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The Ethics of Reversibility: Why High-Stakes Clinical Decisions Need Paths Back

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Abstract

High-stakes clinical decisions are usually evaluated through familiar ethical categories: informed consent, capacity, shared decision making, proportionality, best interests, and respect for autonomy. Less attention is given to whether the decision pathway itself preserves a meaningful opportunity to reconsider before options, bodily states, information, or time are irretrievably lost. This article develops a normative decision-design account of clinical reversibility. It distinguishes the technical reversibility of an intervention from the broader reversibility of a decision pathway and analyzes four dimensions: temporal, biological, procedural, and informational. Reversibility is defended as a pro tanto moral value because it can protect diachronic autonomy, accommodate uncertainty, permit learning, and require renewed justification for continuation rather than treating initial authorization as indefinitely sufficient. The article then proposes a qualitative classification of high-stakes decisions according to the degree of meaningful revisability available and the seriousness of the losses at stake. Time-limited trials, explicit pause points, and planned reassessment are examined as existing or extendable decision-design strategies, not as universally appropriate solutions. The account also recognizes decisions in which meaningful reversal is impossible or itself harmful. Reversibility therefore does not function as an absolute duty, validated metric, or substitute for substantive clinical judgment. Its ethical relevance depends on urgency, expected benefit and burden, relational authority, institutional capacity, and the consequences of delay. The central proposal is that high-stakes care should ask not only whether a choice is authorized now, but whether its design preserves a defensible path for justified reconsideration later.

Keywords: Clinical ethics, Reversibility, Shared decision making, Autonomy, Time-limited trials, Reassessment

Introduction

The overlooked moral value of paths back

Some clinical choices acquire moral weight not only because the outcomes matter, but because choosing changes what can still be chosen later. At the margins of neonatal viability, for example, the information needed for judgment may itself evolve during treatment, so the ethical problem cannot always be reduced to selecting once among fixed options [1]. Serious illness can also alter the patient's evaluative standpoint, preferences, or sense of self, complicating assumptions that a single decision expresses an unchanged chooser across time [2]. These situations expose a feature of high-stakes care that conventional accounts of authorization can understate: decisions unfold within trajectories, and trajectories can preserve or destroy future opportunities for agency.

Shared decision making already provides important resources for responding to this problem. Normative analysis emphasizes that genuinely shared medical decisions are not equivalent to simply transferring responsibility to the patient [3]. Decision aids can improve knowledge, risk understanding, and value clarification in treatment and screening choices [4]. The Three-Talk model likewise conceptualizes shared

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decision making as a staged process rather than a single consent event [5]. Yet these approaches generally focus on the quality of deliberation leading to a choice. They do not by themselves ask whether the structure of care leaves a meaningful route back after the choice has begun to operate.

This article proposes that reversibility should be treated as a distinct, defeasible value in clinical decision design. Revisability under evolving facts, structured decision support, and staged deliberation are complementary resources for decisions under uncertainty [1, 4, 5]. The additional normative question is whether a pathway preserves a realistic opportunity to change direction before morally important options are lost. A path back does not imply restoration to the predecision state, nor does it require indefinite indecision. It means preserving enough temporal, biological, procedural, and informational room for reconsideration to remain meaningful. The claim developed here is deliberately limited: reversibility is neither an absolute principle nor an empirically validated determinant of better outcomes. It is a proposed feature of ethically attentive decision architecture.

Defining clinical reversibility

Clinical reversibility should first be distinguished from simple stoppability. A drug may be discontinued, a ventilator setting changed, or a procedure interrupted, yet the relevant decision may already have altered prognosis, bodily integrity, relationships, eligibility for alternatives, or the time remaining to pursue another course. Conversely, an intervention may not be fully reversible while the surrounding decision process still preserves opportunities to revise goals, burdens, or subsequent steps. Temporal bioethics is useful here because it treats the distribution and loss of future options as ethically significant rather than viewing autonomy only at the instant of consent [6].

The proposed definition is therefore relational and diachronic: clinical reversibility is the degree to which a decision pathway preserves a meaningful opportunity for an authorized decision-maker to reconsider and alter direction before ethically significant losses become nonrecoverable. “Meaningful” matters. A formally available alternative that is clinically futile, practically inaccessible, or no longer compatible with the patient's condition is not a genuine path back. Accounts of autonomy grounded in lived clinical experience likewise caution against treating the patient as an abstract chooser detached from illness and circumstance [7]. Reversibility concerns actual agency within an evolving clinical world. The language of “degree” should not be mistaken for a claim that reversibility is already measurable on a validated scale. Two pathways could preserve different kinds of opportunity without being rankable on a single continuum. One might preserve biological options while sharply narrowing procedural authority; another might leave formal choice intact while consuming the time in which an alternative could still work. The proposed construct is therefore comparative and diagnostic before it is quantitative: it asks what remains recoverable, for whom, for how long, and at what cost.

This account also rejects a one-size-fits-all requirement. Purposeful shared decision making argues that the form of collaboration should respond to the problem the patient and clinician are trying to solve [8]. Reversibility should be similarly decision-sensitive. Its importance rises when uncertainty is substantial, consequences are serious, preferences may develop through experience, and options can be preserved at proportionate cost. It may matter less when delay itself is dangerous, when no alternative will remain medically meaningful, or when reopening a settled decision creates greater burden than protection. The concept is thus a design consideration, not a universal command to postpone commitment.

Temporal, biological, procedural, and informational dimensions

The manuscript's proposed account becomes more precise when reversibility is separated into four dimensions. Temporal reversibility concerns whether sufficient time remains to reconsider before the clinical opportunity changes or disappears. It is therefore not merely “having more time”; delay can narrow options as easily as it can preserve them. Biological reversibility concerns whether bodily changes, treatment effects, disease progression, or lost physiological function can be undone or meaningfully compensated. A technically stoppable intervention may still be biologically path-dependent once consequences accumulate.

Procedural reversibility concerns whether the decision process permits reopening, review, appeal, second opinion, changed authorization, or a planned shift in goals without treating the initial choice as institutionally final. Informational reversibility concerns whether uncertainty can be reduced through observation, testing, experience, or further deliberation before a more consequential commitment is made. Ethical analysis of

delegated procedural consent illustrates why process and information tasks can be distinguished from substantive authorization and judgment [9]. The distinction matters because a pathway may be procedurally flexible while remaining informationally poor, or informationally rich while becoming biologically irreversible.

The dimensions can also conflict. Waiting for better information may consume the very time needed to preserve an option. A reversible procedure may produce irreversible psychosocial or opportunity costs. Anticipated decision regret is especially salient in choices with durable reproductive consequences, but regret cannot itself determine what ought to be chosen [10]. The purpose of multidimensional analysis is therefore not to calculate a reversibility score. It is to expose where a purported "path back" is real, partial, or illusory and to identify what kind of loss would occur if the decision crossed a particular boundary.

Table 1 summarizes these manuscript-derived distinctions and the principal ways in which an apparently revisable pathway can cease to offer meaningful reconsideration.

Table 1. Dimensions of clinical reversibility and the losses that can make reconsideration non-meaningful

Dimension	What must remain recoverable	Typical threat to a path back	Ethical question at the decision point	Evidence status
Temporal	Sufficient opportunity to reconsider before alternatives expire	Urgency, progression, delay, closing eligibility	Will waiting preserve choice or silently remove it?	Temporal option-loss grounded in [6]; application proposed here
Biological	Bodily state or clinically meaningful alternatives	Irreversible bodily change, accumulated treatment burden, disease progression	Can direction change without leaving the patient in a materially worse state?	Permanence and regret concern grounded in [10]; dimension proposed here
Procedural	Authority and institutional permission to reopen the plan	Default continuation, rigid orders, inaccessible review	Who can reopen the decision, when, and with what authority?	Process/substantive distinction informed by [9]; framework proposed here
Informational	Ability to reduce uncertainty before deeper commitment	Missing data, false certainty, information arriving too late	Can observation or further deliberation change what is reasonably knowable?	Procedural-information distinction informed by [9]; framework proposed here

Note: The four-dimensional matrix is an original normative synthesis. It does not represent a validated instrument, numerical scale, or hierarchy.

Why reversibility has moral value

The first moral reason for preserving revisability is diachronic autonomy. Respect for autonomy should not be exhausted by asking whether a person authorized an intervention at one moment. When circumstances, understanding, or values can legitimately change, a decision architecture that permits reconsideration may better respect agency across time. This does not imply that every preference change should control care or that earlier decisions lack authority. It means that authorization for an evolving trajectory may require ethically relevant opportunities to reaffirm, revise, or withdraw from it.

Second, reversibility can support epistemic humility. High-stakes medicine often requires action before uncertainty is resolved. A path back allows clinicians and patients to learn from response, prognosis, lived burden, or emerging information without pretending that uncertainty has disappeared. Evidence that decisional conflict and regret occur after major oncological choices makes later appraisal clinically relevant, but it does not show that reversibility would prevent either outcome [11]. Prospective evidence in low-risk thyroid cancer likewise demonstrates that decision regret can be studied across different management trajectories without establishing a universal causal advantage for one decision design [12].

Third, reversibility can discipline continuation. Initiating treatment and continuing it are not ethically identical merely because the first choice was authorized. When a pathway includes a meaningful review point, continuation can require renewed reasons in light of what has been learned. This creates an important asymmetry. Preserving an option may sometimes protect future agency, but keeping every option open can itself impose costs, prolong uncertainty, consume resources, or postpone psychologically important closure. The ethical question is not whether more reversibility is always better, but whether the value of keeping a path open exceeds the burdens and risks created by doing so.

The moral value is therefore not simply "avoiding regret." It lies in preserving agency, making uncertainty

visible, and preventing initial commitment from becoming an unexamined default. These values remain defeasible. Some patients reasonably prefer closure, repeated reconsideration can create distress, and delay may itself produce irreversible harm. Reversibility is ethically valuable when it preserves meaningful agency at proportionate cost, not when openness becomes an end in itself.

Classifying decisions by reversibility and stakes

A useful decision-design framework must distinguish cases rather than assume that all high-stakes choices require the same safeguards. A systematic review of shared decision making found that judgments about its appropriateness vary with characteristics of the decision itself [13]. The same premise supports, but does not validate, a proposed reversibility classification. Two questions are especially important: how serious are the losses that may follow the decision, and how much meaningful revisability remains once the pathway begins?

Some decisions remain substantially revisable even when consequences matter. These cases may require good information and ordinary opportunities to reconsider but not elaborate pause structures. Other decisions combine high stakes with unresolved prognosis and partial reversibility. Critical-care time-limited trials illustrate why bounded treatment followed by planned reassessment can be preferable to either indefinite continuation or premature limitation when uncertainty remains important [14]. A third group includes decisions in which the intervention can be stopped but important effects, opportunities, or burdens accumulate quickly; here technical reversibility may conceal ethical irreversibility. Finally, some choices cross a boundary after which no meaningful alternative can be restored.

The two dimensions should not be interpreted as a simple grid in which "high stakes" automatically produces a stronger duty to defer. Stakes may concern mortality, serious morbidity, bodily integrity, future fertility, loss of capacity, enduring dependence, or other consequences whose importance varies with the person's values and circumstances. Likewise, reversibility can be asymmetric: changing from one pathway to another may remain feasible while returning in the opposite direction does not. Classification therefore identifies the decision-design problem; it does not resolve the substantive choice.

Institutional context modifies every category. Hospital policies governing withholding and withdrawal of life-sustaining treatment vary, showing that the practical space for reconsideration is partly structured by organizations rather than physiology alone [15]. High-stakes decisions therefore differ not only in clinical characteristics but also in uncertainty and institutional constraints [13–15]. The classification proposed here is qualitative and action-guiding, not a score. It asks what kind of protection is proportionate before a path narrows. **Table 2** translates this analysis into a qualitative classification of decision conditions and the corresponding design problem that each creates.

Table 2. Proposed decision classes according to stakes, uncertainty, and remaining revisability

Decision condition	Reversibility profile	Main ethical hazard	Proportionate design response	Status
Consequential but broadly revisable	Alternatives remain realistically accessible	Over-formalizing an ordinary choice	Clear deliberation and ordinary opportunity to revisit	Proposed classification informed by [13]
High stakes with uncertainty and partial reversibility	Learning can occur before commitment becomes final	Premature closure or indefinite drift	Predefined review point or bounded trial where clinically appropriate	Proposed class informed by TLT literature [14]
Technically stoppable but rapidly path-dependent	Treatment can stop while burdens or options accumulate	Mistaking stoppability for meaningful reversibility	Early reassessment and explicit recognition of accumulating loss	Proposed synthesis
Near an irreversible boundary	Important alternatives will soon become nonrecoverable	Crossing the boundary without adequate justification	Intensified prospective deliberation; document why delay or review is or is not feasible	Proposed synthesis; institutional feasibility informed by [15]

Note: The matrix is an original normative classification. Categories are qualitative, overlap is possible, and no validated threshold separates them.

Designing pause points, time-limited trials, and reassessment

If reversibility has moral significance, its most concrete expression is not perpetual choice but deliberately placed

reconsideration. A pause point is a prospectively identified moment at which the patient or legitimate representative and clinical team ask whether the reasons that justified beginning or continuing a course still hold. It need not require stopping treatment. Its function is to prevent momentum from silently converting a provisional choice into a final one. Time-limited trials provide the clearest existing clinical model. Recent ethical analysis treats them as more than technical trial periods: their justification depends on autonomy, benefit and burden, relationships, justice, and the circumstances under which uncertainty is being managed [16].

A genuine reassessment point requires more than putting a date in the chart. An American Thoracic Society workshop report defines time-limited trials through explicit therapeutic goals, a bounded period of treatment, and planned reassessment [17]. Generalizing cautiously beyond critical care, the proposed design principle is that a pause point should specify what uncertainty is being addressed, what observations could change the plan, who participates in reassessment, and what options remain available at that time. The point is not to precommit mechanically to withdrawal or escalation. It is to ensure that continuation is justified by updated reasons rather than inherited by default.

This distinction is central to the proposed ethics of reversibility. A pause point is ethically weak if it occurs only after one branch of the decision has effectively disappeared. It is also weak if the reassessment criteria are so vague that continuation becomes the unquestioned default. By contrast, a meaningful pause is located while more than one clinically and normatively credible direction remains available. Its timing is therefore justified prospectively by the expected evolution of evidence, burden, goals, and option loss rather than by a universal interval.

Pause points also have limits. They are inappropriate when delay would predictably foreclose the best available option, when no new information could alter the decision, or when repeated reopening would impose disproportionate distress or burden. Nor should a nominal review create false reassurance if biological or temporal irreversibility has already removed alternatives. The ethical design task is therefore to locate reassessment before, not after, the relevant losses become nonrecoverable.

Figure 1 presents the resulting manuscript-derived decision-space architecture, showing how meaningful reconsideration can be preserved without treating openness as an unlimited requirement.

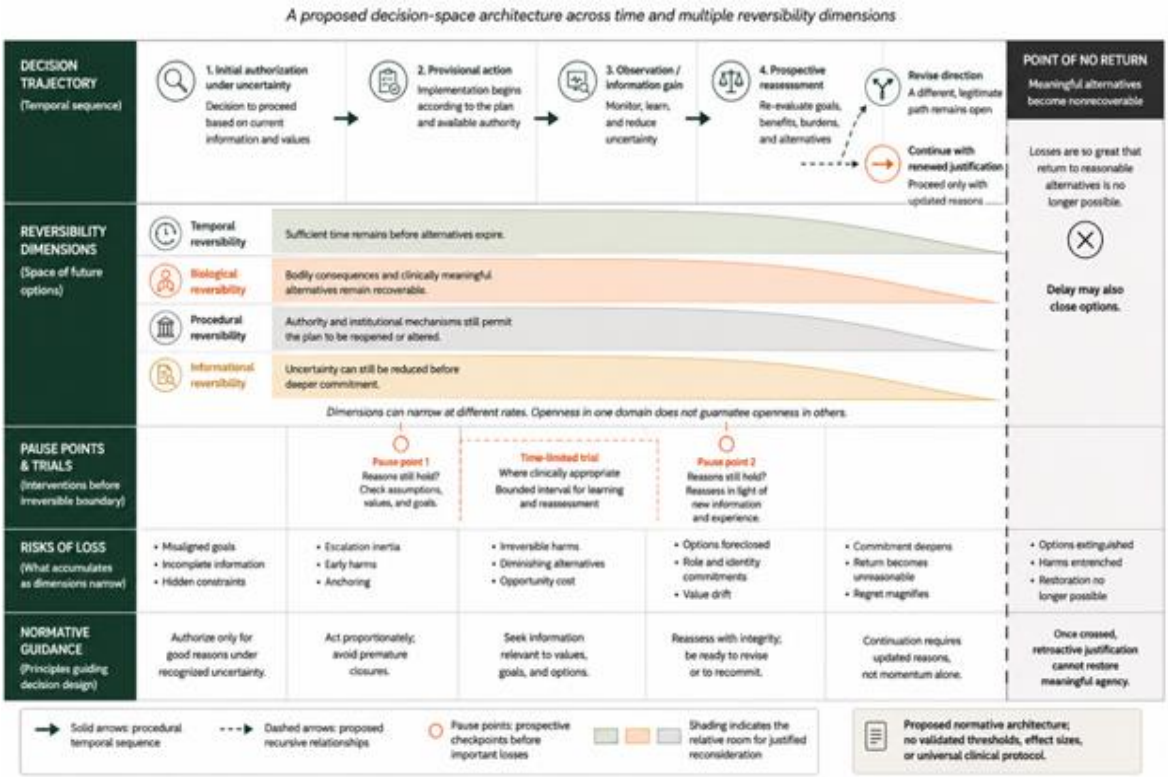

Figure 1. Preserving a meaningful path back in high-stakes clinical decision trajectories

Decisions that cannot be made reversible

A framework centered on paths back must acknowledge cases in which no satisfactory path back exists. Some decisions alter bodily conditions, consume time, or redistribute risks in ways that cannot later be neutralized. Obstetric ethics makes this visible because maternal choice, fetal interests, urgency, and time-sensitive consequences can converge without leaving a fully reversible option [18]. Calling such cases "irreversible" does not make them ethically simple. It means that moral work shifts from preserving later reconsideration to strengthening deliberation before the relevant boundary is crossed.

Loss of decisional capacity creates a different form of irreversibility. Advance directives attempt to preserve earlier values and preferences when later autonomous choice is no longer possible, but their authority remains interpretive rather than mechanically self-executing [19]. Dementia care illustrates practical difficulty: clinicians report barriers involving timing, communication, documentation, and uncertainty about advance-care planning across a changing illness trajectory [20]. A path back cannot be created after capacity has disappeared merely by declaring earlier planning sufficient.

The proposed response is a compensatory design principle. When meaningful reversal cannot be preserved, the ethical burden should move prospectively toward clearer explanation of irreversibility, value-sensitive deliberation, documentation of reasons, appropriate involvement of representatives, and independent review where justified. These are not universal procedural mandates. Emergency necessity, rapidly changing physiology, resource constraints, and patient preferences for closure can legitimately limit additional process.

Irreversibility must also be described precisely. "No path back" may mean that a bodily change cannot be undone, an alternative has expired, decisional capacity will not return, or another person's interests have been affected in ways that later preference change cannot erase. The objective is not to manufacture reversibility, but to identify the boundary early enough for the reasons for crossing it to be examined.

Application to high-stakes clinical decisions

The proposed account is most useful as a question about the structure of care rather than as a new consent form. In emergency and anticipatory care, instruments such as ReSPECT can carry prior deliberation forward into later best-interests decisions when the patient may no longer participate directly [21]. Their ethical importance lies less in freezing a prior preference than in creating continuity between earlier reasoning and later judgment. A reversibility perspective asks whether that continuity remains responsive to changed circumstances or merely converts earlier documentation into an inflexible endpoint.

Acute treatment-escalation decisions show the opposite pressure. Clinicians caring for older people describe time, uncertainty, authority, and deterioration as constraints on idealized shared decision making [22]. In such settings, insisting on maximal deliberative openness could itself be harmful. Reversibility therefore requires a proportionate question: what opportunity for reconsideration can realistically be preserved without compromising timely care? Sometimes the answer will be a brief checkpoint, sometimes a provisional escalation plan, and sometimes the clinical window will be too narrow for either.

High-stakes decisions are also rarely the work of one patient and one clinician. Intensive-care decision making is frequently interprofessional, with responsibilities distributed across professionals, patients, and surrogates [23]. A nominal path back may fail if no actor has authority to reopen the plan, information is fragmented, or reassessment is treated as another service's responsibility. Prospective planning, acute escalation decisions, and intensive-care deliberation together show that high-stakes choices are often relational, temporally distributed, and team-mediated rather than reducible to an isolated choice [21–23].

Applied across these settings, the proposed framework asks four practical questions. What may become nonrecoverable? What meaningful information may emerge before that happens? Who has authority and responsibility to reconsider? What would justify continuation, revision, or closure at the next decision point? These questions do not decide whether treatment should be started, withheld, continued, or withdrawn. They reveal whether the pathway supports justified reconsideration.

The framework is therefore most relevant where stakes are serious, uncertainty is material, consequences unfold over time, and some meaningful alternative remains preservable. It is less useful where choices are routine, reassessment would add no relevant information, or delay would predictably worsen the patient's position. Its contribution is diagnostic: identifying where decision

architecture may prematurely convert uncertainty into commitment.

Policy and institutional implications

If reversibility is partly a property of decision architecture, institutions matter because they shape whether reconsideration is possible in practice. Normative requirements do not translate themselves automatically into clinical routines. Transformative medical ethics argues for connecting ethical analysis to structures capable of changing practice rather than leaving norms at the level of abstract recommendation [24]. A reversibility-oriented institution would therefore examine not only whether consent occurred, but whether high-stakes pathways contain proportionate opportunities for review before important alternatives are lost.

This does not imply a universal "reversibility policy." Institutional rules can structure practice while remaining incomplete proxies for what clinicians actually do. Evidence on withholding and withdrawal of life-sustaining treatment shows that hospital policy can influence clinician decisions without mechanically determining them [25]. Governance is therefore broader than drafting a rule. It includes responsibility assignment, documentation, access to relevant expertise, communication across teams, and mechanisms for timely escalation when disagreement or uncertainty persists.

The article proposes three institutional questions rather than mandatory standards. Does the pathway identify points at which continuation becomes increasingly path-dependent? Is responsibility for reassessment assigned clearly enough that review cannot disappear into organizational diffusion? Are patients and legitimate representatives given a realistic opportunity to revisit high-stakes choices when circumstances materially change? These questions should be adapted to clinical context rather than converted into fixed intervals or universal thresholds.

Equity is an important boundary. Time, specialist review, second opinions, prolonged trials, and repeated family meetings are resources, not abstract possibilities. A policy that formally permits reconsideration may distribute that opportunity unevenly if some patients have greater access to expertise, advocacy, language support, or institutional attention. The present evidence does not establish the magnitude of such inequities, so the claim here is normative: institutions creating paths back should examine who can actually use them.

Policy evaluation should distinguish written availability from lived accessibility. Future studies could assess whether reassessment occurs as intended, whether different patient groups receive comparable opportunities, whether reopening decisions causes avoidable burden, and whether clinicians recognize when provisional decisions have become effectively irreversible. Until such work is available, reversibility should be treated as a governance hypothesis worthy of testing, not an implementation-ready standard.

Objections, trade-offs, and limits

The strongest objection is that reversibility can become an ethic of endless hesitation. High-stakes care sometimes requires commitment, and repeated reopening may prolong suffering, destabilize plans, exhaust families, or consume scarce resources. The answer is not to maximize revisability. The proposed value is pro tanto: preserving a path back matters only while the expected moral benefit remains proportionate to its burdens and risks.

A second difficulty concerns who exercises the path back when the patient lacks capacity. Proxy authorization cannot simply be assumed to reproduce competent personal consent; it requires separate normative justification concerning representation, interests, and authority [26]. Clinical treatment and research are not identical contexts, so this principle must be transferred cautiously. It nevertheless exposes a central limit: reversibility does not solve disagreement about who may legitimately revise a decision.

Third, surrogate decision making is culturally and institutionally situated. Ethnographic work in intensive care shows that family relationships, professional hierarchy, emotion, and cultural expectations can shape how surrogates understand decision responsibility [27]. A framework presuming one model of individual choice would therefore overstate its portability.

Other limits are conceptual. Technical stoppability may conceal irreversible opportunity loss; conversely, a biologically irreversible choice may still preserve later choices about goals or burdens. Reconsideration may improve justification without changing the eventual decision. The framework should not be judged solely by how often decisions reverse, but by whether important commitments remain open to justified review while review is still meaningful.

Conclusion

High-stakes clinical decisions matter ethically not only because of what is chosen, but because choosing can alter what remains possible. This article has proposed clinical reversibility as a decision-design value: preserving a meaningful opportunity for justified reconsideration before temporal, biological, procedural, or informational losses make alternatives nonrecoverable.

The proposal does not make reversibility an absolute duty, numerical property, or substitute for clinical judgment. Some decisions cannot be reversed; some should not be delayed; and some patients may reasonably prefer closure. Where paths back are impossible, the ethical burden shifts toward stronger prospective deliberation and justification. Where they can be preserved proportionately, pause points, bounded trials, reassessment, and institutional review may prevent provisional choices from becoming final through momentum alone.

The central normative claim is modest but consequential. Ethical decision design should ask not only whether a high-stakes choice is justified now, but whether the pathway preserves an appropriate opportunity to ask again before the possibility of asking meaningfully has disappeared.

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References

1. Lantos JD. When facts are not fixed: Rethinking shared decision making at the margins of neonatal viability. BMC Med Ethics. 2026;27(1):82. doi:10.1186/s12910-026-01431-5
2. Hofmann B. Undermining autonomy and consent: The transformative experience of disease. J Med Ethics. 2024;50(3):195-200. doi:10.1136/jme-2023-108906
3. Engelsma C. Sharing a medical decision. Med Health Care Philos. 2024;27(1):3-14. doi:10.1007/s11019-023-10179-3
4. Stacey D, Lewis KB, Smith M, Carley M, Volk R, Douglas EE, et al. Decision aids for people facing health treatment or screening decisions. Cochrane Database Syst Rev. 2024;1(1):CD001431. doi:10.1002/14651858.CD001431.pub6
5. Elwyn G, Durand MA, Song J, Aarts J, Barr PJ, Berger Z, et al. A three-talk model for shared decision making: Multistage consultation process. BMJ. 2017;359:j4891. doi:10.1136/bmj.j4891
6. Shaw D. The ethics of time: Towards temporal bioethics. J Bioeth Inq. 2024;21(4). doi:10.1007/s11673-024-10336-0
7. Lewis J, Holm S. Patient autonomy, clinical decision making, and the phenomenological reduction. Med Health Care Philos. 2022;25(4):615-27. doi:10.1007/s11019-022-10102-2
8. Hargraves IG, Montori VM, Brito JP, Kunneman M, Shaw K, LaVecchia C, et al. Purposeful SDM: A problem-based approach to caring for patients with shared decision making. Patient Educ Couns. 2019;102(10):1786-92. doi:10.1016/j.pec.2019.07.020
9. Allen JW, Earp BD, Koplin J, Wilkinson D. Consent-GPT: Is it ethical to delegate procedural consent to conversational AI? J Med Ethics. 2024;50(2):77-83. doi:10.1136/jme-2023-109347
10. Mertes H. The role of anticipated decision regret and the patient's best interest in sterilisation and medically assisted reproduction. J Med Ethics. 2017;43(5):314-8. doi:10.1136/medethics-2016-103551
11. Heirman AN, Arends CR, de Jel DVC, Dirven R, van der Molen L, Halmos GB, et al. Decisional conflict and decision regret in head and neck oncology: A systematic review and meta-analysis. JAMA Otolaryngol Head Neck Surg. 2024;150(5):393-404. doi:10.1001/jamaoto.2024.0214
12. Sawka AM, Ghai S, Rotstein L, Irish JC, Pasternak JD, Monteiro E, et al. Decision regret following the choice of surgery or active surveillance for small, low-risk papillary thyroid cancer: A prospective cohort study. Thyroid. 2024;34(5):626-34. doi:10.1089/thy.2023.0634
13. van der Horst DEM, Garvelink MM, Bos WJW, Stiggelbout AM, Pieterse AH. For which decisions is shared decision making considered appropriate? A systematic review. Patient Educ Couns. 2023;106:3-16. doi:10.1016/j.pec.2022.09.015
14. Kruser JM, Nadig NR, Viglianti EM, Clapp JT, Secunda KE, Halpern SD. Time-limited trials for patients with critical illness: A review of the

literature. Chest. 2024;165(4):881-91. doi:10.1016/j.chest.2023.12.014
15. Piscitello GM, Lyons PG, Koch VG, Parker WF, Huber MT. Hospital policy variation in addressing decisions to withhold and withdraw life-sustaining treatment. Chest. 2024;165(4):950-8. doi:10.1016/j.chest.2023.12.028
16. Ten CW, Tsai DFC. Ethical analysis on time-limited trials in critical care. J Med Ethics. 2026. doi:10.1136/jme-2026-111765
17. Kruser JM, Ashana DC, Courtright KR, Kross EK, Neville TH, Rubin E, et al. Defining the time-limited trial for patients with critical illness: An official American Thoracic Society workshop report. Ann Am Thorac Soc. 2024;21(2):187-99. doi:10.1513/AnnalsATS.202310-925ST
18. Wilkinson D, Teli S, Litchfield C, Madeley A, Kelly B, Impey L, et al. Ethics round table: Choice and autonomy in obstetrics. J Med Ethics. 2025;51(9):588-92. doi:10.1136/jme-2024-110503
19. Porteri C. Advance directives as a tool to respect patients' values and preferences: Discussion on the case of Alzheimer's disease. BMC Med Ethics. 2018;19(1):9. doi:10.1186/s12910-018-0249-6
20. Tjia J, D'Arcangelo N, Carlston D, Bronzi O, Gazarian P, Reich A, et al. US clinicians' perspectives on advance care planning for persons with dementia: A qualitative study. J Am Geriatr Soc. 2023;71(5):1473-84. doi:10.1111/jgs.18197
21. Eli K, Bernstein CJ, Harlock J, Huxley CJ, Walsh J, Blanchard H, et al. Using the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) in a community setting: Does it facilitate best interests decision-making? J Med Ethics. 2025;51(8):526-32. doi:10.1136/jme-2024-110144
22. Warner BE, Wells M, Vindrola-Padros C, Brett SJ. Shared decision-making with older people on TReatment Escalation planning for Acute deterioration in the emergency Medical Setting: A qualitative study of Clinicians' perspectives (STREAMS-C). Age Ageing. 2024;53(9):afae204. doi:10.1093/ageing/afae204
23. Michalsen A, Long AC, DeKeyser Ganz F, White DB, Jensen HI, Metaxa V, et al. Interprofessional shared decision-making in the ICU: A systematic review and recommendations from an expert panel. Crit Care Med. 2019;47(9):1258-66. doi:10.1097/CCM.0000000000003870
24. Kuehlmeyer K, Jansky B, Mertz M, Marckmann G. Transformative medical ethics: A framework for changing practice according to normative-ethical requirements. Bioethics. 2024;38(3):241-51. doi:10.1111/bioe.13185
25. Piscitello GM, Wolwowicz EL, Huber MT, Vranas KC, Sullivan DR, Hauschildt KE, et al. The influence of hospital policies on clinicians' decisions to withhold or withdraw life-sustaining treatment. Chest. 2025;168(6):1446-58. doi:10.1016/j.chest.2025.06.036
26. Sim J, Wrigley A. Proxy consent to clinical research participation: How should it be justified? Med Health Care Philos. 2026;29(2):465-81. doi:10.1007/s11019-026-10326-6
27. Wu L. The dilemma of surrogate decision-making in the intensive care unit: A focused ethnographic study. Nurs Ethics. 2026;33(2):365-82. doi:10.1177/09697330251374393