



LETTER TO THE EDITOR

Veteran or novice in end-of-life decision-making in intensive care medicine? Promote ethical deliberation[☆]



¿Intensivistas veteranos o noveles en la toma de decisiones al final de la vida en medicina intensiva? Promueva la deliberación ética

To the Editor,

I have read with great interest the study published by Blazquez et al.¹ paying special attention to their statement that limitation of life-support treatment (LLST) decisions are related to centers where over 60% of their health providers have 10+ years of experience. In their discussion, the authors suggest that this may have to do with better communication skills with the patients and their families. If so, this has more to do with the acquisition of competences than it has to do with experience.²

It is interesting in the sense that there is a very similar scenario in the actual staff of most intensive care units with more veterans than novices. Two questions have come to my mind after reading this statement: Does experience really lead to making more earlier LLST decisions? Would it then be alright to assume that the more LLST decisions made the better the decision-making process that led to them really was?

There is no doubt that experience is something to take into account in the complex decision-making process of a specialty like intensive medicine. In the Nicomachean Ethics,³ Aristotle defines caution or phronesis [Φρόνησις, *phronēsis*] as practical wisdom, and in Book IV he says that young people cannot be prudent precisely because of their lack of experience: «A sign of what has been said is that the young can be geometricians and mathematicians, and wise in both fields, but they do not seem to be prudent. The reason for this is that the objective of prudence is also particular, but becomes familiar through experience, and the young do not have experience because it requires a lot of time».

In my own opinion, in intensive medicine it can take us months to learn a new technique, years to know its

indication, and unfortunately decades to know when it was not indicated. The vision of experience is a degree *per se* in the indication of procedures, resolution of diagnostic challenges, and therapeutic decision-making process. Still, I don't know if this is the case with conflict resolution.

In end-of-life decisions we should promote ethical deliberation at the ICU setting away from individual decisions or biased decisions by this or that group of professionals. The veterans should not be the ones who make these decisions based on their own experience and novices should not make these decisions either just because they have more updated knowledge. Let us avoid individual decisions made from the head of the department or the expert in bioethics. The prudent thing to do is to promote collective deliberation including these professionals. The more different perspectives we have, the fewer biases. The difficulty of deliberation is modifying different points of view by applying a methodology that analyzes clinical facts. Also, deliberating on conflicting values while taking into consideration the opinion of the treating physician and the rest of the team, and the patient's values as expressed by himself or his relatives.

Standing on this ground, facts and values, a deliberative environment should be established from which team decisions should arise by reducing individual biases and gaining specific weight after being communicated to the patient and/or his relatives.

The finding that correlates belonging to a transplant center with LLST decisions is controversial since these clinical decisions should be independent from transplant activity *per se*.⁴ The high participation from the nursing team is obviously a remarkable fact that varies with the trend reported in former series⁵ where its involvement was marginal.

Funding

The authors declared they received no funding whatsoever while conducting this study.

References

- Blazquez V, Rodríguez A, Sandiumenge A, Oliver E, Cancio B, Ibañez M, et al. Factors related to limitation of life support within 48h of intensive care unit admission: a multicenter study. *Med Intensiva*. 2019;43:352–61.
- Arnold RM, Back AL, Barnato AE, Prendergast TJ, Emler LL, Karpov I, et al. Fellows' communication skills. *J Crit Care*. 2015;30:250–4.

[☆] Please cite this article as: Estella Á. ¿Intensivistas veteranos o noveles en la toma de decisiones al final de la vida en medicina intensiva? Promueva la deliberación ética. *Med Intensiva*. 2020;44:201–202.

3. Aristóteles. *Ética a Nicómaco*. 1985; VI, 8, 1142a. Alianza editorial ISBN: 9788420688459.
4. Estella Á. Reply to «The right to become an organ and tissue donor at the end of life of critically ill patient». *Med Intensiva*. 2020;44:60.
5. Bertolini G, Bofelli S, Malacarne P, Peta M, Marchesi M, Barbisan C, et al. End of life decision making and quality of ICU performance: an observational study in 84 Italian units. *Intensive Care Med*. 2010;36:1495–504.

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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, our 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 (48h) 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

References

1. Blazquez V, Rodríguez A, Sandiumenge A, Oliver E, Cancio B, Ibañez M, et al. Factors related to limitation of life support within 48h of intensive care unit admission: a multicenter study. *Med Intensiva*. 2019;43:352–61.
2. Gracia D. La deliberación moral: el método de la ética clínica. *Med Clínica*. 2001;117:18–23.
3. Belloc Rocasalbas M, Girbes ARJ. Toma de decisiones al final de la vida, el modo neerlandés a través de ojos españoles. *Med Intensiva*. 2011;35:102–6.
4. Bodí MA, Pont T, Sandiumenge A, Oliver E, Gener J, Badía M, et al. Potencialidad de donación de órganos en muerte encefálica y limitación del tratamiento de soporte vital en los pacientes neurocríticos. *Med Intensiva*. 2015;39:227–344.
5. Estella Á, Saralegui I, Rubio Sanchiz O, Hernández-Tejedor A, López Camps V, Martín MC, et al. Puesta al día y recomendaciones en la toma de decisiones de limitación de tratamientos de soporte vital. *Med Intensiva*. 2019, <http://dx.doi.org/10.1016/j.medin.2019.07.006>, pii: S0210-5691(19)30185-8.

[☆] Please cite this article as: Blazquez V, Rodríguez A, Sandiumenge A, Bodí M. En respuesta a «¿Intensivistas veteranos o noveles en la toma de decisiones al final de la vida en medicina intensiva? Promueva la deliberación ética». *Med Intensiva*. 2020;44:202–203.

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