Enferm Intensiva. 2019;30(3):148–150

SEEIUC
Sociedad Española de Enfermería Intensiva y Unidades Coronarias

Enfermería Intensiva

www.elsevier.es/ei

LETTERS TO THE EDITOR

In reply to the question: ''Are we really playing together in the same team?''☆

En respuesta a la pregunta: «¿Jugamos todos en el mismo equipo?»

Dear Editor,

Following mindful reading of the study by Lomero-Martínez et al.[1] published in your journal, we would like to congratulate the authors for their work and also offer some considerations on the same.

Firstly, we have been speaking for some time about limitation of life-sustaining treatment (LLST) in Intensive Care Medicine and possibly the more extended term of limitation of therapeutic efforts (LTE), and the term which currently tends to be adopted of the adequacy of life-sustaining treatment efforts (ALST).[2] It is possible that with the technification of medicine and the measures that can be applied to treat our patients, doctors and all other healthcare staff have become aware of the need to customise the measures applied to each patient, to avoid therapeutic obstination, and when death may not be avoided, to accompany the patient and guarantee them a dignified death.[3]

From their results the authors also concluded that the patients feel excluded from protocol development and from decision-making processes in the LLST. In this sense, we, the undersigned, as workers in a multipurpose 12 cubicle ICU, have been dealing with this difficulty for some time. To tackle the problem and provide the best care for our patients, our optimisation strategies began with initiating a combined physician-nurse ICU round patient review during the mornings where these decisions were taken jointly and information was communicated more easily between all healthcare professionals.

The withdrawal of mechanical ventilation (MV) is particularly outstanding here as a measure of LLST, having been described in the past as the most difficult treatment for the medical team to withdraw.[4] From the article we understand that among the nurses 36.5% would not be in favour of MV removal, but this percentage drops to 12.9% for the physicians. Studies confirm that in up to 54% of cases this is done with the intention of accelerating death and not wishing to prolong life.[4] Perhaps the origin of the ethical conflict suggested by the removal of MV would be to consider it in this way, whilst in the majority of cases its removal occurs after a period of treatment and is done after confirming that the measures implemented are not useful, and they are therefore futile.

Lastly, it is no less certain that on no few occasions the decisions of LLST derive from the futility of treatments which have already been established for our patients or from future therapies to be initiated.[5] At this point, we consider it inexcusable that evaluation of their futility, whether this be from a physiopathological, probabilistic or qualitative viewpoint, should fall on our medical staff. Our observation is mainly based on two very clear criteria. Firstly, the continuous care which the doctor in charge of the patient undertakes under normal circumstances and which on many occasions (at least in our unit), due to issues involving working hours, the nurses cannot perform. Secondly, without wishing to disrespect the work of any professional, we consider that responsibility for updating and obtaining knowledge about new therapies or diagnostic tests which will often influence many decisions regarding futility should fall on the personnel who have been trained for this purpose. In this context, this would be the medical staff.

To conclude, our experience of a combined physician-nurse ICU round patient review has helped to improve decision-making in LLST situations. The proposal of medical futility in treatments, assessment and follow-up of these therapies from the nurse and the communication of emotions, feelings and assessments from family members who are near the patient are key and must be taking into consideration by us in improving patient care.

Financing

No financing was received for this document.

Conflict of interests

All the authors have no conflict of interests to declare.

DOIs of original articles: https://doi.org/10.1016/j.enfi.2018.10.003, https://doi.org/10.1016/j.enfi.2018.10.004

☆ Please cite this article as: Escudero-Acha P, Rodriguez-Borregán JC, Chicote-Álvarez E, Ortiz-Lasa M, Jimenez-Alfonso AF, González-Castro A. En respuesta a la pregunta: «¿Jugamos todos en el mismo equipo?». Enferm Intensiva 2019. https://doi.org/10.1016/j.enfie.2018.10.004

References

1. Lomero-Martínez MM, Jiménez-Herrera MF, Bodí-Saera MA, Llauradó-Serra M, Masnou-Burrallo N, Oliver-Juan E, et al. Decisiones en los cuidados al final de la vida. ¿Jugamos en el mismo equipo? Enferm Intensiva. 2018;29:147–90, http://dx.doi.org/10.1016/j.enfi.2018.01.003.
2. Estella A. Toma de decisiones en equipo en los cuidados al final de la vida. Rev Clin Esp. 2018;218:266–7, http://dx.doi.org/10.1016/j.rce.02.007.
3. Requena Meana P. ¡Doctor, no haga todo lo posible!. Albolote, Granada: Editorial Comares; 2017.
4. Christakis NA, Asch DA. Biases in how physicians choose to withdraw life support. Lancet. 1993;342:642–6.
5. Sprung CL, Woodcock T, Sjokvist P, Ricou B, Bulow HH, Lippert A, et al. Reasons, considerations, difficulties and documentation of end-of-life decisions in European intensive care units: the ETHICUS study. Intensive Care Med. 2008;34:271–7, http://dx.doi.org/10.1007/s00134-007-0927-1.

P. Escudero-Acha (MD)*, J.C. Rodriguez-Borregán (MD), E. Chicote-Álvarez (MD), M. Ortiz-Lasa (MD), A.F. Jimenez-Alfonso (MD), A. González-Castro (PhD)

Servicio de Medicina Intensiva, Hospital Universitario Marqués de Valdecilla, Santander, Spain

*Corresponding author.
E-mail address: escudero.acha@gmail.com
(P. Escudero-Acha).

https://doi.org/10.1016/j.enfie.2018.11.001
2529-9840/

Comment to ''In reply to the question: Are we really playing together in the same team?''☆

Comentario a «En respuesta a la pregunta: ¿Jugamos todos en el mismo equipo?»

Dear Editor,

After reading the Escudero-Acha et al. director's letter to the publication of our article, we wished to thank him for his contribution to the extremely interesting debate represented by the role of nursing and medicine in end-of-life care in intensive care services.[1]

Firstly we would like to congratulate the team for the combined physician–nurse ICU round consultations. As stated in their letter, work shifts do not help in the decision-making processes of either profession. This fact is reflected in a multicentre study conducted in 2014 by the Bioethical Group of the Spanish Society of Intensive Medicine, Critical care and Coronary Units (SEMICYUC), where only 26.3% of nurses participated in the decision to limit life-sustaining treatment (LST) in clinical practice.[2]

This percentage differs considerably to that of the ETHICUS study, which revealed that the physicians' perception of the nurses' participation in decision-making at end-of-life care varied between northern European countries (95.8%) and southern European countries (60.7%).[3] This difference was made evident in a similar manner in our study, when we asked both professionals whether the LST decisions were taken jointly in their centre: the doctors considered that this was so in 92.6% of cases, whilst the nursing staff believed it to be so in 63.5% of cases. There was clearly a difference in perception by the two professions regarding participation in decision-making. Added complexities, as highlighted by Oberle and Hughes, are that finally it is the doctor who is ''the person in charge of taking decisions'' and the nurses who ''have to abide by these decisions''.[4]

Nurses play a major role in patient care, because they spend a lot of their time with the patient and the family and are often involved in discussions on the end-of-life wishes. Their role is fundamental and essential in connecting with the other health professionals, the patient and their enviornment.[5] Not permitting the nurse to participate in decision-making and carrying out their role as the representative of the values and beliefs of the patient may often trigger moral distress or burnout,[6] resulting in even more difficult decision-making.[7]

Several international documents of consensus highlight the fact that the role of both professions, among other healthcare professionals, is essential and singular in guaranteeing quality end-of-life care.[7,8]

For this reason we believe that educating both professions with regard to end-of-life care must be carried out jointly, in a forum where all outlooks may be openly debated and both professions may learn together, by each understanding and accepting responsibilities. This idea drove the authors to conduct this multicentre study, which we hope will be the first of many to pinpoint the development of interprofesssional teams within intensive care services.

References

1. Escudero-Acha P, Rodriguez-Borregán JC, Chicote-Álvarez E, Ortiz-Lasa M, Jimenez-Alfonso AF, González-Castro A. En respuesta a la pregunta: «¿Jugamos todos en el mismo equipo?». Enferm Intens. 2018, http://dx.doi.org/10.1016/j.enfi.2018.10.00.
2. Estella A, Martín MC, Hernández A, Rubio O, Monzón J, Cabré L, et al. Pacientes críticos al final de la vida: estudio multicéntrico en Unidades de Cuidados Intensivos españolas. Med Intens. 2016;40:448–56.

☆ Please cite this article as: Lomero-Martínez MM, Jiménez-Herrera MF, Bodí-Saera MA, Llaurado-Serra M, Masnou-Burrallo N, Oliver-Juan E, et al. Comentario a «En respuesta a la pregunta: ¿Jugamos todos en el mismo equipo?». Enferm Intensiva. 2019. https://doi.org/10.1016/j.enfie.2018.11.001