

## Bibliografía

1. Marín-Olalla F. La eutanasia: un derecho del siglo XXI. *Gac Sanit.* 2018;32:381–2.
2. Rodríguez E. La eutanasia y sus argumentos. *Ars Medica.* 2000;2:45–57.
3. Hendin H. Assisted suicide euthanasia and suicide prevention: The implications of the Dutch Experience. *Suicide Life Threat Behav.* 1995;25:193–204.
4. Herranz G. Las razones médicas en contra la legalización de la eutanasia. En: Fibla C, editor. *Debate sobre la eutanasia.* Barcelona: Planeta; 2000. p. 11–20.
5. Simón Lorda P, Barrio Cantalejo IM, Alarcos Martínez FJ, Barbero Gutiérrez J, Couceiro A, Hernando Robles P. Ética y muerte digna: propuesta de consenso sobre un uso correcto de las palabras. *Rev Calid Asist.* 2008;23:271–85.
6. Keown J. Euthanasia in the Netherlands: Sliding down the Slippery Slope. *9 Notre Dame J.L. Ethics & Pub Pol'y.* 1995;407:407–48.
7. Bollen J, ten Hoopen R, Ysebaert D, van Mook W, van Heurn E. Legal and ethical aspects of organ donation after euthanasia in Belgium and the Netherlands. *J Med Ethics.* 2016;42:486–9, <http://dx.doi.org/10.1136/medethics-2015-102898>.
8. Ver Emanuel EJ. Pain and symptom control patient rights and physician responsibilities. *Hematol Oncol Clin North Am.* 1996;10:4155.
9. Martínez Otero JM. La hipertrofia del principio de autonomía en el debate bioético. *Cuadernos de Bioética.* 2017;28:329–40.
10. Morán S. Una reflexión sobre la eutanasia. *Ars Medica.* 2001;5:115–8.

P. Escudero-Acha<sup>a,\*</sup> y A. González-Castro<sup>a,b</sup>

<sup>a</sup> *Servicio de Medicina Intensiva, Hospital Universitario Marqués de Valdecilla, Santander, España*

<sup>b</sup> *Presidente del Comité de Ética Asistencial, Hospital Universitario Marqués de Valdecilla, Santander, España*

\* Autor para correspondencia.

Correo electrónico: [patricia.escudero.acha@gmail.com](mailto:patricia.escudero.acha@gmail.com) (P. Escudero-Acha).

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## Perception of a lack of social support in patients with chronic obstructive pulmonary disease. A real problem. How can we face it?



## Percepción de falta de apoyo social en pacientes con enfermedad pulmonar obstructiva crónica. Un problema real, ¿cómo podemos afrontarlo?

Dear Editor,

In contrast to cancer or dementia, chronic obstructive pulmonary disease (COPD) progresses in a much more complex way. Some authors suggest that the extent of the needs of patients with advanced chronic diseases reaches beyond the purely clinical and disease management aspects and must include multidimensional questions in their evaluation (functional, social, psychological, and ethical points).<sup>1</sup> Advanced disease, invalidating dyspnoea, and functional deficits limit the patients' access to the outside world, like going out into the street and meet people, as they are not able to overcome the barriers of their homes (i.e. stairs, flats without a lift, etc.). The forced seclusion and social isolation inevitably form a handicap difficult to overcome. They restrict access to instrumental, leisure, and social life activities, which in turn lead to the occurrence of depressive states, anxiety or both.<sup>2</sup>

To evaluate the psychosocial situation in a cohort of patients with COPD, followed up at the Outpatient Clinics of Pneumology of the University Hospital Nuestra Señora de Candelaria (HUNSC), Santa Cruz de Tenerife, a descriptive observational study was conducted from January 2011 to December 2013. The Gijón as well as the Goldberg scale

were applied. Out of a database of 308 COPD patients, 100 agreed to participate in the study. The patients' mean age was  $68 \pm 8.5$ . The majority (84%) were males; 18% were active smokers with a forced expiratory volume in the first second (FEV1) mean of the predicted  $46\% \pm 18$  and a mean BODE index of 4. A total of 84% of the patients stated not to have any support from their social network (Table 1), 42% had incomes below the inter-professional minimum salary, and 56% had some signs of depression.

The perception of lack of social support has harmful effects on health and leads to an increase in depressive symptoms, a decrease in physical activity and quality of sleep, an increase in tobacco consumption, and also to reduced social interactions when spending a long time in solitude. These conditions augment morbidity and mortality to a similar extent as other known factors, such as smoking, obesity, or hypertension.<sup>3-5</sup>

COPD goes beyond a purely pulmonary dysfunction,<sup>6</sup> and the lack of social support reported by our COPD patients must be taken into account, as it can significantly affect patient management. Improving the follow up and handling during the care process for this group includes an adequate health education on the disease itself as well as putting emphasis on a correct treatment adherence and self care and should also consider the need for a family approach.<sup>7</sup>

Informal caregivers (IC) provide technical and emotional support. We can find that patients supported by IC are less likely to smoke, seek emergency services less frequently, and adhere better to pharmacological treatment.<sup>8</sup> Therefore, the role of IC is fundamental to a comprehensive framework of patient care and provides benefits to both the patient and the health system. However, we must take into account how the caregiver perceives the disease, as this could lead to a higher degree of dependence of the patient on their environment, so that health professionals should evaluate the role of the IC.<sup>8,9</sup>

**Table 1** Data obtained through the Gijón scale.

	%
<i>Family situation</i>	
-Lives with the family without physical psychological dependence	2
-Lives with a partner of similar age	77
-Lives with the family and/or partner and exhibits some degree of dependence	0
-Lives alone with nearby living children	11
-Lives alone with children living far away or no children	10
<i>Economic situation</i>	
-More than 1.5 times the minimum salary	21
-From 1.5 times the minimum salary to the minimum salary only	21
-From the minimum salary to the minimum contributory pension	10
-LISMI, FAS, or non-contributory pension	23
-No income or less than listed in point 4	9
<i>Housing</i>	
-Adequate for the needs	88
-Architectural Barriers in the dwelling or at the entrance	3
-Humidity, poor hygiene, inadequate equipment	2
-Missing lift, telephone	7
-Inadequate home (shanties, housing declared in ruins, lack of minimal equipment)	0
<i>Social relationships</i>	
-Social relationships	71
-Social relationships with family and neighbours only	10
-Social relationships with either family or neighbours	9
-Does not leave home, receives visits	9
-Does not leave home nor receive visits	1
<i>Social network support</i>	
-With family and neighbourhood support	14
-Social volunteers, home help	2
-No support at all	84
-Pending admission to geriatric residence	0
-With permanent care	0

LISMI: Law on the Social Integration of the Disabled; FAS: health assistance for illness/old age.

In a situation of poverty, the possibilities of receiving support are limited, given that the members of this support network are in a similar situation of precariousness and vulnerability. Thus, help would need to be sought outside said setting, e.g., in the health sector. However, it must be

taken into account that the services provided throughout the territory are heterogeneous.<sup>9</sup> Professional awareness of this "other reality" and its approach from a perspective that comprehends the patients' daily life situation are essential to meet sometimes hidden and not sufficiently expressed needs. Adapting to this reality is key to alleviate symptomatology and its functional and psychological repercussion, which would allow persons with COPD to better cope and manage their situation more effectively.

## Bibliografía

- Ferris FD, Balfour HM, Bowen K, Farley J, Hardwick M, Lamontagne C, et al. A model to guide patient and family care: based on nationally accepted principles and norms of practice. *J Pain Symptom Manage.* 2002;24:106–23.
- Pinnock H, Kendall M, Murray SA, Worth A, Levack P, Porter M, et al. Living and dying with severe chronic obstructive pulmonary disease: multi-perspective longitudinal qualitative study. *BMJ.* 2011;24:342, d142.
- Cacioppo S, Cacioppo JT. Why may allopregnanolone help alleviate loneliness? *Med Hypotheses.* 2015;85:947–52.
- Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D. Loneliness and social isolation as risk factors for mortality: a meta-analytic review. *Perspect Psychol Sci.* 2015;10:227–37.
- Holt-Lunstad J, Smith TB, Layton JB. Social relationships and mortality risk: a meta-analytic review. *PLoS Med.* 2010;7:e1000316.
- Marx G, Nasse M, Stanze H, Boakye SO, Nauck F, Schneider N. Meaning of living with severe chronic obstructive lung disease: a qualitative study. *BMJ Open.* 2016;6:e011555.
- Llauger Roselló MA, Pou MA, Domínguez L, Freixas M, Valverde P, Valero C, et al. Treating PD in chronic patients in a primary-care setting. *Arch Bronconeumol.* 2011;47:561–70.
- Nakken N, Janssen DJ, van den Bogaart EH, Wouters EF, Franssen FM, Vercoulen JH, et al. Informal caregivers of patients with COPD: Home Sweet Home? *Eur Respir Rev.* 2015;24:498–504.
- Palomar Lever J, Cienfuegos Martínez YI. Poverty and social support: a comparative study in three socioeconomic levels. *Interam J Psychol.* 2007;41:177–88.

D. Díaz Pérez, L. Llanos Rodríguez,  
J.M. Figueira Gonçalves\*

*Pneumology and Thoracic Surgery Service, University Hospital Nuestra Señora de la Candelaria (HUNSC), Santa Cruz de Tenerife, Spain*

\* Corresponding author.

E-mail address: [juanmarcofigueira@gmail.com](mailto:juanmarcofigueira@gmail.com)  
(J.M. Figueira Gonçalves).

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