Clinically Differentiating Palliative Care and Hospice

Knowing the differences and potential benefits of hospice and palliative care can help healthcare professionals advocate for their patients and make proactive decisions about patient care. Providing admission into the appropriate program can facilitate symptom management and impart the best quality of life possible for this vulnerable population. Case studies will be used to differentiate hospice from palliative care, and the history, philosophy, availability, requirements, and barriers to receiving care will be discussed.

Within the United States, hospice care is available for individuals with an anticipated life expectancy of six months or less. Once certified by a physician, hospice care can be provided in a variety of settings (i.e., inpatient, home, extended-care facility, or a freestanding hospice facility). Hospice care is designed to support individuals in the final stage of life when aggressive or curative treatments are no longer appropriate and when focus shifts to quality of life and relief from physical and psychological pain (American Cancer Society, 2009). Palliative care is sought out earlier in the disease trajectory; it should be integrated with treatments and therapies and uses a multidisciplinary focus to attain the best quality of life possible. Palliative care can be provided in conjunction with curative treatments or with interventions that aim to minimize the symptoms associated with the disease (Center to Advance Palliative Care, 2009). Palliative care is available within many hospitals, extended-care facilities, clinics, and homecare settings (Meier, 2006). Delineating the differences between the two care philosophies often is difficult, which is a result of the overlap between the two and the proven reluctance of healthcare professionals to initiate palliative care or hospice referrals (Egan & Labyak, 2006). The purpose of this article is to describe the similarities and differences of these two care philosophies and provide case studies that demonstrate the appropriate use of each care model.

Hospice Care

Since the first hospice in the United States opened in New Haven, CT, in 1974, the availability of hospice within the U.S. has grown from a volunteer-led movement to a significant force within the healthcare system. According to the Hospice Foundation of America (2009), one of three people in the United States choose hospice care when they are dying. To date, more than 4,700 hospice programs in the United States provide care for about 1.4 million people (National Hospice and Palliative Care Organization, 2009a, 2009b).

The biggest barrier toward initiating hospice services surrounds the ability of the physician to initiate an end-of-life conversation and the patient’s willingness to comprehend the notion that no curative treatments exist (Steinhauser, Christakis, et al., 2000). Accepting one’s mortality is a difficult concept to grasp, even when a life-threatening or life-limiting healthcare condition is present. When the hospice medical directors and the attending physician certify that the patient’s prognosis is six months or less given normal progression of the disease, the timing of the conversation and a caring attitude can prevent the perception of “giving up” and minimize the use of ineffective, futile, and often painful treatments (Steinhauser, Clipp, et al., 2000).

Palliative Care

The Institute of Medicine ([IOM], 2003) defined palliative care as the total active care of the body, mind, and spirit. The aim “of palliative care is to prevent or lessen the severity of pain and other symptoms, and to achieve the best quality of life” (IOM, 2003, p. 2) throughout the course of any life-threatening or life-limiting healthcare condition. In the United States, the availability of inpatient and outpatient palliative care programs has grown exponentially since 1980. At that time, palliative care programs were...