

LEADERSHIP & PROFESSIONAL DEVELOPMENT

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Bringing an Inpatient Palliative Care Program to a Teaching Hospital: Lessons in Leadership

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Most people in the United States die in hospitals. In 2004, more than 50% of critically ill patients died in acute care settings (National Center for Health Statistics, Centers for Disease Control and Prevention, 2005). Patients in intensive care units (ICUs) have a mortality rate of 5%–40%, depending on type of critical care unit and severity of illness (Knaus, Wagner, Zimmerman, & Draper, 1993). Studies suggest that patients still die in hospitals with poor quality of life. The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT) documented in detail that many critically ill hospitalized people undergo prolonged deaths characterized by use of invasive life-sustaining medical technologies and that physician-patient-family communication is inadequate (SUPPORT principal investigators, 1995). Other studies have reported similar findings, including poor symptom control at the end of life for patients in ICUs (Desbiens, Wu, Broste, Wenger, & Connors, 1996; Hawryluck, Harvey, Lemieux-Charles, & Singer, 2002; Lynn et al., 1997) and family dissatisfaction with care that includes a lack of communication between families

and medical teams (Abbott, Sago, Breen, Abernethy, & Tulskey, 2001; Azoulay et al., 2000; Malacrida et al., 1998).

Kaufman (2005) stated that palliative care is a pragmatic attempt to introduce an alternative pathway for end-of-life care. Palliative care is an interdisciplinary team approach that improves the quality of life of patients and families living with life-threatening illness through early identification, assessment, and treatment of pain and other physical, psychological, and spiritual problems (World Health Organization, 2002). A study reported that palliative care programs are increasing in U.S. hospitals (Morrison, Maroney-Galin, Kralovec, & Meier, 2005). The authors cited a survey by the American Hospital Association (2003) that reported that palliative care programs increased from 632 (15% of hospitals) in 2000 to 1,027 (25% of hospitals). The increase may be explained by more hospital demand for better quality of care and mounting evidence that supports the benefits of palliative care programs.

Studies have demonstrated substantial reductions in direct and indirect costs associated with hospital palliative care compared with

conventional care (Campbell & Guzman, 2003; Gilmer et al., 2005; Schneiderman et al., 2003; Smith et al., 2003). Researchers have shown that proactive consultation with the palliative care team improves decision making, conflict resolution, and patient-family-physician communication, which, in turn, improves patients' quality of care and reduces lengths of stay in the ICU (Aulisio, Chaitin, & Arnold, 2004; Campbell & Frank, 1997; Campbell & Guzman; Carlson, Devich, & Frank, 1988; Dowdy, Robertson, & Bander, 1998; Field, Devich, & Carlson, 1989; Schneiderman, Gilmer, & Teetzel, 2000; White & Luce, 2004).

This article describes the process of developing an inpatient palliative care proposal, using a leadership model combined with business planning. The project was done as part of the lead author's participation in the Oncology Nursing Society's (ONS's) Leadership Development Institute. The project team, led by two advanced practice nurses, completed a pilot project in the ICU and then presented a proposal to hospital administration for an inpatient consultative palliative

Leadership & Professional Development

This feature provides a platform for oncology nurses to illustrate the many ways that leadership may be realized and professional practice may transform cancer care. Possible submissions include but are not limited to overviews of projects, interviews with nurse leaders, and accounts of the application of leadership principles or theories to practice. Descriptions of activities, projects, or action plans that are ongoing or completed are

welcome. Manuscripts should clearly link the content to the impact on cancer care. Manuscripts should be six to eight double-spaced pages, exclusive of references and tables, and accompanied by a cover letter requesting consideration for this feature. For more information, contact Associate Editor Paula Klemm, PhD, RN, OCN®, at klemmpa@udel.edu or Associate Editor Judith K. Payne, PhD, RN, AOCN®, at payne031@mc.duke.edu

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