When to stop treatment and deciding next steps

What it means to stop treatment

Stopping treatment means discontinuing a specific intervention because it is no longer the best way to meet the patient's goals or medical needs. It does not mean abandonment, neglect, or the end of professional responsibility. In ethical guidance on withholding or withdrawing life-sustaining treatment, the American Medical Association emphasizes that an intervention may be stopped when it no longer helps achieve the patient's goals for care or desired quality of life. The same principle, applied carefully, is relevant across many areas of pregnancy and reproductive medicine.

In fertility care, stopping may mean ending a current IVF cycle, deciding not to start another ovarian stimulation cycle, discontinuing a medication because of risk or lack of response, or moving away from treatment using one's own gametes. In pregnancy care, it may mean declining an intervention with low likelihood of benefit, choosing expectant management instead of active intervention in a complex clinical scenario, or shifting toward comfort-focused care when serious maternal, fetal, or neonatal outcomes are anticipated.

The language matters. Many patients hear "stop" as failure. A more accurate frame is "reassess and redirect." Treatment is a tool; care is the broader

commitment. If the tool is causing harm, not working, or no longer aligned with the patient's values, changing course may be the most medically and ethically sound next step.

Medical signs that continuing treatment may no longer be appropriate

There is no single universal threshold for stopping treatment. Decisions depend on diagnosis, prognosis, gestational age if pregnant, maternal health, fetal or embryo considerations, prior response to treatment, and the patient's values. Still, several clinical patterns commonly prompt reassessment.

Failure to improve despite appropriate treatment: If the expected response does not occur after a reasonable interval, the team may need to revisit whether continuing offers meaningful benefit.
Clear deterioration over time: Guidelines on end-of-life decision-making note that ongoing deterioration can indicate that continuing active treatment is no longer appropriate, especially when treatment cannot reverse the underlying trajectory.
Disproportionate treatment burden: Severe pain, repeated procedures, hospitalizations, medication toxicity, ovarian hyperstimulation risk, psychological distress, or financial strain may outweigh the probability of success.
Low likelihood of achieving the intended outcome: In fertility treatment, this might involve repeated failed cycles, poor ovarian response, recurrent embryo aneuploidy, or a medical risk profile that changes the balance of benefit and harm. In pregnancy care, it may involve severe maternal illness or fetal conditions with limited expected survival.
Conflict with the patient's goals: A technically possible intervention may still be inappropriate if it does not support what the patient considers an acceptable outcome.

These signs should not be interpreted in isolation or used to self-diagnose. They are prompts for a structured conversation with the treating team, ideally including the relevant specialists, such as a reproductive endocrinologist, maternal-fetal medicine physician, obstetrician, neonatologist, anesthesiologist, intensivist, genetic counselor, palliative care clinician, or mental health professional.

Goals of care: the center of the decision

Good decision-making begins with a deceptively simple question: What are we trying to achieve? In reproductive and pregnancy care, goals can shift over time. At first, the goal may be pregnancy at almost any emotional cost. Later, it may become avoiding further loss, protecting maternal health, preserving the possibility of future treatment, reducing trauma, or making space for grief. In a high-risk pregnancy, the goal may be prolonging pregnancy safely, optimizing neonatal outcomes, preventing maternal harm, or ensuring a peaceful birth and time with the baby.

Clinicians can explain probabilities, but patients define what outcomes are meaningful or unacceptable. A medically literate patient may want detailed data: live birth rate per cycle, cumulative success estimates, miscarriage risk, maternal morbidity, fetal prognosis, neonatal survival, likelihood of long-term impairment, and the uncertainty around each estimate. These numbers matter, but they should be interpreted alongside lived realities: the patient's body, relationships, work, finances, prior losses, cultural values, spiritual beliefs, and tolerance for risk.

Useful questions include: What outcome are we hoping this treatment will make possible? What would count as meaningful improvement? What burdens are we willing to accept, and for how long? What outcome would feel worse than stopping? Are we continuing because there is a realistic chance of benefit, or because stopping feels emotionally unbearable? These questions do not make the decision easy, but they make it more honest.

Using a time-limited trial when the answer is unclear

When prognosis is uncertain, a time-limited trial can be a helpful bridge between continuing indefinitely and stopping abruptly. The AMA's ethics guidance specifically identifies discussion of time-limited trials as part of a practical decision-making approach. In this model, the patient and clinical team agree to continue a treatment for a defined period or through a defined milestone, while also agreeing in advance what signs would support continuing, changing, or stopping.

For example, in fertility care, a time-limited plan might define how many

cycles will be attempted before reassessment, what ovarian response would be considered adequate, or what embryo development outcome would justify another cycle. In pregnancy care, a time-limited trial might focus on maternal stabilization, fetal monitoring trends, response to medication, or reaching a gestational milestone if doing so is medically reasonable. In critical care, it may involve physiologic markers such as organ function, ventilatory requirements, infection control, or neurologic status.

The value of a time-limited trial is that it reduces ambiguity. It protects patients from open-ended treatment that silently accumulates burden. It also protects against premature decisions when a short period of observation could clarify whether improvement is possible. The key is documentation: what is being tried, why it is being tried, what will be measured, when the team will meet again, and who will be involved in the decision.

Decision-making capacity, advance directives, and family involvement

Whenever possible, the patient receiving treatment should be the primary decision-maker. Decision-making capacity means the person can understand relevant information, appreciate how it applies to their situation, reason about options, and communicate a choice. Capacity can fluctuate, especially in severe illness, pain, medication effects, delirium, or critical care settings, so it may need reassessment.

Advance care directives, prior written preferences, and documented conversations can be crucial when a patient cannot speak for themselves. NSW Health guidance emphasizes the role of advance care directives, decision-making capacity, and consultation with family or the legally responsible person. In pregnancy-related emergencies, this can be emotionally complex because family members may be distressed, clinicians may be balancing maternal and fetal considerations, and time may be limited. Clear documentation and early conversations reduce the chance that decisions are made in crisis without knowing the patient’s wishes.

Family involvement can be deeply supportive, but it should not replace the patient’s values. A partner, parent, or relative may have strong hopes about continuing treatment, but ethically the focus remains on what the patient would choose, or what best aligns with their known preferences if they lack capacity.

If disagreement persists, an ethics consultation can help clarify options, obligations, and communication. Ethics consultation is not a sign that anyone has failed; it is a structured way to manage a genuinely difficult decision.

When fertility treatments fail: stopping, pausing, or changing direction

Fertility treatment often creates a cycle of hope, intervention, waiting, and grief. After repeated failed cycles, it is common to wonder whether stopping means losing the chance to become a parent. In reality, the decision is often not simply "continue or quit." It may involve pausing, changing protocols, seeking another opinion, considering donor eggs or sperm, using gestational surrogacy where legal and appropriate, exploring adoption, or choosing a child-free life with intention and support.

Medical reassessment after unsuccessful treatment may include reviewing ovarian reserve, sperm parameters, uterine cavity evaluation, embryo quality, genetic testing results where relevant, stimulation response, laboratory factors, transfer technique, miscarriage evaluation, and comorbidities such as thyroid disease, diabetes, autoimmune disease, or thrombophilia when clinically indicated. A second opinion from another reproductive endocrinologist can sometimes clarify whether there are reasonable alternatives or whether another cycle would likely repeat the same pattern.

It is also medically reasonable to consider the cumulative burden. IVF and related treatments can involve injections, anesthesia, monitoring, pelvic discomfort, ovarian hyperstimulation risk, procedure complications, mood effects, and substantial cost. Emotional burden matters too. Sleep disruption, relationship strain, sexual distress, workplace stress, and repeated pregnancy loss are not "soft" concerns; they are part of the risk-benefit analysis. If treatment no longer supports the life the patient is trying to build, stopping or pausing can be a protective decision.

Pregnancy complications and comfort-focused care

Some pregnancy-related situations involve serious maternal illness, fetal anomalies, periviable birth, severe placental disease, infection, hemorrhage, or multi-organ compromise. In these circumstances, continuing an intervention may not always improve outcome, and treatment goals may need to shift. This

does not erase hope; it redefines hope in medically honest terms. Hope may become time, comfort, memory-making, survival of the pregnant patient, avoidance of suffering, or the chance to make decisions consistent with deeply held values.

Palliative care can be introduced alongside active treatment, not only after treatment stops. Perinatal palliative care may help families facing life-limiting fetal diagnoses plan birth preferences, symptom management, neonatal comfort care, spiritual support, photography or memory-making, lactation decisions, and bereavement follow-up. For a severely ill pregnant or postpartum patient, palliative care can support symptom control, communication, and alignment of medical interventions with the patient's priorities.

Comfort-focused care is active care. It may include pain control, breathlessness management, nausea treatment, anxiety relief, privacy, family presence, cultural or religious rituals, and careful communication. If life-sustaining treatment is withdrawn, clinicians should continue to treat distress and preserve dignity. Patients and families deserve to know that stopping a burdensome intervention is not the same as being left alone.

How to prepare for the conversation

Before a decision-making appointment, it can help to write down questions and identify who should be present. If the situation is complex, ask for enough time to talk rather than trying to make a major decision in a rushed visit. Request clear language: "What is the best-case scenario, worst-case scenario, and most likely scenario?" and "What would you recommend if my main goal is maternal safety, live birth, avoiding suffering, or preserving future options?"

Patients may also ask the team to distinguish between what is medically possible, what is medically recommended, and what is legally or institutionally available. These categories are not always the same. In pregnancy care, local laws and hospital policies may affect options, so timely referral may be important. If communication feels fragmented, ask for a multidisciplinary meeting with all relevant clinicians so that everyone hears the same information.

Consider bringing a written values statement. It might include acceptable and

unacceptable outcomes, religious or cultural needs, preferred decision-maker if capacity is lost, wishes about resuscitation or intensive care, and what quality of life means to the patient. In fertility care, it might include a maximum number of cycles, financial boundaries, acceptable donor or surrogacy options, and what kind of emotional support is needed before trying again.

Deciding the next step after stopping

The period after stopping treatment can feel strangely quiet. Appointments may decrease, and the structure that once carried the patient forward may disappear. Planning the next step helps prevent a sense of abandonment. The plan should include medical follow-up, symptom monitoring, emotional support, and a clear point of contact.

Possible next steps include a recovery period, counseling, genetic counseling, a second opinion, a new fertility strategy, medical optimization before future pregnancy, palliative care referral, bereavement support, social work consultation, financial counseling, or spiritual care. If treatment stopped because of maternal risk, preconception consultation with maternal-fetal medicine may be helpful before any future pregnancy attempt. If treatment stopped after repeated fertility failure, a structured debrief with the fertility team can help identify whether future treatment is medically reasonable and emotionally acceptable.

Grief after stopping treatment may be disenfranchised: others may not recognize the loss if there was no birth, no visible illness, or no clear "event." Yet the loss may include embryos, pregnancies, expected parenthood, bodily trust, time, money, and imagined futures. Supportive care should acknowledge this. The next step is not only a medical plan; it is also a way to help the patient live with what has happened and make decisions without shame.