# Academic disobey

## Desobediencia académica

The article by Cardinal-Fernández et al.[1] highlights four fundamental ideas that can be summarized as follows: the clinical definition of ARDS has evolved over time, while maintaining a ïrigidc̈onceptual framework based on acute lung injury. However, the new global definition of ARDS has become more open and inclusive, which has the positive effect of facilitating recruitment into clinical trials. However, the inclusion of heterogeneous groups may hinder the demonstration of beneficial results in such trials, moving away from the goal of personalized medicine and slowing the transfer of scientific advances from basic research into clinical practice. In other words, the main complaint is the dilution of methodological quality.

On the one hand, we would like to support the criticism made and, on the other hand, extend it beyond the methodological criteria to the biological criteria.

The new global definition of distress[2] does not include ontological/biological advances, which are of real interest, but rather an operational expansion to enable the diagnosis of distress to be made, as it incorporates definitions based on technologies such as pulse oximetry, high-flow therapy, blood gases, and ultrasound imaging. These inclusions are intended to encompass a greater diversity of clinical, social and geographical scenarios and thus include the majority of clinical practices. For example, the authors point out that p̈atients with acute hypoxemic respiratory failure treated with HFNO do not meet the Berlin definition of ARDS.̈ However, this is not a problem in clinical practice[3] and would even demonstrate the inadequacy of the new definition in certain scenarios, such as äwake ECMO,̈ thus even causing it to fail in its intended inclusiveness.

Since the new definition degrades the quality of studies, slows the progress of precision medicine, and does not add anything at the biological level, a more interesting question arises: Is there an obligation to follow this new definition? Apparently, there is no ontological, epistemic[4,5] or deontological reason to abandon the previous definition altogether. The change of definition is not motivated by biological criteria, but by monitoring and noninvasive treatment criteria. This new definition is therefore a new operational form that aims to integrate other practices and other sociosanitary scenarios, but it does not bring us any closer to the truth, since it does not contain any greater veracity than the previous definition. Perhaps, for this very reason, there should be academic disobedience, in certain healthcare settings, towards this new global definition if we really wish to secure greater rigor, precision and depth of knowledge.

Scientific knowledge is based on the fact that what is stated (respiratory distress) is precise and clear, i.e., it has a restricted real reference. This new definition does not progress in this direction, which may go against its own interests, as already commented by Cardinal-Fernández et al.[1]

## Declaration of competing interest

The authors declare that they have no conflicts of interest.

## References


1. Cardinal-Fernández P, Ortiz G, Blanch L. Definición global del síndrome de distrés respiratorio agudo: una visión epidemiológica. Med Intensiva. 2024;48:272–81, http://dx.doi.org/10.1016/j.medin.2024.08.002.
2. Matthay MA, Arabi Y, Arroliga AC, Bernard G, Bersten AD, Brochard LJ, et al. A new global definition of acute respiratory distress syndrome. Am J Respir Crit Care Med. 2024;209:37–47, http://dx.doi.org/10.1164/rccm.202303-0558WS. PMID: 37487152; PMCID: PMC10870872.
3. Wiesner O, Hadem J, Sommer W, Kühn C, Welte T, Hoeper MM. Extracorporeal membrane oxygenation in a nonintubated patient with acute respiratory distress syndrome. Eur Respir J. 2012;40:1296–8, http://dx.doi.org/10.1183/09031936.00076912. Epub 2012 Aug 9. PMID: 22878882.
4. Rapezzi C, Lorenzini M. How far should guidelines be followed? Eur Heart J Suppl. 2020;22 Suppl L:L121–3, http://dx.doi.org/10.1093/eurheartj/suaa150. PMID: 33239985; PMCID: PMC7673602.
5. Einav S, O'Connor M. The limitations of evidence-based medicine compel the practice of personalized medicine. Intensive Care Med. 2024;50:1323–6, http://dx.doi.org/10.1007/s00134-024-07528-y. Epub 2024 Jun 27. PMID: 38935271.



Marcos Valiente Fernández*,
Francisco de Paula Delgado Moya,
Amanda Lesmes González de Aledo, Isaías Martín Badía

*Servicio de Medicina Intensiva, Hospital Universitario 12 de Octubre, Madrid, Spain*

* Corresponding author.
*E-mail address:* mvalientefernandez@gmail.com
(M. Valiente Fernández).




DOI of refers to article: https://doi.org/10.1016/j.medin.2024.10.006