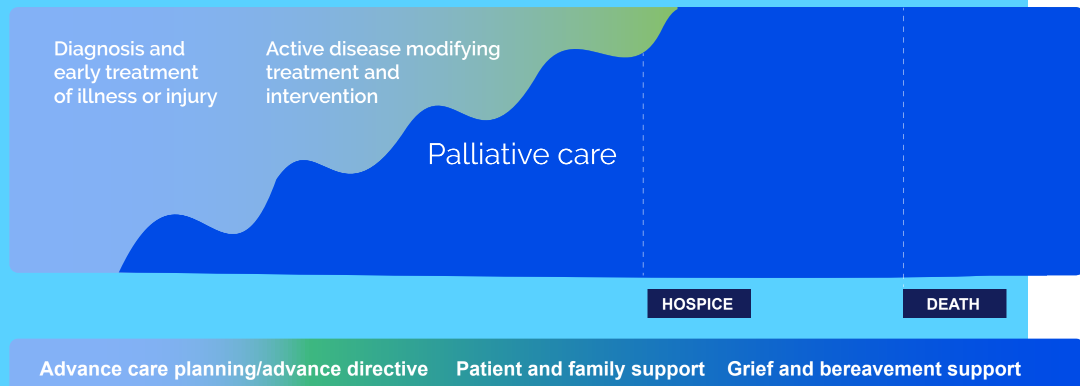
Five palliative care myths debunked

Studies have shown that palliative care can improve individuals' quality of life, reduce hospital admissions, and decrease the cost of care—provided individuals are referred at the right time. So what's preventing that? Often, misconceptions about palliative care. In our infographic below, we debunk five common myths about palliative care that can impede individuals' access to it.

MYTH #1: Palliative care and hospice are the same



THE FACTS:

Palliative care and hospice are distinct phases on the care continuum[1]

Despite many similarities, including a common association with end-of-life care, palliative care and hospice play unique roles.

Palliative care is suited for individuals with serious illness regardless of disease stage (whether newly diagnosed or advanced) who are receiving treatment intended to cure their condition or prolong life.

On the other hand, hospice care is an alternative to life-prolonging therapies.

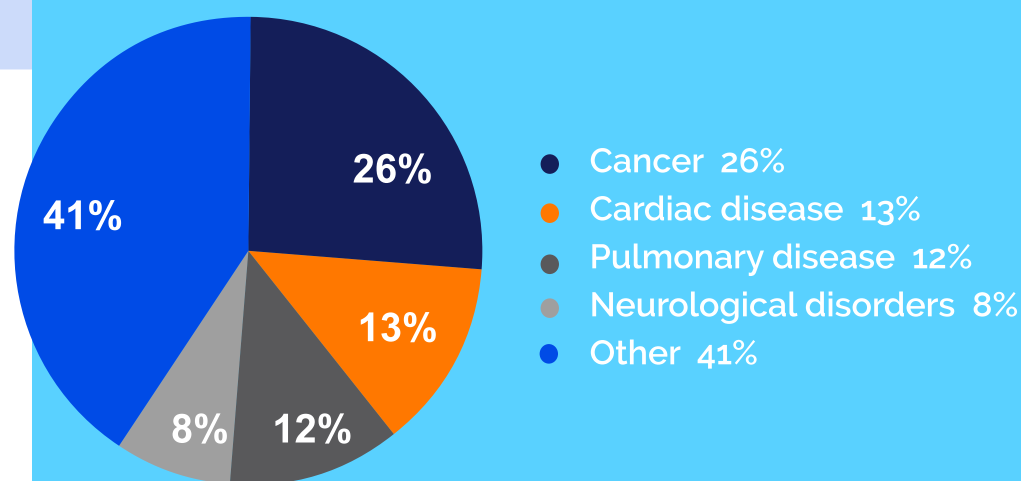
MYTH #2: Palliative care is only for individuals with certain diseases, especially cancer

THE FACTS:

Palliative care supports patients and families affected by a broad spectrum of conditions[2]

Many patients with cancer receive palliative care, but patients with other conditions do as well.

Palliative care can benefit those with cardiac or pulmonary diseases, neurologic disorders, infectious diseases (like COVID-19 or Lyme disease), genetic disorders (like sickle cell anemia), or even traumatic injuries.



MYTH #3: A hospital is the only setting where an individual can receive palliative care

THE FACTS:

Individuals can receive palliative care wherever they call home

Though more than 75% of hospitals with 50-plus beds offer palliative care[3], many individuals can receive care wherever they reside—whether it's their home or a skilled nursing facility. Palliative care providers can deliver many services virtually, too. And with digital medical exam devices, palliative care providers can even monitor vital signs and administer physical exams remotely.

MYTH #4: Palliative care addresses only individuals' physical discomfort

THE FACTS:

Palliative care can address medical, behavioral, and social needs

Palliative care teams are staffed to address physical, psychosocial, emotional, and spiritual needs of individuals, as well as their families.

For example, to ensure whole-patient care, Aspire palliative care teams include physicians, pharmacists, advanced practice providers, behavioral health specialists, nurses, nutritionists, social workers, care coordinators, and even a network of clergy.

MYTH #5: The palliative care team replaces the individual's primary provider

THE FACTS:

The palliative care team partners with a patient's providers

The palliative care team delivers care in partnership with an individual's primary and specialty providers.

While the latter direct curative and life-prolonging therapies, the palliative care team provides an extra layer of care: they manage disease symptoms and adverse effects from treatment, address behavioral health and social needs, help with practical needs, such as procuring durable medical equipment, and facilitate advance care planning.

Better care for patients with serious illness

With the Aspire palliative care program, CareMore Health provides an extra layer of multidisciplinary support for patients with serious illnesses, and their families.

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1. National Hospice and Palliative Care Organization, 2019. https://www.nhpco.org/wp-content/uploads/2019/04/PalliativeCare_VS_Hospice.pdf
2. Rogers M, Dumanovsky, T. How We Work: Trends and Insights in Hospital Palliative Care. The Center to Advance Palliative Care and the National Palliative Care Research Center. February 2017.
3. Center to Advance Palliative Care. The Case for Hospital Palliative Care. 2018.

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