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https://doi.org/10.1016/j.enfie.2021.09.003

Methodological bases, taxonomy and critical thinking: Authors' response☆

Bases metodológicas, taxonomía y pensamiento crítico: respuesta de los autores

First of all, the authors of the manuscript entitled "Rhabdomyolysis in a patient with McArdle's disease"[1] would like to thank the authors Alconero-Camarero and Ibáñez-Rementería for their contributions to the aforementioned paper,[2] given that every contribution generates debate on issues of interest to us, promoting critical reflection and the scientific consistency of the knowledge that underpins the whole profession.

We agree with the authors that in the development of a clinical case it is important to raise the appropriate nursing diagnoses that arise from the case assessment, as well as any collaboration problems. We are aware of the relevance of using our own language, although we must recognise that there may be different ways of approaching the same case, given that the patient himself, based on his personal and clinical profile, and even his knowledge and attitude towards his health problem, will be a determining factor in the approach of the nursing approach to the diagnosis, the objectives to be achieved (NOC) and the interventions necessary for this (NIC).

In the case in question, the approach differs from other cases of patients with McArdle's disease (inability to degrade glycogen at a muscular level), precisely because on this occasion we are dealing with an expert patient, with extensive knowledge and a high level of autonomy in the management of a disease of low prevalence,[3] which is largely unknown to many health professionals, including nurses. For this reason, after assessing the patient, it was decided not to include ineffective health management as a nursing diagnosis. We believe it is appropriate to point out that the diagnosis proposed by the authors corresponds to a diagnosis from the NANDA-I version 2012-2014.[4] Currently, the NANDA-I version 2021-2023 identifies this diagnosis as *Ineffective self-management of health (00276)*. However, with the mastery and management capacity that the patient has in the expert category, the authors of the paper consider that a more accurate diagnosis that could be considered is that of *Willingness to improve self-management of health (00293)*, and more specifically, that of *Willingness to improve exercise (00307).*[5] This is based on the fact that the patient demanded information throughout the clinical process to improve their present and future state of health, as well as the intention to improve and adapt physical activity to the disease.

One of the most salient points of the clinical case is the role of the patient, who is fully aware of his or her disease, so the patient's perspective was taken into account at all times. Physical activity is one of the therapeutic pillars, together with an adequate diet, for people living with McArdle's disease. In this particular case, the patient was aware of and monitored the therapeutic approach to the disease, as well as the early warning signs and symptoms. He therefore followed the relevant dietary management to promote better adaptation to physical activity and went to the emergency department when the symptoms were present. This is an example of the importance of relying on the patient's experience to address chronic diseases and, in general, any aspect of health, as it makes the healthcare system more efficient and sustainable, as well as promoting a better therapeutic relationship between the patient and the professional.[6]

The authors would like to stress the importance of including patients in the management and care of their health, as patient empowerment must be one of the objectives to be pursued by all health actions. In this way, the aim is to achieve a consensus between the scientific-technical experience of healthcare professionals and the subjective experience of individuals.[7] In this case, with McArdle's disease being a rare condition, it is much more important to have the patient as an expert and to include his or her own experience within his or her own context as part of the comprehensive assessment.

In conclusion, we would like to highlight the importance of encouraging debate on the evidence generated and thank the journal ENFERMERÍA INTENSIVA for the opportunity to do so. It is undoubtedly a process of continuous improvement that allows the exchange of information and different points of view on the published work, bringing dynamism to the publications.

DOI of original article: https://doi.org/10.1016/j.enfi.2021.09.008.
☆ Please cite this article as: Nafría-Soria H, Moreno-España J, Sánchez-Herrero H, García-Menéndez E, Moreno-Del Castillo C, Fernández-Valle I. Bases metodológicas, taxonomía y pensamiento crítico: respuesta de los autores. Enferm Intensiva. 2022;33:108–109.

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https://doi.org/10.1016/j.enfie.2021.09.004

Why do we call them nursing diagnoses when they are problems of collaboration?*

¿Por qué los llamamos diagnósticos de enfermería cuando son problemas de colaboración?

Dear Editor:

We congratulate the authors,[1] for the publication in the Enfermería Intensiva journal of their clinical case report, corresponding treatment with a left ventricular assist device, for stimulating a constructive debate that is always positive for our professional development. Nevertheless, certain methodological inaccuracies were found, unless these are clarified they may lead to errors in clinical practice, our profession accepting assignments which do, not correspond to it.

Although the authors describe a clinical case using NANDA I taxonomy, the nursing diagnoses (ND) mentioned in the text are problems with co-working rather than ND. According to the NANDA I-accepted definition:[2] ''a *ND is a clinical judgement on the response of an individual, family or community to vital processes/real or potential health problems which supply the basis for the therapy to achieve the aims for which the nurse is responsible*''. The patient is under sedation and analgesia with orotracheal intubation, so that the ND which appear in the manuscript have no basis within the situation that is described, as no supporting verbal communication takes place. None of the clinical judgements in question are such, firstly because we cannot resolve a fall in cardiac output or a deterioration in spontaneous ventilation if the doctor does not provide guidelines for a series of measures to be adopted, which the nurse has to implement, given that we are not independent in this respect. On the other hand, risk diagnoses cannot be associated with medical problems or treatments, as if we do no eliminate the source of the risk the problem will continue to exist, and once again it is the doctor who has the independence to be able to do so.[3] Although in this situation the ''*risk of cutaneous integrity deterioration*''[2] would be valid, this would be so in connection with the humidity, pressure or shear forces that the patient may suffer in their disease process. Nevertheless, nor would it be methodologically correct if the appropriate tasks for the relevant independence problems were implemented.

We are also surprised by the lack of family data, in the search for ND given the severity of the case.

Lastly, we find it striking that the evaluation is based on needs and practically omits certain relevant systems for this pathology (the neurological system and haemodynamics) and that the sole potential complication is constipation, more so in a situation where the first 48–72 hours are crucial. We cannot place this consideration before other more important ones, such as the arrhythmias, hypovolemia, lack of right ventricle or complications deriving from the poor working of the device, such as the pump ceasing to work.[4]

Skin care to prevent the appearance of pressure ulcers should be given the emphasis it deserves, as the authors mention this almost anecdotally. Although the appearance of club foot is mentioned, at no time do the authors refer to alternating pressures in the relevant zones. They use a diaper as a precaution, although this would not be indicated given that an excess of humidity arises in the perineal and sacral areas, and although it is more than evident that a patient with an open thorax cannot be placed on one side,

DOI of original article: https://doi.org/10.1016/j.enfi.2021.12.004.
* Please cite this article as: Alconero-Camarero AR, Ibáñez-Rementería MI and Sarabia-Cobo C, ¿Por qué los llamamos diagnósticos de enfermería cuando son problemas de colaboración? Enfermería Intensiva. 2022;33:109–110.