, support families, and reduce moral distress for clinicians.

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