MedCrave
Step into the World of Research

MOJ Surgery

Case Report

The surgeon's dilemma in the face of terminal illness: Conceptual clarifications and bioethical reflections at the end of life

Abstract

Background: Surgeons are trained to intervene, rescue and prolong life. Yet when a patient approaches the end of life, the ethical challenge shifts from how to act to whether further intervention remains beneficial. Recognizing this translation requires clinical judgement and ethical discernment.

Case presentation: We present the case of a 56-year-old patient with advanced gastric carcinoma complicated by catastrophic gastrointestinal bleeding. Despite maximal surgical and intensive care support, continued escalation would have constituted therapeutic obstinacy. In consensus with the patient and his family, life-sustaining treatment was limited and continuous palliative sedation was initiated to relieve refractory suffering.

Discussion: This case illustrates the ethical importance of therapeutic proportionality in surgical practice. Differentiating appropriate limitation of treatment and palliative sedation from euthanasia is essential to preserve professional integrity, avoid non-beneficial interventions, and respect patient dignity. Shared decision-making, transparent communication, and adequate documentation serve as ethical safeguards.

Conclusion: Surgical excellence includes not only technical mastery but also the moral maturity to recognize when cure is no longer possible. Integrating palliative care and limiting disproportionate treatment do not represent failure, but rather a responsible and compassionate expression of surgical practice at the end of life.

Keywords: end-of life care, therapeutic futility, continuous deep palliative sedation, euthanasia, surgical decision-making, palliative care

Volume 14 Issue 1 - 2026

Alejandro Weber-Sánchez MD,[1] Pablo Weber-Alvarez MD,[2] Erick Vidal-Andrade[3]

[1]Department of General Surgery. Hospital Ángeles Lomas, Huixquilucan, México. Professor of Bioethics. Universidad Anáhuac México Norte, Mexico
[2]General Practitioner. Hospital Ángeles Lomas. Huixquilucan, México. Professor of Interdisciplinary clinic and bioethics analysis. Universidad Anáhuac México Norte, Mexico
[3]Department of Intensive Care Unit. Hospital Ángeles Lomas. Huixquilucan, Mexico

Correspondence: Alejandro Weber Sánchez MD Vialidad de la Barranca s/n C410, Valle de las Palmas, Huixquilucan, 52763, Estado de México, México, Tel 52469527

Received: February 23, 2026 | **Published:** March 16, 2026

Introduction

Surgeons are generally accustomed to successful interventions that sometimes even save lives that were in danger. Therefore, encountering a terminally ill patient may cause them feelings of frustration that make him doubt whether he can intervene to help, even under those circumstances. Given the nature of the specialty, the tension between intervening or refraining from doing something is always difficult and require deep reflection and mature judgment, fundamental skills he must have, because sometimes his actions may become what is known as therapeutic obstinacy.[1] Ethical complexity of disproportionate treatment in surgical settings at the end of life emphasize the need for shared decision-making, early integration of palliative and compassionate care to avoid futile interventions given the therapeutic advances that allow the prolongation of patient's life.[2]

The objective of this article is to present a case of end-of-life management in a surgical setting, to review fundamental concepts in the face of terminal illness, and to make reflections to facilitate decision-making that seeks the greatest benefit of the patient.

Clinical case

A 56-year-old male patient presented to the hospital's emergency department with abdominal pain and significant deterioration of his general condition. He was diagnosed by laparoscopy with diffuse metastatic, full-thickness infiltrating gastric carcinoma (Figure 1 & 2). When he was stabilized and the diagnosis was confirmed, he was informed about the advanced nature of the disease and the alternatives of treatment. He was discharged and later he was started on chemotherapy and palliative care, to delay disease progression.

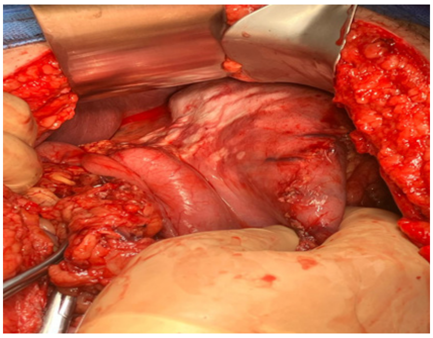

Figure 1 Gastric tumor

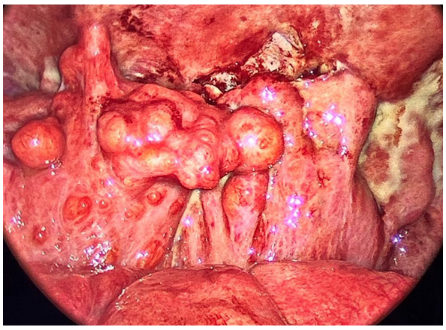

Figure 2 Tumor metástasis.

One month later, the patient was admitted to the hospital with significant upper gastrointestinal bleeding, severe pain and abdominal distension. Endoscopy was unable to locate and control the bleeding site. Despite transfusions and medication, the patient continued with uncontrollable active bleeding, leading to progressive hemodynamic deterioration. The patient and their family were informed about the severity of the condition, and the unfavorable prognosis. The lack of effective treatments was explained and alternatives were discussed. The share authorized and signed decision was made to limit therapeutic efforts, focusing exclusively on palliative care and comfort, and it was agreed that cardiopulmonary resuscitation would not be performed.

Given the persistent active bleeding with regurgitation of fresh blood despite nasogastric decompression, accompanied by restlessness and pain refractory to conventional management, and in the context of irreversible disease without therapeutic response, the patient and his family were consulted regarding goals of care. The institutional Therapeutic Effort Limitation (TEL) form was completed, following consensus within the multidisciplinary medical and legal team, and a structured plan of care was established within the formal TEL process.

By shared decision-making, continuous deep palliative sedation was initiated to relieve refractory suffering, using titrated midazolam infusion combined with opioid analgesia, under continuous monitoring and with an exclusive focus on comfort. Airway protection was ensured, and despite ongoing hematemesis, dyspnea and distress were actively prevented. The procedure was carried out in the hospital ward, surrounded by family members and under supervision of the multidisciplinary team. Hemodynamic deterioration progressed to cardiorespiratory arrest, and the patient died peacefully.

Fundamental concepts in end-of-life patient care

The term "end of life" is a complex concept for which there is no concrete and universal definition, and it is not a common situation in surgical practice. For clinical practice and research, it may refer to different temporal windows and perspectives such as epidemiological, hospice or actively dying phase criteria. It covers key elements such as: limited life expectancy (frequently operationalized in hospice as ≤6 months), advanced, progressive, incurable disease, shifts in the goals of care to symptom management and quality of life. For example, in the discussed case, it was clear that death was imminent, the patient and his family were suffering, and there were no other therapeutic options to cope with the bleeding of the obstructed stomach. Commonly includes diseases as advanced cancer as this case, end-stage organ failure, or other advanced diseases, and it involves multidimensional care needs including physical, psychological, social, and spiritual support.[3–7]

As a response to meet the needs of these patients with advanced and life-limiting illnesses, palliative care emerged in the second half of the last century.[8] According to the World Health Organization (WHO), palliative care is defined as an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, impeccable assessment, and treatment of pain and other physical, psychosocial, and spiritual problems.[9] When the patient was stabilized he was offered chemotherapy to delay disease progression and avoid complications. This type of care is not an abandonment, but rather a shift in therapeutic goals—from cure to comfort, from prolongation of biological life at any cost to proportional, patient-centered care.[10,11]

It involves symptom control (pain, dyspnea, nausea, delirium), communication, and shared decision-making aligned with patient values, clarification of goals of care, and when prognosis is limited, avoiding non-beneficial or disproportionate interventions. It neither intends to hasten nor to postpone death and differs clearly from euthanasia and physician-assisted suicide, while also providing an alternative to therapeutic obstinacy.

Euthanasia is the deliberate intervention with the explicit intention of ending a patient's life, at the patient's voluntary and competent request, in order to relieve suffering. The key elements are intentionality (to cause death), causation (the physician's act directly leads to death) with patient's consent (in cases of voluntary euthanasia). This practice is distinctive from the withdrawal or withholding of life-sustaining treatment, in which death results from the underlying disease rather than from a lethal act. Euthanasia is against the nature of the patient-physician relationship, the medical profession, and fundamentally alters its role in society.[9,12,13]

On the other hand, therapeutic obstinacy—also referred to as medical futility, disproportionate treatment, non-beneficial treatment, or the term "potentially inappropriate treatments" recommended by the Society of Critical Care Medicine—describes the persistence of diagnostic or therapeutic interventions that offer no reasonable hope of benefit to the patient or impose burdens grossly disproportionate to the expected clinical gain as is sometimes seen in cases when needless procedures were done.[14–17] Clinical uncertainty, physician overestimation of survival or misjudge functional decline, frequently contributes to ongoing aggressive treatment in situations where real benefit is minimal. Sometimes physicians and families struggle emotionally to perform maximal intervention.[18] In the presented case, both the patient and his family understood perfectly the advanced nature of the disease and agreed the goals focused to give a compassionate care and comfort. Therapeutic obstinacy does not arise from malice, but from a convergence of professional identity, uncertainty, systemic pressures, and emotional complexity. The persistence of non-beneficial or disproportionate treatment carries significant consequences: prolonging the dying process, moral distress, unnecessary consumption of critical care resources, and distortion of ethical principles.[19–21]

In surgical culture in particular, there is a deep commitment to rescue, and technical problem-solving. Death is often perceived as failure rather than as a natural outcome of disease progression. This "rescue imperative" may drive continued intervention even when prognosis is poor and therapeutic goals are no longer attainable. Surgeons may sometimes experience moral discomfort in recommending non-intervention, equating it with abandonment.[11]

To decide for the best end-of-life patient care, it is important to have in mind the concept of therapeutic proportionality. A strong ethical evaluation of the expected benefit of a medical intervention in relation to the burden it imposes on the patient. It distinguishes between ordinary means that offer a reasonable expectation of benefit with an acceptable burden, and extraordinary means which impose a disproportionate affliction relative to the anticipated benefit.[22] This concept has historical roots in Catholic moral theology but it has been fully incorporated into contemporary bioethics as a central criterion for determining when it is ethically justified to initiate, withhold, or withdraw medical treatments.[23,24] It requires a multidimensional assessment including patient and family values and goals. Consequently, any intervention including palliative sedation as in this patient, must be administered only to the extent necessary to achieve symptom relief.

All of the above is closely related with patient autonomy. The patient's right to receive adequate information, and to accept or refuse the indicated interventions, it is not an easy task to give this kind of disclosure, but it is an unavoidable duty of the treating doctor. However, it does not oblige the physician to offer or continue interventions when the balance between benefit and burden is negative.[25,26] In cases of incapacity, respect for autonomy is maintained through substituted judgment or legal representation, prioritizing the patient's previously expressed wishes and values.

Within this ethical context, as was decided in the case presented here, limitation of therapeutic effort (LTE), the decision of not to initiate or to withdraw disproportionate treatments in dialogue with the multidisciplinary team and the patient and his family is an option.[24,27,28]

Within this framework, treatment is redirected toward comfort-oriented measures, including proportional analgesia and anxiolysis. Symptom-driven supportive interventions such as non-invasive ventilatory support or high-flow oxygen therapy for dyspnea, airway adjuncts, maintenance fluids, and drainage procedures to relieve abdominal or bladder distension are considered if appropriate. It is a responsible and compassionate redirection of care goals toward symptom control and accompaniment aligned with the patient's best interest.

Palliative care including LTE is distinguished precisely by its commitment to accompaniment until death.[29] It is important to mention that spiritual support is of paramount significance for some people. This was of particular importance to our patient, a devout Catholic, for whom this assistance was of great help and provided him and his family with tranquility and peace.

When patients in the final phase of life suffer intolerable physical symptoms and psychosocial, spiritual, and existential distress, refractory to all forms of relief despite optimal palliative care at the end of life, palliative sedation is an ethically acceptable option to not consciously experience this suffering. Palliative sedation is the monitored use of medications to induce a reduction in consciousness to relieve this intolerable suffering, when other interventions have failed or are not feasible. The final event for our patient, who presented with massive, uncontrollable bleeding from the upper gastrointestinal tract caused by the tumor in an obstructed stomach, was a catastrophic and devastating experience for the patient and his family, causing them great distress. Deep sedation allowed the patient's imminent death to be more peaceful, enabling his family to lovingly attend to him, cleaning him and comforting him with words and gestures.

This challenging decision should be clearly understood and accepted by the patient and his family and multidisciplinary assessed and documented on the medical record. Informed consent is mandatory, whether obtained directly from the patient or through legal representatives in cases of incapacity. The principle of proportionality requires that sedation be individualized, titrated to the minimum depth and duration necessary to relieve suffering, and periodically reassessed. It should be clearly distinguished from euthanasia in terms of aim (to alleviate suffering and not to end life), means (to lower consciousness proportionally until distress is relieved), result (relief of suffering with life-shortening as exceptional side-effect) and timing (reserved for the terminal phase of life).[30,31] It should remain as a last alternative, thus it requires transparency, documentation, and, when possible, involvement of specialized palliative care teams.

Discussion

Some surgeons instinctively perceive a patient's death as a professional failure. However, when a patient is clearly approaching the end of life, the true dilemma lies not in doing less, but in recognizing when further intervention ceases to be beneficial. In such circumstances, the surgeon's responsibility shifts toward acknowledging appropriate limitations of treatment, expression of professional integrity and respect for human dignity, ensuring comfort at the end of life toward a peaceful death. The patient presented here exemplifies this tension. Despite maximal surgical and intensive care support, the patient's clinical trajectory made clear that continued escalation would have constituted therapeutic obstinacy rather than beneficence.

Surgeons must therefore be familiar with the ethical and clinical principles that guide end-of-life accompaniment. Understanding the distinction between proportionate limitation of treatment, palliative care integration, and euthanasia is essential. Whereas euthanasia intentionally seeks to cause death, appropriate end-of-life care aims to relieve suffering while allowing the underlying disease to follow its natural course. Confusing these categories risks either therapeutic obstinacy or inappropriate withdrawal of meaningful care. Surgical training traditionally emphasizes rescue and cure; however, it must also prepare physicians to recognize when cure is no longer possible.

These ethical principles are reinforced by the legal framework governing end-of-life care. For example, the Mexican General Health Law, recognizes the right of terminally ill patients to receive comprehensive palliative care, emphasizing pain relief, dignity, autonomy, and the limitation of therapeutic effort when treatments become disproportionate, and the Federal Penal Code establishes that euthanasia constitutes a criminal offense, as it is classified as homicide, thereby delineating a clear legal boundary for medical practice.[32,33]

At the international level, widely recognized guidelines further define the clinical, ethical, and legal parameters for palliative sedation. The framework of the European Association for Palliative Care (EAPC), other national recommendations of palliative care, and the Position Statement of the National Hospice and Palliative Care Organization (NHPCO) converge on essential criteria.[34–36]

Surgeons do not have an absolute obligation to pursue cure; rather, their duty is to act in the patient's best interest, which includes recognizing when a surgical intervention will not provide meaningful improvement and may instead increase suffering.[37–40] When surgery does not align with the patient's goals, fails to improve prognosis, or imposes excessive burden relative to expected benefit, there exists a moral duty to limit intervention. Even when patients or families request non-beneficial procedures, physicians are not ethically obliged to provide interventions that are medically inappropriate.[17,37,39,40]

The ethical distinction between omission and causation is particularly relevant. Withholding or withdrawing a futile intervention does not equate to causing death, but rather a responsible decision aimed at avoiding therapeutic obstinacy. The phenomenon of "surgical optimism," characterized by an overestimation of the capacity of surgery to resolve complex problems in critically ill patients, can contribute to disproportionate interventions and loss of perspective regarding realistic outcomes.[39]

Conflicts between family pressure and clinical judgment are common in these emotionally charged contexts; therefore, transparent communication, shared decision-making, and the involvement of ethics committees and palliative care teams are essential safeguards.

In surgical end-of-life care, communication and informed consent are not procedural formalities but moral safeguards. They are not merely relational skills but an ethical obligation. Honest discussion of prognosis is essential. Decisions regarding limitation of life-sustaining treatment, avoidance of disproportionate interventions, or transition to comfort-focused care require transparent, compassionate, and structured dialogue between the surgical team, the patient, and the family, enabling them to make decisions consistent with their values. Delayed or inadequate goals-of-care discussions are associated with increased use of non-beneficial treatments.[41] Informed consent at the end of life requires more than technical disclosure of procedural risks. It must include the probability of achieving meaningful recovery, the possibility of prolonged stays in intensive care units, the alternatives, including non-operative management and palliative care, and the option to decline or withdraw treatment without abandonment.[42] True informed consent is compromised when discussions focus solely on procedural details without addressing global prognosis and overall goals of care. Consent obtained under conditions of unrealistic optimism or incomplete disclosure may be ethically inadequate. When decision-making capacity is impaired, surrogate decision-makers must be guided by substituted judgment (what the patient would have wanted) or, when unknown, by the best-interest standard. Clear communication with surrogates reduces conflict and moral distress. The aim is to protect patients from disproportionate intervention, protect surgeons from acting beyond proportional benefit, and preserve the integrity of the therapeutic relationship.

Finally, adequate documentation of clinical assessments, goals-of-care, and decision-making processes is a core component of ethics and professionalism in these complex cases. It confirms transparency demonstrating that decisions were guided by proportionality, patient values and certifies that all members of the healthcare team and the patient agreed plan of care. It also provides legal protection, particularly when Do-Not-Resuscitate (DNR) is decided to avoid ambiguity. Just as technical precision defines operative excellence, conceptual clarity in documentation defines ethical excellence.[43,44]

In the postoperative intensive care unit (ICU), ongoing reassessment of benefit is imperative. At that stage, the surgeon's moral responsibility shifts toward limiting therapeutic effort and redirecting care toward symptom management and accompaniment. This transition does not signify abandonment but rather reflects ethical maturity and fidelity to the patient's dignity. Ultimately, therapeutic proportionality provides the ethical guide for decision-making in palliative and surgical contexts involving the end of life, ensuring that medical practice remains oriented not toward the indefinite prolongation of biological life, but toward the relief of suffering, the respect for autonomy, and the preservation of human dignity.

Conclusion

Surgical identity traditionally centers on intervention and rescue; however, a surgeon's moral responsibility and their adherence to ethical surgical practice at the end of life, demand discernment, proportionality, and the compassionate courage to recommend comfort-focused care at the end of life, even by means of LTE, or deep palliative sedation when indicated, when operative measures no longer serve the patient's best interest.

Integrating palliative care and recognizing appropriate limitation of treatment do not signify failure, but rather a commitment to patient dignity and to the moral maturity of surgical practice.

Author contributions

Dr. Alejandro Weber-Sánchez contributed to the conceptualization and design of the study, clinical management of the case, literature review, and drafting of the manuscript. Dr. Pablo Weber-Alvarez, and Dr. Erick Vidal-Andrade contributed to clinical management of the case, literature review, critical revision of the manuscript, and approved the final version. All authors have read and approved the final manuscript and agree to be accountable for all aspects of the work.

The authors used an artificial intelligence (AI)–assisted language model solely for language refinement, structural suggestions, and editorial improvement of the manuscript. All clinical content, ethical analysis, interpretations, and conclusions were independently conceived, critically evaluated, and approved by the authors. The authors assume full responsibility for the integrity, originality, and accuracy of the work.

All the listed authors have participated actively in the study. Dr. Alejandro Weber-Sánchez designed the study, performed research and wrote the final version of the manuscript. Dr. Pablo Weber-Alvarez and Dr. Erick Vidal-Andrade assisted in the research and collaborated with the text.

Acknowledgements

None.

Conflicts of interest

The authors declare that they have no conflicts of interest for this article.

References

1. International Association for Hospice and Palliative Care. Therapeutic obstinacy. IAHPC Pallipedia. 2026.
2. Lee L, Tan SXY, Solomon M, et al. When is surgery futile? A systematic review of conflicting definitions and patterns in surgical care for advanced gastrointestinal cancer. *Eur J Surg Oncol.* 2025;51(11):110399.
3. End of life care for adults: service delivery. London: National Institute for Health and Care Excellence (NICE); 2019.
4. Koffman J, Yorganci E, Murtagh F, et al. The AMBER Care Bundle for hospital inpatients with uncertain recovery nearing the end of life: the ImproveCare feasibility cluster RCT. *Health Technol Assess.* 2019;23(55):1–150.
5. Etkind SN, Karno J, Edmonds P, et al. Supporting patients with uncertain recovery: the use of the AMBER care bundle in an acute hospital. *BMJ Support Palliat Care*. 2015;5(1):95–98.
6. Hui D, Nooruddin Z, Didwaniya N, et al. Concepts and definitions for "actively dying," "end of life," "terminally ill," and "transition of care": a systematic review. *J Pain Symptom Manage*. 2014;47(1):77–89.
7. Teno JM, Gozalo PL, Bynum JPW, et al. Change in end-of-life care for Medicare beneficiaries. *JAMA.* 2013;309(5):470–477.
8. Saunders C. The evolution of palliative care. *Patient Educ Couns.* 2000;41(1):7–13.
9. World Health Organization. WHO definition of palliative care. Geneva: WHO; 2002 (updated 2020).
10. Lilley EJ, Cooper Z, Schwarze ML, et al. Palliative care in surgery: defining the research priorities. *Ann Surg.* 2018;367 (1):66–72.
11. Schwarze ML, Brasel KJ, Mosenthal AC. Beyond 30-day mortality: aligning surgical quality with outcomes that patients value. *JAMA Surg.* 2014;149(7):631–632.
12. Emanuel EJ. Euthanasia and physician-assisted suicide: a review of the empirical data. *JAMA.* 2002;288(19):2450–2460.
13. Sulmasy DP, Mueller PS. Ethics and the legalization of physician-assisted suicide. *Ann Intern Med.* 2017;167(8):576–578.

Citation: Weber-Sánchez A, Weber-Alvare P, Vidal-Andrade E. The surgeon's dilemma in the face of terminal illness: Conceptual clarifications and bioethical reflections at the end of life. *MOJ Surg.* 2026;14(1):10–14. DOI: 10.15406/mojs.2026.14.00307

14. Hoffmann LB, Neves Forte D. Palliative obstinacy: when palliative care approaches therapeutic obstinacy. *J Palliat Med*. 2026;29(2):257–258.

15. Poveda-Jara IJ, Rodríguez-Plasencia A, Romero-Fernández AJ. Therapeutic obstinacy in critically ill patients: analysis of its effectiveness and bioethical considerations. Salud Vida. 2025;9(2):202–209.

16. Bacoanu G, Poroch V, Aniței MG, et al. Therapeutic obstinacy in end-of-life care: a perspective of healthcare professionals from Romania. *Healthcare (Basel).* 2024;12(16):1593.

17. Bosslet GT, Pope TM, Rubenfeld GD, et al. An official ATS/AACN/ACCP/ESICM/SCCM policy statement: responding to requests for potentially inappropriate treatments in ICUs. Am *J Respir Crit Care Med.* 2015;191(11):1318–1330.

18. Raus K, Sterckx S, Mortier F. Is there a duty to treat futile medical interventions? *J Med Ethics*. 2013;39(4):209–213.

19. Schneiderman LJ, Jecker NS, Jonsen AR. Medical futility: its meaning and ethical implications. *Ann Intern Med.* 1990;112(12):949–954.

20. Dzeng E, Curtis JR. Understanding ethical climate, moral distress, and burnout. *BMJ Qual Saf*. 2018;27(10):766–770.

21. Cardona-Morrell M, Kim JCH, Brabrand M, et al. What is inappropriate hospital use for elderly people near the end of life? *BMJ Support Palliat Care.* 2017;7(3):245–256.

22. Grant SB, Modi PK, Singer EA. Futility and the care of surgical patients: ethical dilemmas. *World J Surg.* 2014;38(7):1631–1637.

23. Schofield G, Baker I, Bullock R, et al. Palliative opioid use, palliative sedation and euthanasia: reaffirming the distinction. *J Med Ethics.* 2020;46(1):48–50.

24. Ford DW, Koch KA, Ray DE, et al. Palliative and end-of-life care in lung cancer. *Chest.* 2013;143(5 Suppl):e498S–e512S.

25. Hsu HS, Kao CH, Chang SS, et al. Evaluation of symptom-management medications for predicting short-term survival in advanced cancer patients with machine learning. *Digit Health.* 2026;12:20552076261419945.

26. ten Have H, Welie JV. Palliative sedation versus euthanasia: an ethical assessment. *J Pain Symptom Manage.* 2014;47(1):123–136.

27. Finucane TE, Nirmalasari O, Graham A. Palliative care in the ambulatory geriatric practice. *Clin Geriatr Med.* 2015;31(2):193–206.

28. Hollenberg SM, Warner Stevenson L, Ahmad T, et al. 2019 ACC Expert Consensus Decision Pathway on Risk Assessment, Management, and Clinical Trajectory of Patients Hospitalized With Heart Failure: A Report of the American College of Cardiology Solution Set Oversight Committee. *J Am Coll Cardiol.* 2019;74(15):1966–2011.

29. Back AL, Young JP, McCown E, et al. Abandonment at the end of life. *Arch Intern Med.* 2009;169(5):474–479.

30. Claessens P, Menten J, Schotsmans P, et al. Palliative sedation, not slow euthanasia: a prospective, longitudinal study of sedation in Flemish palliative care units*. J Pain Symptom Manage.* 2011;41(1):14–24.

31. Koper I, Hasselaar J, Payne C, editors. The Role of Palliative Sedation in Palliative Care. [eBook]. European Association for Palliative Care; 2024.

32. Congreso de los Estados Unidos Mexicanos. Ley General de Salud. Diario Oficial de laFederación. 1984 (última reforma 2024).

33. Secretaría de Salud. Norma Oficial Mexicana NOM-004-SSA3-2012, del expedienteclínico. Diario Oficial de la Federación; 2012.

34. Surges SM, Brunsch H, Jaspers B, et al. Revised EAPC recommended framework on palliative sedation: an international Delphi study. *Palliat Med.* 2024;38(2):213–228.

35. Kirk TW, Mahon MM; Palliative Sedation Task Force of the National Hospice and Palliative Care Organization Ethics Committee. National Hospice and Palliative Care Organization (NHPCO) position statement and commentary on the use of palliative sedation in imminently dying terminally ill patients. *J Pain Symptom Manage.* 2010;39(5):914–923.

36. Beauverd M, Mazzoli M, Pralong J, et al. Palliative sedation - revised recommendations. *Swiss Med Wkly.* 2024;154:3590.

37. Lazenby KA, Angelos P. What do we owe our patients? surgeon obligations when patients are too sick for surgery. *J Am Coll Surg*. 2024;239(4):394–399.

38. Lajam CM, Hutzler LH, Lerner BH, et al. Ethical considerations of declining surgical intervention: balancing patient wishes with fiduciary responsibility. *J Bone Joint Surg Am.* 2024;106(19):1831–1835.

39. Kodadek LM, Cook M, Young J, et al. American Association for the Surgery of Trauma Critical Care Committee. Primary palliative care in acute care surgery: an American Association for the Surgery of Trauma Critical Care Committee and Palliative Care Committee clinical consensus document. *Trauma Surg Acute Care Open.* 2025;10(1):e001616.

40. Hofmann B, Håheim LL, Søreide JA. Ethics of palliative surgery in patients with cancer. *Br J Surg.* 2005;92(7):802–809.

41. Tulsky JA, Beach MC, Butow PN, et al. A Research agenda for communication between health care professionals and patients living with serious illness. *JAMA Intern Med.* 2017;177(9):1361–1366.

42. Bernat JL. Ethical issues in informed consent for surgery. *Arch Surg.* 2013;148(2):123–124.

43. Sudore RL, Lum HD, You JJ, et al. Defining advance care planning for adults: a consensus definition from a multidisciplinary delphi panel. *J Pain Symptom Manage*. 2017;53(5):821-832.e1.

44. American College of Surgeons. Statement on advance directives by patients: "do not resuscitate" in the operating room. *Bull Am Coll Surg*. 2014;99(1):42–43.