Journal of Palliative Care & Medicine

Gutierrez, J Palliat Care Med 2017, 7:5
DOI: 10.4172/2165-7386.1000321

Letter to Editor OMICS International

Out-of-Hospital Transfers: When the Intention is not to Cure

Cristina Gutierrez*

Division of Anesthesia and Critical Care, Department of Critical Care, University of Texas MD Anderson Cancer Center, Houston, TX, USA

***Corresponding author:** Cristina Gutierrez, Division of Anesthesia and Critical Care, Department of Critical Care, University of Texas MD Anderson Cancer Center, Houston, TX, USA, Tel: +1 713-792-2121; E-mail: cgutierrez4@mdanderson.org

Received date: Sep 13, 2017; **Accepted date:** Sep 20, 2017; **Published date:** Sep 25, 2017

Citation: Gutierrez C (2017) Out-of-Hospital Transfers: When the Intention is not to Cure. J Palliat Care Med 7: 321. doi:10.4172/2165-7386.1000321

Letter to Editor

Our published single-center cohort study determined the outcomes of out-of-hospital transfer of cancer patients to the Intensive Care Unit (ICU) at MD Anderson Cancer Center [1]. In this three year study 228 patients were transferred for further care to our ICU from outside hospitals all over the country. Surprisingly, and contrary to what was reported in the literature, we observed that transferring critically ill oncological patients to a specialized center did not lead to worse outcomes or increased resource utilization [1].

Further analysis of our data (not published) showed that 7.9% of patients that were transferred to our ICU had Do Not Resuscitate (DNR) orders written within 24 hours of transfer. These findings are noteworthy and deserve further examination. We observed that these patients with early DNR orders 50% had hematological malignancies, 35% had leukemia, their average age was 61 ± 14.8 years old and all had received treatment for their malignancy at our institution. These patients had been in the outside hospital for an average of 6.1 ± 8.5 days, 61% required mechanical ventilation, 50% were on vasopressors and only 1 patient was on hemodialysis at the time of transfer. Within 24 hours of arrival to our ICU none of these patients worsened clinically. Of the patients that had DNR orders written within 24 hours of transfer, 67% died within 48 hours of admission and all patients died during the ICU stay.

So why transfer these patients to our institution instead of discussing goals of care at the outside hospital? Why strain the system and these families when the data suggest that the physicians thought their overall prognosis was poor at the time of transfer to our ICU? It is clear that the ideal moment to address end of life preferences is the outpatient setting, however this happens infrequently in the oncological population [2]. Moreover, data show that oncologists are unlikely to make patients DNR unless a patient has already received aggressive ICU treatment or has had a cardiac arrest [3]. These narratives could account for why these patients were transferred to our institution despite their prognosis.

There could be however some hidden benefits of bringing these patients to our institution that are not revealed in the data. How patients die has a significant long-term impact on family members [4]. Having the opportunity to discuss overall prognosis in the comfort of an already known institution and with an oncologist that knows the patient from the outpatient setting, could have a significant positive impact on these families. It is hard to say, but these factors while subjective, could play an important role in our patient population. Sometimes our responsibility as physicians is not only to cure but also to support our patients, no matter where they are, to have a good death.

References

1. Gutierrez C, Cardenas YR, Bratcher K, Melancon J, Myers J, et al. (2016) Out-of-hospital icu transfers to an oncological referral center. J Intensive Care Med 1.
2. Kumar P, Temel JS (2013) End-of-life care discussions in patients with advanced cancer. J Clin Oncol 31: 3315-3319.
3. Baile WF, Lenzi R, Parker PA, Buckman R, Cohen L (2002) Oncologists' attitudes toward and practices in giving bad news: An exploratory study. J Clin Oncol 20: 2189-2196.
4. Gaeta S, Price KJ (2010) End-of-life issues in critically ill cancer patients. Crit Care Clin 26: 219-227.