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Withdrawing Continuous Monitoring while Sustaining Nursing Presence: A Normative Framework for Reconfiguring Observation, Reassurance, and Bedside Attention during the Last Days of Life

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Abstract

Continuous physiological monitoring can retain clinical value near the end of life, yet its informational benefits may diminish or become disproportionate when technological surveillance disturbs rest, reinforces treatment-oriented routines, or conflicts with a patient's priorities for comfort. Decisions to reduce monitoring therefore carry a distinctive nursing-ethical problem: removing or scaling back a technology can be appropriate while withdrawal of nursing attention, symptom observation, communication, or reassurance is not. This philosophical and normative practice paper develops an evidence-informed framework for distinguishing these responsibilities during the last days of life. Recent nursing, palliative-care, critical-care, ethical, and goal-concordant-care scholarship is used to examine three connected questions: what continuous observation is still expected to accomplish; what burdens or relational consequences accompany it; and what responsibilities remain when its technological component is reduced. The analysis identifies proportionality, patient preferences, relational responsibility, epistemic uncertainty, and protection against discriminatory undertreatment as central normative considerations. It proposes that justified monitoring withdrawal should be understood as a reconfiguration of vigilance rather than its disappearance. Technological observation may decrease while bedside assessment, recognition of discomfort, communication, reassurance, documentation, and readiness to respond remain active nursing obligations. The framework is deliberately conditional rather than algorithmic because evidence directly evaluating monitoring withdrawal during the last days of life remains limited. Its purpose is to make the ethical structure of such decisions explicit and empirically testable without converting comfort-focused care into technological neglect.

Keywords: End-of-life care, Physiological monitoring, Nursing presence, Proportionality, Patient preferences, Comfort-focused care

Introduction

Technological monitoring has become deeply embedded in contemporary healthcare, including care delivered near the end of life. Its functions are varied: measurements can alert clinicians to physiological deterioration, support documentation, facilitate communication, and provide a sense of surveillance when a patient's condition is unstable. Nurses working in end-of-life settings nevertheless describe technology ambivalently. It can assist care while simultaneously competing with hands-on attention, relational connection, or a person's desired experience of dying [1]. The ethical question is therefore more specific than whether technology belongs in end-of-life care. It concerns when the information produced by continuous monitoring remains sufficiently valuable to justify the burden and attention it demands.

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That judgment is complicated by the uncertainty surrounding recognition of dying. Clinical recognition does not generally occur through a single decisive physiological sign. It develops from accumulated observations, knowledge of disease trajectory, changing function, communication across teams, and interpretation of what those changes mean for the individual patient [2]. The last days of life consequently create an epistemic problem alongside a moral one. More data may sometimes be useful, but the mere availability of physiological data cannot determine whether its continued collection remains proportionate to the patient's goals.

Responsibility for these decisions is also organizational. International intensive-care evidence shows substantial variation in nurses' reported involvement in end-of-life decision-making [3]. Formal authority, professional hierarchy, institutional routines, and local expectations influence whether nursing knowledge is actively incorporated into decisions that alter treatment intensity. At the bedside, however, nurses continue to encounter the consequences of those decisions. Nurses describing end-of-life practice report moral distress generated by conflicts involving patients, families, clinicians, organizational structures, and their own professional commitments [4]. Reducing a technology can therefore have consequences beyond the device itself: it may change how vigilance is understood, how family members interpret the direction of care, and how nurses perceive their continuing responsibility.

This paper develops a normative account of that transition. Its central proposition is that withdrawal or reduction of continuous monitoring should be evaluated separately from withdrawal of observation, reassurance, or bedside responsibility. The relevant ethical task is to determine which functions of monitoring remain justified, which have become burdensome or low-value, and how necessary nursing functions will be preserved when technological surveillance changes. The proposed framework is grounded in clinical evidence but does not present monitoring withdrawal as an empirically validated intervention. Instead, it clarifies the conditions under which a monitoring change could be ethically defensible and identifies the responsibilities that should survive such a change.

Clinical and ethical background

Routine physiological observation can acquire moral significance when the patient's goals shift from disease-directed intervention toward comfort. Nursing accounts of overnight vital-sign observation illustrate this tension particularly clearly. Nurses described scheduled observations as important for safety, yet also reported circumstances in which repeated measurements disturbed sleep or appeared disproportionate for patients approaching the end of life. The same study also identified patients who could be insufficiently monitored, underscoring that reducing observation is not inherently safer or more compassionate [5]. What matters is the relationship among expected informational value, likely burden, clinical trajectory, and the consequences of missing deterioration.

Evidence directly concerning continuous monitoring in palliative populations remains limited. A prospective pilot of wearable physiological monitoring among hospitalized palliative-care patients demonstrated that continuous data collection was technically possible, but recruitment was difficult and valid data availability was inconsistent [6]. Such findings do not establish that monitoring lacks value. They indicate that continuous measurement cannot presently be assumed to deliver reliable clinical benefit simply because a device can collect data. A normative decision therefore requires attention to the purpose for which monitoring is being continued: detecting a reversible complication, guiding symptom management, documenting a physiological trajectory, satisfying institutional routine, or reassuring clinicians and families may each represent a different justification.

The clinical transition is further complicated by the culture of acute care. Focused ethnographic work has shown that recognition of dying and movement toward comfort-focused care may be delayed when ward practices remain organized around cure, discharge, task completion, and competing demands [7]. Continuous monitoring can participate in that environment by maintaining a visual language of physiological correction even when the primary goals of care have changed. Yet the appropriate response cannot be derived from symbolism alone. A monitor that appears treatment-oriented may still be performing an important safety or symptom-related function for a particular patient.

Withdrawal of life-sustaining treatment provides an adjacent ethical context. Nurses involved in such care have described role ambiguity, legal and institutional constraints, emotional demands, and uncertainty about what good nursing requires after treatment goals change [8]. These experiences are relevant because technological de-escalation can be misread as a general retreat from care. In normative terms, discontinuing one modality does not determine the fate of the obligations that surrounded it.

Relational care becomes especially important at this point. Realist evaluation of end-of-life care at home suggests that compassionate communication and the time available for it can materially shape how patients and families experience professional care [9]. Reassurance, therefore, need not be equated with continued physiological display. It can also be produced through explanation, visible attentiveness, responsive symptom assessment, and the confidence that a nurse remains available when the technological intensity of care decreases.

The resulting clinical problem is a problem of functional differentiation: continuous monitoring may perform several functions at once, and those functions need not all remain necessary to the same degree. **Table 1**

distinguishes monitoring states by the work the technology is expected to perform, the burden it may create, and the nursing responsibility that persists if monitoring is altered.

Table 1. Clinical-ethical monitoring states requiring different forms of nursing appraisal

Monitoring state	Principal informational function	Potential clinical or experiential burden	Central patient-preference question	Nursing responsibility if technological monitoring is reduced
Monitoring remains linked to a plausible reversible or symptom-relevant change	Detect change that could lead to an intervention consistent with current goals	Sleep disruption, device burden, repeated attention to numerical change	Does the patient regard the potential intervention and its associated monitoring as worthwhile?	Preserve the observation needed to recognize the relevant change and respond within agreed goals
Monitoring produces information but is unlikely to alter the comfort-focused plan	Document physiological change or provide situational awareness	Data collection may become intrusive or reinforce treatment-oriented routines	Does continued measurement add reassurance or unwanted burden from the patient's perspective?	Shift toward clinically purposeful bedside observation and symptom-focused assessment
Monitoring is continued largely because it is routine	Maintain established workflow or customary surveillance	Institutional habit may obscure changes in goals and expose the patient to low-value disturbance	Has continuation been explicitly reconsidered after goals changed?	Reassess the indication, document the decision, and maintain non-technological vigilance
Monitoring provides reassurance primarily to clinicians or family members	Reduce uncertainty for observers	The patient's comfort or preferences may become secondary to others' need for certainty	Whose reassurance is being served, and is that purpose proportionate to the burden imposed on the patient?	Replace unnecessary technological reassurance with explanation, communication, presence, and an agreed observation plan where feasible
Device surveillance is reduced while clinical uncertainty remains	Limit burdensome surveillance without claiming certainty about the trajectory	Risk that reduced technology will be interpreted as reduced care	What forms of observation and response does the patient still value?	Maintain symptom recognition, bedside attention, reassessment, communication, and readiness to respond

Normative foundations

The central ethical requirement for a monitoring decision is proportionality. Beneficence and nonmaleficence support the use of interventions when expected benefits remain meaningful and burdens are acceptable, yet neither principle determines a monitoring decision in isolation. Ethical analysis of care near the end of life shows that familiar principles require contextual interpretation because uncertainty, prognosis, treatment effects, and patient values interact [10]. Continuous monitoring is proportionate only when the purpose served by the information remains important enough to justify the burden of obtaining and acting on it.

This judgment must also account for vulnerability without converting vulnerability into incapacity. Feminist approaches to palliative-care ethics distinguish vulnerability inherent in serious illness from vulnerability that can be created or intensified by social relationships and healthcare practices [11]. A dying patient may depend heavily on clinicians while still retaining preferences about what forms of observation, information, disturbance, and bodily attention are acceptable. Nursing responsibility therefore includes protecting the conditions in which those preferences can influence care.

That protection cannot be presumed to occur automatically. Ethical analysis of palliative nursing encounters has shown how institutional routines and professional assumptions may displace patient involvement even when participation is ostensibly valued [12]. In the context of monitoring withdrawal, this creates two opposite risks. Clinicians may continue surveillance because its value is assumed without asking whether the patient experiences it as beneficial, or they may withdraw it because a dying patient is assumed no longer to value information, safety, or responsiveness. Both errors replace patient-specific judgment with professional presumption.

Evidence from serious-illness care reinforces this concern. Clinicians' perceptions of patients' prioritized goals do not always correspond fully with the goals patients themselves identify [13]. Even the concept of goal-concordant care is methodologically difficult to operationalize, with available approaches measuring different aspects of the relationship between preferences and care received [14]. Patient-centered monitoring decisions therefore require

more than documenting a broad preference such as "comfort." Clinicians must interpret what comfort means for the specific person, whether monitoring itself is experienced as burdensome, which changes the person would still want clinicians to detect, and how uncertainty should be handled if decisional capacity diminishes.

Justice provides an additional safeguard. Ethical analysis of "terminalism" warns that dying status can become an illegitimate reason for offering less consideration or lower-quality care [15]. This distinction is critical for monitoring withdrawal. Reduced surveillance can be ethically appropriate because the burdens exceed the relevant benefit, because an intervention triggered by the information would no longer be consistent with the patient's goals, or because another form of observation better serves those goals. It is not justified merely by the fact that death is expected. Otherwise, de-escalation risks becoming discriminatory neglect disguised as comfort-focused care.

Observational evidence concerning documented comfort goals illustrates why this distinction matters. Among a large cohort of US Veterans, documented comfort-focused goals were associated with different patterns of healthcare use near the end of life, including less acute-care utilization [16]. The association does not demonstrate that reducing monitoring causes better outcomes. It does show that explicit goals can reorganize patterns of care when those goals are recognized and operationalized. Monitoring decisions should be approached in the same way: the technology is evaluated by reference to what the patient is trying to achieve, not by a categorical rule attached to diagnostic or prognostic status.

Taken together, these principles support a normative shift from asking whether monitoring should be "continued" or "stopped" toward asking how vigilance should be configured for this patient at this stage of dying. The answer may retain continuous monitoring, reduce its frequency, remove selected modalities, or discontinue device-based surveillance. Across those possibilities, nursing obligations do not disappear. Their form changes according to the informational need, patient preference, burden of surveillance, available alternatives, and the practical ability to recognize and respond to symptoms.

Figure 1 represents this reconfiguration by separating technological surveillance from the wider field of nursing vigilance and showing how patient preference, proportionality, uncertainty, justice, and relational responsibility constrain the transition.

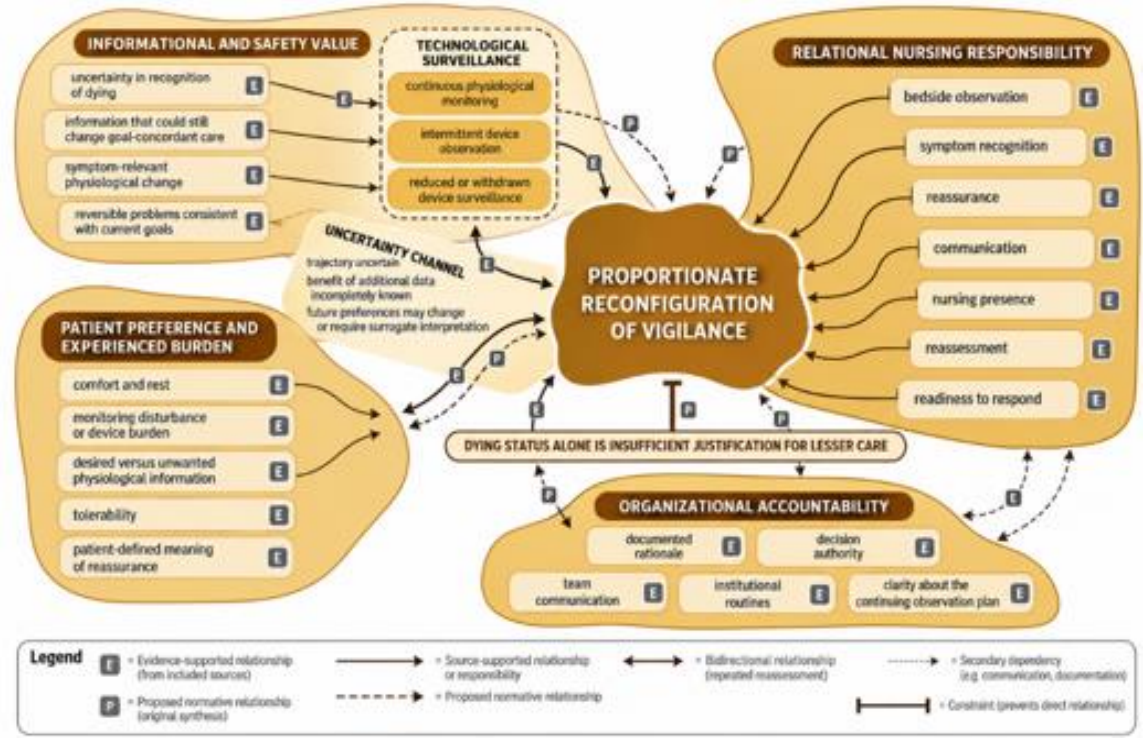


Figure 1. Reconfiguring vigilance when technological monitoring changes during the last days of life

Competing obligations

Continuous monitoring in the last days of life sits within several duties that can point in different directions. Critical-care nurses describe ethical conflict when ongoing treatment, patient wishes, family expectations, and professional judgments cannot be readily reconciled [17]. Technological vigilance can participate in the same conflict. A monitor may support rapid recognition of clinically important change, yet continuing surveillance may also preserve a treatment-oriented posture after the goals of care have shifted. Proportionality therefore concerns

the purpose served by monitoring in the particular case, not simply the presence or absence of physiological abnormality.

Debates about treatment futility illustrate why continuation cannot be treated as the ethically neutral default [18]. When an intervention no longer contributes meaningfully to an agreed goal, continuation itself requires justification. Applied to monitoring, this does not mean that data become irrelevant once a patient is dying. It means that clinicians should be able to explain what information is still sought, what action could reasonably follow from it, and why the burden of surveillance remains acceptable.

Nurses retain substantial responsibilities during withdrawal of life-sustaining treatment. Qualitative synthesis identifies roles in ethical safeguarding, family support, coordination, and preservation of patient-centered care [19]. These functions clarify the distinction central to the present analysis: reducing a technological mode of observation does not dissolve the professional responsibility to notice suffering, respond to symptoms, communicate changes, and remain available at the bedside.

Family concerns intensify the tension. Communication studies and family-focused evidence show that withdrawal of treatment can create needs for preparation, understandable information, proximity, participation, and emotional support [20–22]. Continued monitoring may sometimes reassure relatives, but reassurance has to be weighed against the patient's goals and burdens. When surveillance no longer serves a proportionate clinical function, its continuation solely to manage others' uncertainty requires careful ethical scrutiny. Family reassurance remains an obligation; the appropriate means of providing it may shift toward explanation, presence, anticipatory communication, and a clearly articulated plan for symptom observation.

These competing duties can therefore be understood as obligations that change form without disappearing when monitoring is reduced. **Table 2** identifies the responsibilities that require explicit transfer or preservation so that technological de-escalation does not become practical abandonment.

Table 2. Obligations that must be preserved or reconfigured when continuous monitoring is reduced

Obligation under tension	What may legitimately change	What must remain clinically or ethically active	Principal failure mode	Proposed normative response
Recognition of clinically meaningful change	Frequency or modality of device-based measurement	Observation sufficient to identify discomfort or changes that remain relevant to agreed goals	Equating fewer measurements with permission to notice less	Specify what changes still matter and how they will be recognized
Comfort versus vigilance	Intrusive alarms, repeated measurements, or low-value surveillance	Responsiveness to pain, breathlessness, agitation, distress, and other relevant symptoms	Preserving technological routine at the expense of comfort	Match monitoring intensity to expected benefit and patient-experienced burden
Patient preference versus professional assumption	Clinician-defined default surveillance	Ongoing attention to expressed goals and previously stated preferences	Treating “comfort care” as permission to infer what the patient wants	Revisit preferences when feasible and document how they informed the decision
Family reassurance versus patient burden	Reliance on numerical displays as the main source of reassurance	Clear explanation, preparation, availability, and communication about what staff will continue to observe	Continuing burdensome monitoring primarily to reduce observer anxiety	Reassure through relational and informational support unless surveillance itself remains proportionate
De-escalation versus non-abandonment	Technological intensity	Nursing presence, symptom assessment, communication, reassessment, and readiness to respond	Interpreting withdrawal as cessation of active nursing responsibility	Make continuing duties explicit at the time the monitoring plan changes
Individual decision versus organizational accountability	Particular device configuration	Documented rationale, team awareness, role clarity, and review if circumstances change	An undocumented or poorly communicated reduction in surveillance	Treat monitoring change as an accountable clinical decision rather than an informal drift in practice

Proposed normative framework

End-of-life nursing literature consistently places autonomy, beneficence, relational conflict, communication, and organizational support within the same ethical field [23]. On that basis, monitoring withdrawal should begin with a justification judgment: what clinically relevant purpose does the technology still serve, what burden accompanies it, and is the potential information capable of changing care in a way consistent with the patient's goals? A decision to continue monitoring can be proportionate when these questions have substantive answers. Reduction becomes defensible when informational value has become low relative to burden or when likely responses to monitored deterioration would conflict with agreed goals.

A second requirement is communication continuity. Structured serious-illness communication can be incorporated into critical-care practice and offers a practical model for making goals, uncertainty, and treatment implications discussable [24]. A monitoring change should therefore be explained as a clinical and ethical decision, including what is being withdrawn, why, and what forms of observation will continue.

A third requirement concerns preference interpretation. Families making decisions for hospitalized persons with impaired capacity may struggle to translate prior values into immediate choices [25]. When direct patient preference is unavailable, surrogate interpretation should be supported without presenting uncertainty as certainty. Decisions should remain connected to known values, the current clinical situation, and the proportionality of the monitoring burden.

Communication itself also requires cultural sensitivity. Patients, families, and clinicians may differ in whether they favor protective, family-mediated, gradual, or more direct approaches to end-of-life disclosure [26]. Nurses likewise describe the importance of preparing relatives, communicating truthfully with appropriate pacing, and continuing reassurance during difficult conversations [27]. The framework therefore does not prescribe one script. It requires that monitoring changes be communicated in a manner responsive to the patient's relational and cultural context while preserving truthful explanation of the care plan.

Finally, responsibility must be organizational as well as interpersonal. Work on goal-concordant serious-illness care emphasizes training, documentation, timing, workflow, and institutional infrastructure [28]. The proposed framework accordingly treats a monitoring change as complete only when the rationale and continuing observation plan are understood by those responsible for bedside care.

Together, these requirements form a Normative Monitoring-Withdrawal and Nursing-Presence Framework with four linked duties: justify the monitoring change through proportionality and goals; preserve clinically relevant observation; communicate the change and provide reassurance; and maintain accountable reassessment as the patient's condition evolves. Its central claim is functional: technological surveillance can contract while nursing vigilance remains active through different means.

Results and Discussion

The proposed framework addresses a clinical situation in which neither maximal surveillance nor routine technological withdrawal can serve as an ethically adequate default. Evidence concerning night-time observations demonstrates the risk of unnecessary disturbance while also documenting circumstances in which vulnerable patients may be under-monitored [5]. Direct palliative-care evidence on continuous wearable monitoring remains too limited to resolve that tension empirically [6]. The appropriate stance is therefore conditional proportionality.

The framework also protects against two opposite errors. The first is technological inertia: continuing monitoring because it is customary despite limited relevance to the patient's goals. The second is terminalist de-escalation: reducing observation simply because death is expected [15]. Ethical withdrawal lies between these errors and requires an account of what information is relinquished, what benefit is no longer expected, and which forms of nursing observation will replace or complement the removed technology.

Implementation will depend heavily on role clarity. Withdrawal-of-treatment literature indicates that nurses commonly perform safeguarding, coordination, communication, and family-support functions during transitions in care [19]. Those responsibilities provide a practical basis for sustaining nursing presence after monitoring changes. Their exact expression will vary across acute wards, intensive care, palliative units, staffing arrangements, cultures, and legal environments.

Family concerns require similar restraint. Relatives may understandably experience removal of visible monitoring as a sign that care is being reduced. Communication and preparation therefore matter, but family anxiety should not automatically establish an indication for burdensome surveillance. Culturally variable preferences for disclosure and family involvement further preclude a universal communication model [26].

The framework remains normative and requires empirical testing. Future research should prospectively examine how monitoring changes affect patient comfort, symptom recognition, family understanding, nursing workload, perceived abandonment, safety events, and the timing of bedside responses. Goal-concordance research also cautions that no single measure can capture whether care genuinely matched patient priorities [14]. Evaluation should therefore combine clinical outcomes with patient, family, and nursing perspectives.

Conclusion

Withdrawing continuous monitoring during the last days of life can be ethically justified when its expected informational or safety value has become disproportionate to its burden or inconsistent with the patient's goals. Such withdrawal does not reduce the obligation to observe, recognize discomfort, communicate, reassure, reassess, and remain present. The ethically relevant transition is therefore a reconfiguration of vigilance: technological surveillance may diminish while nursing responsibility remains active, visible, and accountable. The proposed framework provides a structured basis for making that distinction while preserving uncertainty, patient preference, relational responsibility, and protection against abandonment.

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