LETTERS

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PREOPERATIVE FASTING

I enjoyed "Preoperative Fasting: Will the Evidence Ever Be Put into Practice?" (October 2011). Jeannette T. Crenshaw's call to address this issue is long overdue. I've been a nurse for almost 20 years, and it's sad to see patients go hungry unnecessarily. Not only is this a huge source of patient displeasure in an era of transparent customer ratings, but it has continually been proven to be less than desirable for the patient's health and healing.

Kratzing reminds us that the malnutrition imposed by presurgical fasting contributes to biological stress, decreasing immune function and potentially interfering with patient healing.[1] A Cochrane review showed no evidence that a less stringent fasting period increased the risk of aspiration; in fact, lower gastric volumes were evident in patients who had water preoperatively.[2]

Perhaps as quality outcomes continue to become more transparent, and organizations and physicians are subsequently forced to use evidence-based practice more often, the practice and terminology will begin to become more customary. However, until we as nursing leaders can bring together the key stakeholders and implement positive changes for our patients, we'll never shorten the timeline it takes to practice proven care at the bedside—where it matters most.

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REFERENCES

1. Kratzing C. Pre-operative nutrition and carbohydrate loading. *Proc Nutr Soc* 2011;70(3):311-5.
2. Brady M, et al. Preoperative fasting for adults to prevent perioperative complications. *Cochrane Database Syst Rev* 2003(4):CD004423.

DEACTIVATING MEDICAL DEVICES

"Deactivation of ICDs at the End of Life: A Systematic Review of Clinical Practices and Provider and Patient Attitudes" (*Original Research*, October 2011) was an informative and thought-provoking examination of the deactivation of implantable cardioverter-defibrillators (ICDs) in end-of-life care. The intermediate care unit where I work has recently had more end-of-life patients than usual, prompting us to discuss this same issue.

These conversations raise the question of deactivating pacemakers at the end of life. While pacemakers don't deliver painful shocks, it can be argued that they affect the dying process. A study by Kapa et al found that opinions about turning off technology varied according to the device: medical professionals and patients perceived that deactivating ICDs was more acceptable than turning off pacemakers.[1] A large percentage (21%) of patients even thought that turning off pacemakers in non–pacemaker-dependent patients would be similar to physician-assisted death.

Without consensus, providers often find themselves broaching the topic when families are most vulnerable. I'm left questioning how clinicians can best be assisted in handling end-of-life care issues effectively and sensitively for both patients and their families.

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REFERENCE

1. Kapa S, et al. Perspectives on withdrawing pacemaker and implantable cardioverter-defibrillator therapies at end of life: results of a survey of medical and legal professionals and patients. *Mayo Clin Proc* 2010;85(11):981-90.

EVIDENCE-BASED PRACTICE

The recent 12-part series from the Arizona State University College of Nursing and Health Innovation's Center for the Advancement of Evidence-Based Practice, *Evidence-Based Practice, Step by Step*, has enabled me to navigate the previously confusing world of evidence-based practice implementation. Of particular solace to me was the last article in the series, "Sustaining Evidence-Based Practice Through Organizational Policies and an Innovative Model" (September 2011).

It was encouraging, for once, to read about nursing leadership within a "can-do" framework. As a nursing student, I'm now motivated to learn about and use the Advancing Research and Clinical Practice Through Close Collaboration model to engender a culture of support for evidence-based practice in my future workplace.

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