Hospice Care Facts

Hospice is not a place. Those who choose hospice services near the end of life do not "go into" hospice but receive services where they live. This could be a private residence, assisted living community or nursing home. Some hospitals have hospice beds; however, the intention of hospice is to deliver hospice services to the patient wherever he/she calls home.

Loved ones and relatives are not kept from participating in caring for the hospice patient. In fact, they're a part of the team. Every patient has an interdisciplinary team that starts with the patient and family: patient, family caregiver, physician, nurse, social worker, chaplain, hospice aid, bereavement specialist, and volunteer. A plan of care is created that family and loved ones carry out at home to the extent they are willing and able.

Hospice is not a last resort. When medical treatments can no longer cure a disease, hospice professionals can do many things to control pain, reduce anxiety, offer spiritual and emotional support, and improve quality of life for terminally ill people and their families.

Hospice has no religious affiliation. Hospice provides chaplains and other spiritual counselors from all faiths and no faith. They respect all cultures and points of view and are there to lend support and discuss the patient's and the family's feelings.

Hospice is not just for cancer patients. Certainly, cancer patients make up a large number of hospice patients. However, anyone who has a terminal illness, whether it's heart disease, COPD, liver disease, kidney failure, stroke, ALS, Alzheimer's disease, multiple sclerosis, AIDS or any life-limiting condition, is eligible for hospice care.

Hospice care is not expensive. Hospice is usually less expensive than conventional care during the last six months of life. Hospice is an all-inclusive benefit covered by Medicare and most private insurance companies. Under Medicare there are no co-pays for physician visits, nursing care, medications, hospice equipment or medical supplies related to the patient's primary illness.

The patient's personal doctor is not excluded. A patient's personal physician can choose to be part of the hospice care team. Hospice doctors have extensive training in end-of-life care and will work closely with a patient's personal physician to ensure the patient is as comfortable as possible.

Hospice does not forego medications or treatments. On the contrary, hospice takes advantage of state-of-the-art medications and palliative treatments to relieve pain and symptoms to keep patients comfortable.

Families are not shielded from the hospice patient. Hospice professionals believe that when family members—including children—experience the dying process in a caring environment, it helps to counteract the fear of their own mortality and the loss of their loved one.

Hospice does not mean anyone has failed the patient. Hospice is a mode of medical therapy that may be more appropriate than curative procedures for people with terminal illness. Hospice focuses on symptom management, controlling pain and addressing spiritual, emotional and psychological comfort.

Hospice is not about giving up; it's about living in comfort and dignity for the time one has left.

Hospice does not make death come sooner. The goal of hospice is neither to prolong life nor hasten death, but to make the quality of the patient's life the best it can be in their final months, weeks and days. There are no studies that indicate that hospice can hasten death, but there have been studies showing that some patients live longer when receiving hospice services.

Hospice is not the same as euthanasia. Death is a natural part of the cycle of life, and hospice neither prolongs life nor hastens death. The goal of hospice is to provide pain control, symptom management and spiritual and emotional support to help seriously ill people live in comfort and dignity until they die. Euthanasia (youth-en-asia) is purposeful mercy killing to end suffering. It is not provided by hospice.

A hospice death is not the same as a physician-assisted death. In hospice, a patient's terminal disease state is allowed to progress to its natural conclusion. In a physician-assisted death, a physician, at the request of the patient, provides the means for the patient to end life early.

Hospice may withhold nutrition and/or hydration at some point in the dying process. There are many things to consider when it comes to nutrition and hydration for patients near the end of life. Since the natural progression of a patient's disease interferes with the body's ability to process foods and fluids, it is expected that terminally ill patients will begin to eat and drink less and less.

A nasogastric tube (a feeding tube through the nose and throat and into the stomach) or gastrostomy tube (a feeding tube that goes through the abdominal wall and into the stomach) can be put in place to provide nutrients when a patient cannot eat. But these can be painful/uncomfortable medical procedures with potential complications, including infections, electrolyte and mineral imbalances, vomiting and diarrhea.

Artificial nutrition and hydration do not usually help the hospice patient feel better, feel stronger or live longer. Most dying patients do not experience hunger. Those who do feel hunger are satisfied with small amounts offered upon request. Hospice physicians are specially trained to know when it is appropriate to intervene with artificial nutrition and hydration support.

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