
GUEST EDITORIAL

Palliative care unit and medical intensive care unit deaths

We read with interest the paper by Digwood and colleagues (2011) in *Palliative and Supportive Care*, Volume 9, Number 4. The authors report a drop in Medical Intensive Care Unit (MICU) mortality from 21 to 15.8% ($p = 0.003$) after the opening of their Palliative Care Unit (PCU). The authors explain their findings are due to the ability to transfer MICU patients to the PCU in a seamless manner.

Our group previously published similar results at our cancer center. The number of deaths in MICU dropped from 252/271 (38%) before the inpatient palliative care service to 213/764 [28%] after the opening ($p < 0.0001$). During this period, the involvement of the palliative care service in the care of patients dying in the hospital grew from 1% to 35%. In our study, very few patients (less than 15%) were actually transferred from MICU to PCU and the overall hospital mortality rate did not increase. Our findings suggest that the presence of a PCU provides a different pathway for symptomatic, decompensated patients that might prevent an MICU admission (Elsayem et al., 2006). PCUs have been found to provide better care as compared to consultation teams (Casarett et al., 2011), even though patients admitted to PCUs are usually in more severe distress (Bruera & Hui, 2011). Our findings strongly support those of Digwood et al. (2011). Unfortunately, only 23% of US cancer centers have dedicated palliative care beds (Hui et al., 2010). We hope that as a result of this article and the growing literature, palliative

care units will soon become a requirement from a regulatory and ethical perspective in all acute care facilities.

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EDUARDO BRUERA, MD
AHMED ELSAYEM, MD

*The University of Texas MD Anderson Cancer Center
Department of Palliative Care & Rehabilitation
Medicine – Unit 1414 1515 Holcombe Blvd.
Houston TX 77030*