Commentary: Time out—For better outcomes

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Central Message

Patients transferred from institutions that have a cardiothoracic surgery program have increased resource use and mortality.

See Article page 540.

Student athletes graduate and obtain degrees at a higher rate than their general student body counterparts pursuing undergraduate college education.¹ Those athletes who transfer between schools, however, perform poorly in their academic pursuits with time. In fact, athletes who transfer between schools are less likely to obtain a degree. This is the reason the National Collegiate Athletic Association requires a transition period of 1 academic year during which athletes are not allowed to play in their sport.² Requiring student-athletes to sit out of competition for a year after transferring encourages them to make decisions motivated by academics as well as athletics. Most student-athletes who are not eligible to compete immediately benefit from a year to adjust to the new school and focus on classes. Although athletics are an important piece of these students' undergraduate experience, the primary objective is to graduate with a degree.

In this issue of the *Journal*, Beller and colleagues³ provide an article describing the increased resource use of patients who are transferred from hospital to hospital for cardiac surgery.³ The most interesting finding of this article is a subset analysis of transfers from institutions who already have cardiothoracic surgery programs. These specific patients had an increased incidence of major morbidity, prolonged ventilation, and need for reoperation, with nearly a doubling of mortality. These patients were triaged by a cardiothoracic surgeon and were found to be an exceptional risk. This study only included patients with 1 of the 6 Society of Thoracic Surgeons predicted risk of mortality calculable operative procedures; however, in our experience, most patients transferred from other cardiothoracic surgery programs have complex processes not calculable by Society of Thoracic Surgeons predicted risk of mortality. These patients possess complex aortic aneurysms, endocarditis, aortic dissection, or underlying severe pulmonary hypertension, or they are already on some form of mechanical circulatory support. Whether it is marginal targets, poor ventricular function, or complex multivalve disease, these patients being transferred from institutions

with a cardiothoracic surgery program have worse outcomes.

The primary outcome for the student is to graduate with a degree; the primary outcome for the patient is survival. If we believe that the National Collegiate Athletic Association is truly looking out for students' best interests, we should analyze their regulations. Transfer between Division I schools can be compared to patients transferring between hospitals. Undergraduate institutions have figured this out; to improve outcomes, student athletes take time out for a year. In the case of hospital transfer, several studies have elucidated that (1) lack of written communication, (2) delay in definitive operative care, and (3) additional comorbidities are causes of increased costs and mortality in patients transferred for surgical care.⁴⁻⁶ Surgeons who accept these patients must be aware of the increased risk, which may not be reflected in commonly used risk stratification calculators. We as surgeons should also take time out. Take a mental break to think through the risks, and why another surgeon has declined; there is likely sound reasoning behind why the patient has been deemed at higher risk. Transfer from another cardiac surgery service should be considered when weighing a patient's risk to benefit ratio. Contemplate these variables when determining when to operate and what procedure to perform. Agreeing with another surgeon across town is not always a failure!

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