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In reply to «Veteran or novice in end-of-life decision-making in intensive care medicine? Promote ethical deliberation»☆

En respuesta a «¿Intensivistas veteranos o noveles en la toma de decisiones al final de la vida en medicina intensiva? Promueva la deliberación ética»

To the Editor,

We wish to show our appreciation for the remarks made on the multicenter study recently published by our group.[1]

On whether experience leads to more limitation of life-support treatment (LLST) early decisions being made, ours results obtained after conducting an automatic statistical analysis (CHAID) show that in the presence of more veterans in the staff, LLSTs were more common. Although competences are easier to assess today compared to experience in certain settings, in the field of bioethics it seems logical to assume that better training and acquired abilities through the years (experience) will bring more efficiency both in the assessment of treatment proportionality and patient-family communication. This promotes the patient's autonomy and avoids keeping potentially inappropriate therapies and therapeutic obstinacy. It should be reminded that in the clinical judgement, logic is probabilistic *per se*, not apodictic (like exact sciences are). For this reason, clinical judgement should focus on reason, not certainty. This «reasonability» in the clinical judgement is achieved by carefully weighing in all factors involved in a given situation in order to reduce their uncertainty. This is what the Greek called «deliberation». When deliberation takes a long time, it is considered «prudent». As it happens with clinical judgements, «ethical» judgements are basically empirical and concrete. In the latter, conclusions are uncertain and more reasonable the more thought of and reflected upon are all the factors involved. Therefore, ethical deliberation is a complex form of reasoning that avoids aprioristic, emotional or imprudent judgements. It involves weighing in on the principles, values, conflicts of valor, circumstances, and consequences of the decisions made.[2,3]

Our study did not weigh in on the adequacy of whether it is right to assume that the more LLST decisions we make, the better these decisions are. It only speaks of a higher frequency. However, it can be assumed that if «experience» is an added value in the LLST decision-making process, then the decisions made will be the right decisions.

Finally, we all agree that LLST decisions should be independent of transplant activity. In our study, the observation that LLST occurs less commonly in transplant centers is consistent with the study of early LLST decisions (48 h) and with the presence of a high number of neurocritical patients in whom avoiding early LLST is recommended.[4]

These days, LLST decisions are a common clinical practice at the ICU setting and fighting therapeutic obstinacy is an essential goal of end-of-life care. Establishing the proportionality of therapeutic targets and LLST decisions requires long deliberations with the patient's necessary information, limitations of medical treatment, and the patient's last will and wishes. In this context, the experience of the whole team will bring added value to the LLST decision-making process.[5]

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