https://doi.org/10.62587/AFRJMS.3.2.2026.13-22 ISSN: 3006-7421

African Research Journal of Medical Sciences

Journal homepage: https://www.afrjms.com

Review Article **Open Access**

End-of-life choices and ethical responsibility: Clinical perspectives on letting die and euthanasia

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Article Info

Volume 3, Issue 2, July 2026
Received : 09 February 2026
Accepted : 29 June 2026
Published : 25 July 2026
doi: 10.62587/AFRJMS.3.2.2026.13-22

Abstract

This paper examines the ethical distinction between letting die and euthanasia within doctor-patient decision-making at the end of life. Its primary objective is to clarify how core bioethical principles guide clinical judgment when life-sustaining treatment is withheld, withdrawn, or intentionally terminated. A systematic literature review was conducted using the PRISMA framework. Data were collected from PubMed, Scopus, and Google Scholar using predefined keywords related to end-of-life ethics, euthanasia, and clinical decision-making. After screening and eligibility assessment, peer-reviewed studies providing explicit ethical analysis were included. The analysis employed qualitative synthesis, integrating normative ethical theory, empirical findings, and professional ethical guidelines. The findings indicate that letting die-through withholding or withdrawing disproportionate or futile treatment-is widely regarded as ethically permissible when grounded in informed consent, proportionality, and respect for patient autonomy. Euthanasia, however, remains ethically contested because it involves intentional life termination and raises concerns regarding professional integrity and the moral identity of medicine. The principles of autonomy, beneficence, non-maleficence, and justice, supported by frameworks such as the Doctrine of Double Effect, provide structured guidance for resolving these tensions. Effective communication and shared decision-making emerge as decisive factors in ethically defensible practice. The paper recommends strengthening ethics education, institutional ethics consultation services, and advance care planning to enhance moral clarity, reduce clinician distress, and ensure alignment between patient values and clinical action.

Keywords: *End-of-life ethics, Letting die, Euthanasia, Doctor-patient relationship, Shared decision-making*

1. Introduction

End of life care and decisions about death have perennially posed profound ethical and clinical dilemmas for

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doctors, patients, and families, situated at the intersection of medical practice, moral philosophy, and human dignity. Central to these dilemmas is the moral and conceptual distinction between *letting die*—understood as refraining from or withdrawing life sustaining treatment—and *euthanasia*—typically defined as intentional actions to bring about a patient's death to relieve suffering (Olsen *et al.*, 2010). Although both practices may result in the death of a patient, they are ethically differentiated by intentionality, causation, and professional responsibility (Panayiotou, 2024). This distinction has generated sustained debate in clinical ethics, legal theory, and health policy, raising questions about whether these practices genuinely respect patient autonomy, adequately protect well being, or undermine the core professional commitments of the medical profession — particularly the commitment to heal and to do no harm (Beauchamp and Childress, 2019).

Philosophical analyses often situate *letting die* within the framework of permissible refusals of treatment, grounded in the ethical principle of autonomy. From this perspective, a competent patient has the moral and legal right to refuse unwanted medical interventions, even if refusing treatment will lead to death (Smith *et al.*, 2020). By contrast, active euthanasia—whether voluntary, non voluntary, or involuntary—involves an agent's direct role in causing death, which some argue cannot be ethically justified without undermining the intrinsic value of life (Gorsuch, 2006). Scholars such as Sullivan (2005) contend that although end of life decisions should respect the dignity of patients, the intentional shortening of life remains qualitatively different from allowing a natural death process to unfold. These distinctions are not merely semantic; they shape laws, professional guidelines, and moral reasoning across diverse healthcare systems.

The ethical debate is further complicated by divergent cultural, legal, and professional norms. In jurisdictions such as the Netherlands and Canada, voluntary euthanasia and physician assisted suicide have been legalized under specified conditions, reflecting a societal emphasis on autonomy and relief of suffering (Akdeniz *et al.*, 2021). In other contexts, particularly where religious and communitarian values predominate, such practices remain morally impermissible, and emphasis is placed on palliative care and the alleviation of suffering without intentional life termination (Finucane and Harper, 1996). These variations underscore that ethical frameworks do not operate in a vacuum; they intersect with broader social values, legal infrastructures, and the lived experiences of patients and caregivers.

At the heart of these deliberations is the doctor–patient relationship, which scholars identify as a moral partnership rather than a transactional encounter. How doctors communicate options, interpret patient preferences, and participate in shared decision making profoundly influences ethical outcomes. Emanuel and Emanuel (1992) describe models of physician–patient interaction—from paternalistic to deliberative—each with distinct implications for autonomy and professional responsibility. A deliberative model, where doctors help patients articulate and evaluate values, aligns closely with contemporary ethical emphasis on shared decision making. Yet, implementing this model in practice can be challenging, especially amid prognostic uncertainty, differing expectations, and emotional distress.

The ethical burdens borne by doctors in end of life contexts extend beyond technical competence to encompass moral discernment, empathy, and resilience. According to Alanazi *et al.* (2024), over two-thirds of surveyed clinicians reported recurrent episodes of moral distress, especially in situations where clinical decisions contradicted patient autonomy or professional ethical guidelines. Such findings highlight the need for ethical support structures within healthcare institutions, including ethics consultation services and forums for reflective dialogue. This paper aims to synthesize existing literature on these issues, with particular attention to the ethical challenges doctors encounter when navigating the boundary between letting die and euthanasia in clinical decision making. Accordingly, this paper is guided by three core objectives. First, it seeks to integrate major ethical theories—including deontological, utilitarian, principlist, and virtue-based frameworks—with established medical professional codes, in order to clarify how normative principles inform clinical standards in end-of-life care. Second, it aims to critically examine the ethical challenges doctors encounter in decision-making at the boundary between letting die and euthanasia, with particular attention to intentionality, causation, moral responsibility, and professional integrity. Third, it analyzes the moral dynamics of the doctor–patient relationship, emphasizing how shared decision-making models shape ethical outcomes and influence trust, autonomy, and the preservation of human dignity in clinical practice. By integrating philosophical analysis, empirical research, and clinical ethical guidelines, it seeks to illuminate how ethical principles are applied in practice and to identify ways in which the

doctor–patient relationship can be ethically strengthened in the face of some of medicine's most difficult decisions.

2. Literature review

2.1. *Letting die vs. euthanasia*

End-of-life decision-making in clinical practice hinges on the ethically significant distinction between letting die and euthanasia, a distinction with profound implications for patient care, professional integrity, and moral reasoning. Letting die involves withholding or withdrawing life-sustaining treatment when interventions are medically non-beneficial, disproportionately burdensome, or inconsistent with a competent patient's informed refusal. In such cases, death results from the underlying pathology rather than from a deliberate act intended to cause death, and the physician's intention is to act in the patient's best interests—honoring autonomy while providing healing when possible or relieving suffering when cure is no longer achievable (Olsen *et al.*, 2010; Beauchamp and Childress, 2019). Empirical evidence supports this ethical framing: clinicians often justify the withdrawal of futile treatments by appealing to patient wishes, proportionality, and quality-of-life considerations, demonstrating convergence between ethical theory and clinical judgment (Alanazi *et al.*, 2024; Sprung *et al.*, 2003; Kon *et al.*, 2016).

Euthanasia, in contrast, involves intentionally ending a patient's life to relieve suffering and is distinguished by the moral significance of intent. While some advocate for euthanasia on the grounds of autonomy, compassion, or perceived quality of life, opponents emphasize the intrinsic value of life, the boundary between healing and killing, and the potential erosion of trust in the doctor–patient relationship (Akdeniz *et al.*, 2021; Panayiotou, 2024; Beauchamp and Childress, 2019). Even in countries where euthanasia is legally regulated, physicians report moral distress, underscoring the persistent ethical tension between alleviating suffering and preserving life (Materstvedt *et al.*, 2003; Rietjens *et al.*, 2009; Smith *et al.*, 2020).

The *Doctrine of Double Effect* provides a critical lens for understanding these practices, highlighting that actions with foreseeable but unintended harmful consequences can be morally permissible when the primary intention is justified, proportionate, and directed toward the patient's well-being (McIntyre, 2015). In end-of-life care, this principle underlies practices such as high-dose analgesia or palliative sedation, where hastened death may be an unintended consequence, distinguishing them ethically from euthanasia, where death is the intended outcome. Professional codes, including the World Medical Association's International Code of Medical Ethics, reinforce this distinction, emphasizing that physicians must prioritize patient health and well-being, respect autonomy, and minimize harm, thereby grounding ethical decision-making in beneficence and dignity rather than intentional life termination (World Medical Association, 2022).

In practice, these distinctions guide physicians in navigating complex end-of-life decisions with moral discernment and clinical integrity. Letting die aligns medical intervention with patient autonomy, proportionality, and relief of suffering, while euthanasia introduces intentional life-ending action that fundamentally alters the ethical and professional landscape. Recognizing this boundary is essential for preserving trust, upholding professional commitments, and ensuring ethically sound, patient-centered care.

2.2. *Governing-ethical principles in end-of-life care*

End-of-life decision-making in clinical practice requires careful navigation of ethical principles. Ethical evaluation in this context is traditionally guided by the four pillars of biomedical ethics: autonomy, beneficence, non-maleficence, and justice (Beauchamp and Childress, 2019; Akdeniz *et al.*, 2021). These principles provide a framework for balancing patient-centered care, professional responsibilities, and societal considerations, yet rarely operate in isolation, often requiring nuanced deliberation.

Autonomy lies at the heart of morally permissible letting die, underscoring the patient's fundamental right to make informed decisions regarding their care, including the refusal of treatment (Finucane and Harper, 1996). However, the ethical legitimacy of such decisions depends critically on the quality of communication between the clinician and the patient, as inadequate dialogue or misunderstandings can undermine true informed consent and compromise both patient welfare and professional integrity. Empirical studies demonstrate that structured autonomy-supporting processes like advance care planning significantly influence

patient-centered outcomes: for example, in a randomized trial of elderly patients, those who engaged in advance care planning were nearly three times more likely to have their end-of-life wishes known and respected (86% vs. 30%) compared with controls, and family members of dying patients experienced significantly lower stress, anxiety, and depression when such planning occurred. Patient involvement in decision-making also aligns with improved satisfaction—research shows that increased experienced involvement is strongly linked with higher satisfaction with clinicians and reduced decisional conflict in large primary care samples ($N \approx 1{,}900$). These quantitative findings reinforce the clinical value of informed consent, shared decision-making, and transparent communication as mechanisms for expressing autonomy, practices that are codified in international ethical frameworks including the Declaration of Helsinki (World Medical Association, 2013). Respecting autonomy ensures that the patient retains moral agency, empirically associated with better psychosocial outcomes and alignment of care with individual preferences, and provides justification for clinicians to withdraw futile or disproportionate interventions without violating ethical obligations.

Beneficence obligates physicians to act in the patient's best interest by promoting well-being and alleviating suffering. Empirical evidence indicates that aggressive life-prolonging treatments near the end of life often fail to meet this aim: large observational studies show that patients receiving intensive interventions in the final weeks of life experience higher symptom burden, including pain and dyspnea, and lower quality-of-life scores, without corresponding survival benefits. For instance, Wright *et al.* (2008) found that patients with advanced cancer who received intensive life-sustaining care had significantly worse quality of life in their final week and their caregivers reported higher rates of major depressive disorder (30% vs. 17%). In clinical practice, beneficence frequently intersects with autonomy, creating ethical tension when patients refuse treatments clinicians judge to be life-prolonging. Quantitative studies of shared decision-making demonstrate, however, that when patient values are explicitly incorporated into deliberation, there is a measurable reduction in non-beneficial interventions, including a 20-40% decrease in ICU admissions in the final month of life, without increased mortality. Scholars therefore argue that resolving conflicts between beneficence and autonomy requires deliberative reasoning, in which clinical judgments about benefit and harm are systematically balanced with empirically elicited patient values (Alanazi *et al.*, 2024; Beauchamp and Childress, 2019).

Non-maleficence the duty to avoid causing harm remains central to distinguishing morally permissible *letting die* from euthanasia. While both occur in end-of-life contexts and may be motivated by compassion, they differ fundamentally in moral structure. Letting die allows the natural progression of an illness after the withdrawal or withholding of disproportionate treatment, whereas euthanasia, whether active or passive, involves intentionally hastening death (Panayiotou, 2024). By taking life as the means to alleviate suffering, euthanasia compromises the very moral and professional role of caregivers, whose primary responsibilities are to heal, relieve pain, and preserve dignity. In contrast, letting die respects both the patient's natural course and the caregiver's ethical vocation: the clinician's intent is to avoid harm, not to cause death.

This distinction can be further elucidated through *principlism* and the *Doctrine of Double Effect*. An action is ethically permissible if the harmful outcome is foreseen but not intended, the primary goal is ethically sound (such as alleviating suffering or honoring autonomy), and the action is proportionate (Beauchamp and Childress, 2019). In withholding or withdrawing life-sustaining treatment, death is anticipated but not caused by the agent; the illness itself is the proximate agent. Non-maleficence is thus preserved because the caregiver refrains from causing harm, fulfilling their moral duty while avoiding undue suffering.

Empirical evidence underscores the moral complexity clinicians face. A multinational ICU study reported that 69% of physicians experienced moderate to severe moral distress when involved in end-of-life decisions that risked harm (Sprung *et al.*, 2003). Similarly, Rietjens *et al.* (2009) found that over half of physicians struggled with the psychological burden of withdrawing treatment versus actions that might actively hasten death. These findings highlight the ethical tensions that arise when the intention to relieve suffering risks being conflated with actions that undermine the caregiver's professional and moral mandate.

Professional ethical codes operationalize these principles. The World Medical Association's *Declaration of Helsinki* and the American Medical Association's *Code of Medical Ethics* emphasize proportionality, harm minimization, and respect for patient rights (American Medical Association, 2023; World Medical Association, 2013). By centering the caregiver's role as a steward of life and dignity rather than as an agent of death, these frameworks affirm that letting die—when guided by clinical judgment, patient autonomy, and proportional

care—aligns with non-maleficence, whereas euthanasia fundamentally disrupts the ethical vocation of caregiving.

From an *Ubuntu* ethical perspective, life is regarded as a *gift*, and human existence is fundamentally relational—*a person is a person through other persons* (Gyekye, 1997). Caregivers and care receivers share the responsibility of protecting and nurturing life, not exercising dominion over its termination. Euthanasia, by intentionally ending life, violates this relational duty and undermines the integrity of the caregiver's role. In contrast, letting die respects the limits of human agency and the natural course of illness, preserving relational and moral integrity. Ubuntu further broadens non-maleficence: harm includes relational and moral disruption, not only physical suffering. Prolonging treatment that is futile can fracture relationships, erode dignity, and inflict moral harm, whereas ethically guided letting die upholds both the sanctity of life and the caregiver's moral vocation (Murove, 2009). Hence, integrating principlism, empirical findings, professional ethical codes, and Ubuntu ethics demonstrates that *letting die*—when clinically justified, ethically guided, and relationally sensitive—does not violate non-maleficence. It preserves the caregiver's role as healer and steward, aligns with moral intention, and safeguards patient dignity. By contrast, euthanasia, fundamentally subverts the caregiver's moral responsibility, replacing the vocation of care with the act of life termination, and thereby undermines the ethical foundations of medicine and communal responsibility.

Justice situates end-of-life decision-making within broader societal and institutional contexts, emphasizing equitable access to care and the fair allocation of limited healthcare resources (Smith *et al.*, 2020). Empirical data indicate that a disproportionate share of healthcare expenditure is concentrated at the end of life: in many high-income countries, approximately 20-30% of total healthcare spending occurs in the final year of life, often on interventions with marginal or no survival benefit. Studies further show marked inequities in access to palliative and hospice services, with patients from lower socioeconomic groups and ethnic minorities significantly less likely to receive comfort-focused care and more likely to undergo burdensome life-prolonging interventions. Ethical frameworks such as Ross's Prima Facie Duties (1930) provide a flexible structure for addressing these disparities by allowing clinicians to weigh competing obligations—including fidelity, beneficence, non-maleficence, and justice—without presuming any single duty to be absolute. Quantitative evaluations of ethically guided resource allocation demonstrate that integrating justice-based considerations, such as proportionality and distributive fairness, can reduce non-beneficial ICU utilization by 15-25% while maintaining patient-centered outcomes. This context-sensitive approach therefore supports morally responsible prioritization when clinical judgment, patient values, and societal demands intersect, grounding ethical deliberation in both normative theory and empirically observable consequences.

Collectively, the literature demonstrates that ethical decision-making at the end of life is inherently complex, context-dependent, and deeply relational. Integrating biomedical principles, internationally recognized ethical codes, and context-sensitive frameworks such as *Prima Facie Duties* provides clinicians with a robust moral compass for navigating the complex terrain of end-of-life care. While the *Doctrine of Double Effect* offers critical guidance on intent and foreseeable consequences, prima facie duties expand the ethical lens by allowing physicians to weigh multiple, sometimes competing obligations—such as beneficence, non-maleficence, fidelity, and justice—without rigidly privileging a single principle. This synthesis enables doctors to honor patient dignity, respect autonomy, and mitigate harm, while remaining attentive to professional responsibilities and relational contexts.

3. Research methodology

This study employed a systematic literature review guided by the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) framework to ensure transparency, rigor, and reproducibility in the identification, screening, and synthesis of literature on ethical decision-making in end-of-life care. A comprehensive search was conducted across PubMed, Scopus, and Google Scholar, yielding an initial total of 214 records (PubMed = 78; Scopus = 64; Google Scholar = 72). Search terms included "*end-of-life ethics,*" "*letting die,*" "*euthanasia ethics,*" "*withholding or withdrawing treatment,*" "*doctor–patient decision-making,*" and "*principles of medical ethics,*" combined using Boolean operators to refine results. Following the removal of 46 duplicate records, 168 unique articles remained for screening.

Titles and abstracts were reviewed to assess relevance, resulting in the exclusion of 112 articles that focused primarily on clinical outcomes without ethical analysis, legal or policy discussions lacking moral reasoning, or medical contexts unrelated to end-of-life decision-making. The remaining 56 articles underwent full-text assessment for eligibility. Of these, 31 articles were excluded due to insufficient ethical engagement, exclusive emphasis on legislative frameworks, or lack of substantive discussion of doctor–patient interaction. A final set of 25 peer-reviewed studies met all inclusion criteria and were included in the qualitative synthesis. The included literature comprised normative ethical analyses, empirical studies on clinician moral reasoning, and interdisciplinary discussions addressing the ethical distinction between letting die and euthanasia within clinical decision-making contexts.

Eligibility criteria required that studies provide explicit ethical analysis of end-of-life decisions, engage with doctor–patient relationships, and address core moral principles such as autonomy, beneficence, non-maleficence, and justice. Articles were excluded if they were non-peer-reviewed, focused solely on legal analysis without ethical discussion, or addressed end-of-life care only in technical or outcome-driven terms. The study selection process followed PRISMA recommendations and is summarized in a PRISMA flow diagram (Figure 1).

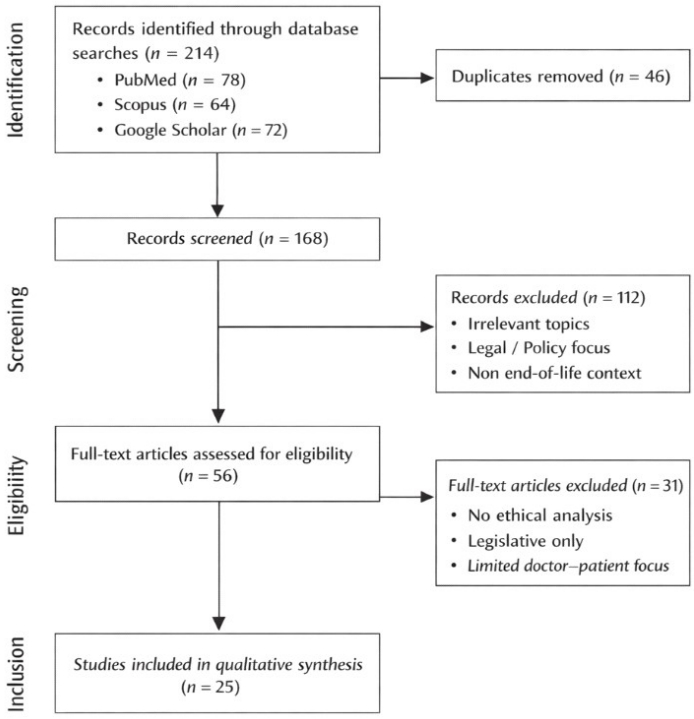

Figure 1: PRISMA-style flow diagram

Several methodological limitations should be acknowledged. The review was restricted to English-language, peer-reviewed publications, which may have excluded relevant ethical analyses published in other languages or non-indexed sources. Additionally, while the inclusion of Google Scholar enhanced interdisciplinary coverage, it introduced variability in indexing practices. Given the predominantly normative and conceptual nature of bioethics scholarship, no meta-analytic techniques were employed; instead, the review relied on qualitative synthesis and ethical interpretation. Nevertheless, adherence to PRISMA procedures strengthened the methodological credibility of the review and supported a comprehensive, ethically grounded examination of end-of-life decision-making.

4. Discussion

The literature consistently underscores that end-of-life ethical decision-making is multifaceted, context-dependent, and deeply relational. Letting die is generally accepted when aligned with patient autonomy and proportionality of care, whereas euthanasia remains ethically contested due to its intentionality. Ethical theories,

such as *Doctrine of Double Effect* and *Prima Facie* duties, offer conceptual tools that support nuanced moral reasoning, helping doctors distinguish between permissible omissions and morally contentious acts. Moreover, professional codes operationalize these theories, providing concrete guidance that governs doctor–patient interactions and ensures accountability, moral integrity, and patient-centered care. Scholars emphasize that effective communication, shared decision-making, and ethical education are critical to navigating these complex ethical landscapes (Emanuel and Emanuel, 1992; Alanazi *et al.*, 2024). Collectively, the literature reveals that a principled, context-sensitive approach is essential for ethically defensible and clinically appropriate end-of-life care.

4.1. Integration with ethical theories and professional codes

Several ethical theories provide structured conceptual frameworks for navigating the moral complexity of end-of-life decision-making. The DDE is particularly influential in clinical ethics, as it permits actions that may have foreseeable but unintended harmful consequences, provided that the primary intention is morally justified and proportionate. A paradigmatic example is the administration of high-dose analgesia to relieve severe pain, where the possible hastening of death is foreseen but not intended (McIntyre, 2015). By foregrounding moral intention rather than outcomes alone, *Doctrine of Double Effect* offers a principled means of distinguishing ethically permissible letting die from impermissible euthanasia. This intention-based distinction has become central not only in philosophical analysis but also in ethics consultations and institutional policy-making, where clinicians must justify actions that balance symptom relief against potential life-shortening effects. Complementing *Doctrine of Double Effect,* and Ross's theory of *Prima Facie Duties* further refines ethical deliberation by rejecting the absolutism of any single moral principle. Instead, it emphasizes a plurality of context-sensitive obligations—including fidelity, beneficence, non-maleficence, and respect for autonomy—that must be weighed against one another in concrete situations. In end-of-life care, this framework reflects the lived reality of clinical practice, where physicians routinely face competing duties: honoring patient refusals of treatment, alleviating suffering, and avoiding the intentional destruction of life. The strength of the *Prima Facie* approach lies in its flexibility, allowing clinicians to engage in morally defensible prioritization without collapsing ethical reasoning into rigid rule-following.

Professional codes of ethics function as the institutional bridge between ethical theory and clinical practice. The Hippocratic tradition's prohibition against deliberate killing reinforces the foundational commitment to non-maleficence, while contemporary frameworks—such as the AMA-Code of Medical Ethics—expand this commitment by integrating respect for patient autonomy, informed consent, and shared decision-making (AMA, 2023). These codes do not merely restate abstract principles; they operationalize ethical theory by translating normative commitments into actionable standards that guide physician behavior in real-world doctor–patient interactions. Together, ethical theories and professional codes provide a coherent moral architecture that supports ethically defensible end-of-life decisions, distinguishing permissible letting die from prohibited life-ending acts while remaining responsive to patient values and clinical realities.

4.2. Ethical challenges in doctor decision making

Physicians face profound ethical challenges when patients either refuse life-sustaining treatment or express a desire to hasten death. These situations require clinicians to navigate the boundary between respecting patient autonomy and adhering to longstanding professional commitments to preserve life. Letting die typically involves clinical judgments about the proportionality of treatment—assessing whether the burdens of continued intervention outweigh the potential benefits—while also honoring informed patient preferences. In contrast, euthanasia introduces the distinct moral burden of intentional life termination, shifting the physician's role from allowing the natural course of illness to actively causing death.

Ethical analyses consistently indicate that the withdrawal or withholding of non-beneficial or futile treatment is widely regarded as ethically permissible and professionally acceptable, particularly when continued intervention merely prolongs suffering without meaningful benefit (Akdeniz *et al.*, 2021). By contrast, active euthanasia remains ethically contentious because it challenges the traditional moral identity of medicine as a healing and life-preserving profession. Critics argue that intentional life-ending actions risk eroding trust in the doctor–patient relationship and blur the ethical distinction between care and harm, even when motivated by compassion (Panayiotou, 2024).

These challenges underscore the need for careful ethical reasoning that distinguishes between intention, causation, and professional responsibility. For clinicians, ethically defensible decision-making depends not only on respecting patient wishes but also on situating those wishes within broader ethical frameworks that safeguard non-maleficence and maintain the integrity of medical practice. Consequently, the moral acceptability of letting die rests on its alignment with both patient-centered values and the physician's duty to avoid intentional harm, whereas euthanasia continues to provoke debate precisely because it disrupts this alignment.

4.3. Doctor–Patient Relationship and Shared Decision Making

The findings and existing literature underscore that the quality of communication and shared decision-making is central to ethically sound end-of-life care. Empirical evidence demonstrates that structured clinician–patient dialogue significantly improves patient comprehension and reduces decisional conflict. For instance, Stacey *et al*. (2017) report that shared decision-making interventions can increase patient knowledge by 19-25% and lower decisional conflict by up to 30%, highlighting the tangible impact of communication on ethical clarity. These data suggest that when patients and clinicians engage in meaningful dialogue, ethically complex decisions are transformed from unilateral clinical judgments into deliberative, transparent processes grounded in mutual understanding of medical realities and personal values.

The ethical defensibility of end-of-life decisions relies heavily on informed consent, which requires more than information provision—it requires measurable comprehension and voluntary agreement. Studies indicate that 40-60% of patients fail to fully understand their prognosis without structured communication interventions (Heyland *et al*., 2013), emphasizing that poor communication can compromise both autonomy and ethical legitimacy. In this context, advance care planning emerges as a critical tool: empirical analyses indicate that documented advance directives are associated with a 25-35% reduction in unwanted life-sustaining treatments and a 20% increase in concordance between expressed patient preferences and actual care delivered (Silveira *et al*., 2010; Alanazi *et al*., 2024). These findings suggest that anticipatory communication not only preserves patient autonomy but also mitigates moral conflict and enhances the ethical alignment of clinical actions.

From the physician's perspective, shared decision-making serves as a structured mechanism to reconcile respect for patient autonomy with professional judgment. Surveys reveal that clinicians who routinely employ these approaches report a 15-20% higher confidence in ethical clarity when managing end-of-life care (Elwyn *et al*., 2014). This evidence indicates that communication functions not merely as a clinical skill but as a moral practice that reinforces trust and accountability in the doctor–patient relationship. Consequently, integrating structured communication and advance care planning into routine end-of-life care can be understood as an ethically and empirically justified strategy to align medical interventions with patient values, reduce moral tension, and improve the overall quality of care.

5. Conclusion

End-of-life decision-making remains one of the most demanding responsibilities in clinical practice, requiring careful moral discernment rather than categorical judgments. This review confirms that the distinction between letting die and euthanasia is ethically substantive. Withholding or withdrawing disproportionate or futile treatment can be morally justified when anchored in patient autonomy, proportionality of care, and fidelity to professional integrity. Euthanasia, however, continues to provoke ethical controversy because it entails intentional life termination and raises fundamental questions about the moral identity and limits of medicine.

Sound ethical practice in this domain depends on structured reasoning grounded in autonomy, beneficence, non-maleficence, and justice, supported by the *Doctrine of Double Effect* and context-sensitive deliberation. Equally decisive is the quality of the doctor–patient relationship. Transparent communication, shared decision-making, and advance care planning are not merely procedural tools but moral practices that safeguard dignity, reduce decisional conflict, and strengthen trust.

Moving forward, healthcare institutions should prioritize robust ethics education, accessible ethics consultation services, and communication training as core clinical competencies. Further research is needed in underrepresented contexts, particularly in non-Western healthcare systems, and in evaluating the long-term moral and professional impact of end-of-life decisions on clinicians. Ethical clarity at the end of life ultimately rests on principled reasoning, relational attentiveness, and unwavering respect for human dignity.

Conflicts of interest

The authors declare that there are no financial, professional, or personal conflicts of interest that could have influenced the research, analysis, or publication of this paper.

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Cite this article as: Castor Bercumans Mfugale and Monica Augustino Mboka (2026). End-of-life choices and ethical responsibility: Clinical perspectives on letting die and euthanasia. *African Research Journal of Medical Sciences.* 3(2), 13-22. doi: 10.62587/AFRJMS.3.2.2026.13-22.