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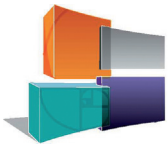

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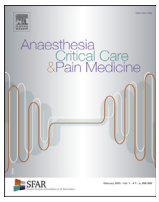

Letter to the Editor

Reply letter to: Physician's experience in decisions of withholding and withdrawing life-sustaining treatments: A multicenter survey in emergency departments

Dear Editor-in-Chief:

We read with interest the survey of Douplat et al. [1] showing that emergency department (ED) physicians are often alone in making decisions about withholding and withdrawing life-sustaining treatments, which could lead to emotional or psychological burnout and decreased job satisfaction. The authors concluded that collegial reflection, collaboration with nurses, and specific training on end-of-life decisions could help improve a physicians' feeling of loneliness, and we agree with these conclusions.

Numerous individuals die in the EDs, and these departments are not suitable for taking care of patients who need end-of-life care. Nurses and medical staff could face real ethical dilemmas when the fundamental values that guide their practice (such as respect for patient autonomy or non-maleficence) and logistical or material constraints (for example, lack of time or written procedures) contradict each other; this exacerbates the feeling of loneliness and culpability among physicians and may result in burnout or decreased job satisfaction. It is crucial to improve ethical discussion with patients when a diagnosis of cancer or severe chronic disease is made or when patients get institutionalised. This is the primary responsibility of all physicians caring for these patients such as for example family physicians, gerontologists and oncologists who must obtain advance directives from patients in case they would not be able to communicate. Clearly, these advance directives are often not sufficiently discussed [2].

When possible, decisions about withholding and withdrawing life-sustaining treatments should be made at home or at a nursing home by prehospital physicians in collaboration with prehospital nurse, family, and via phone with the family physician which knows the patient and would be very helpful in this crucial decision. However, it can sometimes be difficult to communicate with him in the context of emergency and another option is to discuss with the physician of call regulation. This solution offers the advantage of improving the quality of life of patients by keeping them as close as possible to their environment and family. This is already a common practice, and it meets the same constraints as the in-hospital procedure [3]. In our experience, in prehospital setting or in intensive care unit, using a palliative care on-call telephone service as necessary, combined with using decision sheets as proposed by the French Society of Anaesthesia and Intensive Care Medicine, and a written procedure for decisions about withholding and withdrawing life-sustaining treatments are of great help for decision-making process. In any case, the ethics of discussion must be promoted so that everyone feels concerned about this crucial subject that transcends specialties.

Your's sincerely.

Disclosure of interest

The authors declare that they have no competing interests.

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