



## **EXACTLY WHAT ARE PALLIATIVE & HOSPICE CARE— & WHAT IS THE DIFFERENCE?**

*“The relief of suffering and the cure of disease must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick. Physicians’ failure to understand the nature to suffering can result in medical intervention that (though technically adequate) not only fails to relieve suffering, but becomes a source of suffering itself.” ~Eric Cassell, MD*

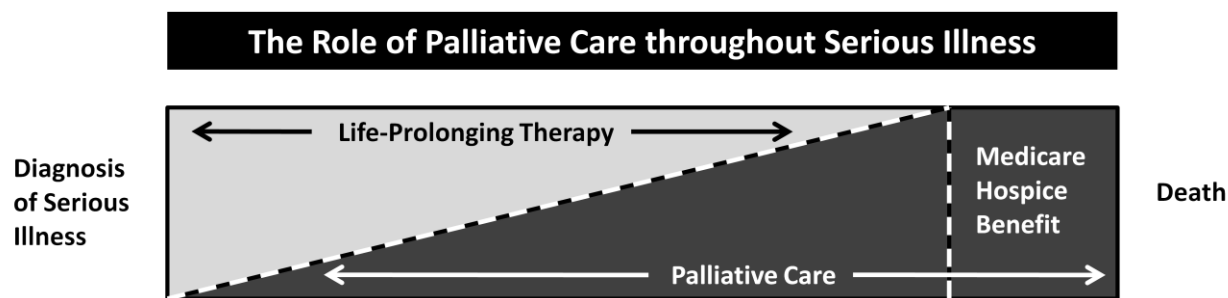
Myths and misinformation abound in the minds of many patients, family members, and even health care professionals about palliative and hospice care. Different, though overlapping at a specific phase in the illness experience, these two relatively young medical specialties are often mistakenly clumped together.

Hospice is not a place. Rather, similar with palliative care, it is a philosophy of care. While conventional medical practice focuses on the control and cure of illness, the main goal of these emerging medical specialties is comfort care and the alleviation of suffering. The hospice movement was founded in the 1960’s by Dame Cicely Saunders of London. Interestingly, Saunders was a nurse, social worker, medical doctor and researcher; she was also a deeply spiritual person—in all embodying the ‘interdisciplinary’ team model of care. Her focus was on care of the total person and their total, *not merely physical*, illness and pain experience (Reith & Payne, 2009).

Hospice migrated to the U.S. in 1974, in Connecticut. In transferring hospice from philosophy to policy as a qualified Medicare benefit in 1982, Congress *limited* the terms of its delivery and accessibility. Two qualifications were instituted: 1) the discontinuation of curative and life-prolonging medical interventions, and 2) a prognosis of six-months or less to live. These defining parameters are its confining barriers, placing reluctant physicians as the gatekeepers of hospice referrals. Policy designed to quantify boundaries has resulted in significant underutilization of services and lack of timely referrals, compromising its benefits to patients and families (Hospice, Inc, n.d.; Reith & Payne, 2009). On the positive side, the Medicare benefit maintains the philosophy of hospice and palliative care by *requiring* multi-discipline holistic care, including social work (Reith & Payne, 2009). In returning death to its proper context, hospice professionals help us to experience the end-of-life as a normative stage within the continuum of illness and of life, rather than a medical emergency requiring hospitalization.

Fear of death is strongly associated with fear of pain. Not unwarranted, many patients experience significant pain not only at the end of life, but throughout the illness trajectory. To palliate

means to cover or cloak (Meier, Isaacs, & Hughes, 2010). In the case of medicine it refers to the alleviation of symptoms, especially pain. Palliative care is an umbrella term; while all hospice care is palliative in nature, not all palliative care is hospice care. Palliative care is based on the same philosophy as hospice but without the federal policy-induced parameters. Theoretically, as an adaptation of hospice care, it fills gaps and broadens parameters of hospice accessibility; however, this is not always the case in practice. Hospice, palliative, and end-of-life care are interlinking concepts. Optimally utilized they constitute a continuum of care.



Adapted from The National Consensus Project for Quality Palliative Care (2009)

According to the National Consensus Project definition (NCP, 2004):

The goal of palliative care is to prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies. Palliative care is both a philosophy of care and an organized, highly structured system for delivering care...concurrently with life-prolonging care or as the main focus of care....Palliative care incorporate[s] psychosocial and spiritual care with consideration of patient/family needs, preferences, values, beliefs, and culture. Evaluation and treatment should be comprehensive and patient-centered with a focus on the central role of the family unit in decision making. Palliative care affirms life by supporting the patient and family's goals for the future, including their hopes for cure or life-prolongation, as well as their hopes for peace and dignity throughout the course of illness, the dying process, and death (as cited in NCP, 2009, p. 6).

Like hospice, palliative care's key goals includes enhancing quality of life for patient and family, optimizing function, assisting decision making, and providing opportunities for personal growth. Hospice and palliative models of care extract the most current advances in pharmacopeia to achieve medicine's "most ancient of goals...the relief of suffering" (Meier et al, 2010, p. IX), while expanding on the traditional biomedical disease-model to fit individual needs. The simple and direct words of the mother of the modern hospice movement, Cicely Saunders, remind me of what hospice care encourages us to do: "We must not lose the chance of making good on a great deal of untidiness in our lives, or of making time to pack our bags and say, 'Sorry, goodbye and thank you.'" This perhaps has always been the work of the living, and the dying.

*Contributed by Elise Lark and reprinted with permission from "Celebrate Life!"  
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