The traditional approach to palliative care delivery in the United States has been to refer patients to a hospice [1]. United States hospices developed in the 1970s and early 1980s, following the initial efforts of the British hospice system [2]. However, the American hospices focused more on the delivery of home care services by specialized nurses with minimal medical input, as opposed to the multidisciplinary institutional care more prevalent in the United Kingdom and Canada [3].

In recent years it has become apparent that only a minority of patients with cancer and other diseases have access to hospice care in the United States [4, 5]. The reasons for the under-utilization of hospice care are multiple. Some of them are related to the current structure of and reimbursement system for the traditional hospital system, while some are related to financing limitations and clinical limitations of the hospice system [6].

In recent years it has become apparent that most American patients continue to die in acute care facilities [7]. Therefore, palliative care programs in tertiary hospitals and comprehensive cancer centers have been developed with the goals of delivering care to these inpatients, providing an appropriate bridge towards community hospice programs, providing education for undergraduate and postgraduate and medical and nursing students, and conducting the research required to improve the state of the art in cancer care.

The following paragraphs will describe the development of such a program at The University of Texas M.D. Anderson Cancer Center.

The University of Texas M.D. Anderson Cancer Center

The University of Texas M.D. Anderson Cancer Center opened its doors in 1941. This hospital is a state institution focused on providing innovative care to patients from the area of Houston, other areas of the State of Texas, other areas of the United States, and around the world. The University of Texas M.D. Anderson Cancer Center (UTMDACC) also has a major role in the education of future specialists in surgical, medical, and radiation oncology, in continuing medical education and international education, and in the training of healthcare professionals connected with cancer medicine such as physicists, nurses, pharmacists, and rehabilitation specialists. UTMDACC has one of the largest basic and clinical research programs in the world. This research program focuses on extremely diverse aspects of cancer, such as prevention, basic tumor biology and pharmacology, preclinical studies, clinical trials, and supportive care research.

UTMDACC is one of the 37 comprehensive cancer centers in the United States and is considered one of the largest and most reputable cancer centers in the world. In 1999, a total of 65,000 patients were served by the institution.
The Development of Palliative Care

In July 1999, the Department of Symptom Control and Palliative Care was established in the Division of Anesthesiology, Critical and Palliative Care. The mission of the department is to help patients and their families diminish their physical and psychosocial distress and to allow them to maintain the maximal level of autonomy and dignity.

At the present time, the department has four full-time palliative care medical faculty physicians, one full-time Ph.D. faculty biostatistician, and three full-time clinical fellows. In addition, a variable number of research fellows, visiting professors, and faculty members on sabbatical leave participate in the clinical activities.

The Brown Foundation Symptom Control and Palliative Care Center

This center was developed following the format of the Pain and Symptom Control Center at the Cross Cancer Institute in Edmonton, Canada. It has a number of unique characteristics that distinguish it from regular outpatient facilities.

1. No waiting room
   This center was conceived for patients with rapid progressive illness and devastating symptoms. These patients have great difficulty waiting in waiting rooms, since this can not only be uncomfortable but also psychologically distressing. Patients check in at a front desk and are immediately taken to a private room where the formal process of assessment and management take place. Figure 1 shows the check-in area in the clinic.

2. Private rooms
   Patients with major palliative care needs frequently require long visits and assessment by a number of different healthcare professionals. In some cases, a number of family members must be present, and because of the sensitive nature of many of these discussions privacy is very important. Therefore, all of the rooms are private and each has a full-sized bed, unlike a regular examination room. There are also multiple chairs in the room and a private bathroom. This allows patients not only to undergo assessments, but also to receive treatments, such as infusion of different medications and enemas, in a comfortable environment. Figure 2 shows a patient’s room in the clinic.

3. Multidisciplinary clinics
   Patients referred for an initial palliative care consultation undergo a multidisciplinary evaluation by a physician, a nurse, pharmacists, physical and occupational therapists, a clinical nurse specialist in psychiatry, a social worker, nutritionists, a speech therapist, and a pastoral care worker. At least one representative of each of these disciplines visits each of the patients and the family members in their