The Fear Factor: Confronting the Myths and Realities of Palliative and Hospice Care

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Objectives

- Identify common fears and misconceptions about palliative/hospice care
- Distinguish between palliative and hospice models
- Apply communication strategies to reduce fear and stigma
- Use practical tools in real-world NP settings

Audience Poll

What comes to mind when you hear 'palliative' or 'hospice care'?

The 'Scare' in Healthcare

- Fear of 'giving up’
- Fear of 'death tomorrow’
- Fear of 'loss of control’
- Fear of 'no treatment'

Myth vs. Fact Quiz (Poll)

1. Hospice is only for cancer patients.
2. Palliative care means no more treatment.
3. Hospice means someone will die within 24 hours.

Evidence Snapshot

- Earlier palliative = better quality of life
- Reduced ED visits/readmissions
- Improved patient & family satisfaction
- May extend life in some cases

Palliative

Any stage, alongside treatment

Overlap

Symptom management, holistic care, team approach

Hospice

Prognosis ≤ 6 months, comfort-focused

Palliative Care or Hospice?

- 78-year-old COPD, hospitalizations, still on inhalers
- 62-year-old pancreatic cancer, stopping chemo
- 90-year-old dementia, recurrent infections

The NP’s Role

- Identify unmet needs
- Normalize early conversations
- Bridge across settings
- Advocate for quality of life

Serious Illness & End-of-Life Conversations

- Normalize advance directive discussions early
- Use structured frameworks (POLST, Five Wishes, etc.)
- Focus on patient values, not just treatments
- Address cultural and family dynamics
- Revisit conversations regularly—not one-time events

Words that Help / Words that Hurt

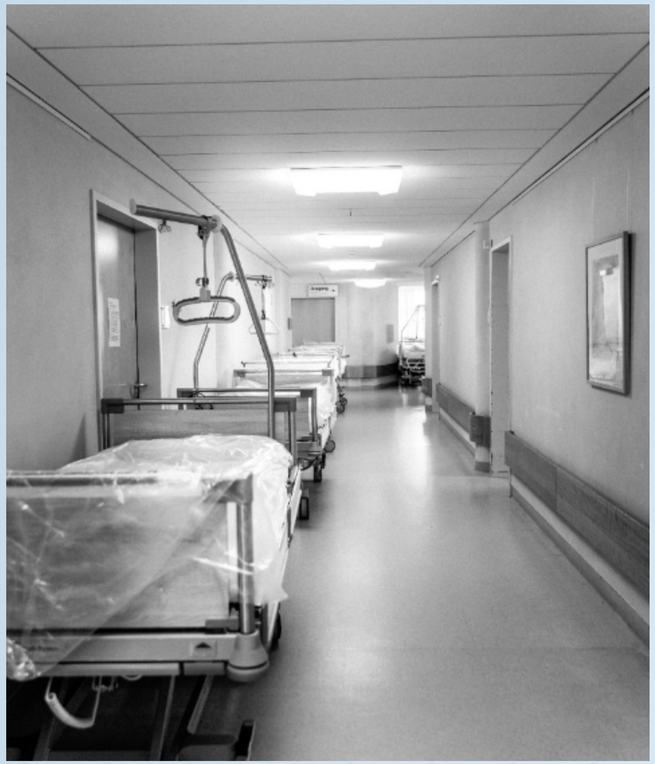
- Helpful: 'Our focus is on what matters most to you.’
- Helpful: 'We’ll support you through every stage.’
- Hurtful: 'There’s nothing more we can do.’
- Hurtful: 'It’s time to give up.'

Role-Play Prompt

- Patient says: “I don’t want palliative care because it means I have to give up everything.”
- How would you respond?

Role-Play Prompt

- Patient says: “I don’t want hospice because it means I’ll have to give up.”
- How would you respond?



Case Scenario 1

Hospitalist NP: CHF, 3 readmissions in 2 months

Fear: More hospital = better chance

Opportunity: Palliative consult for symptom management & goals of care

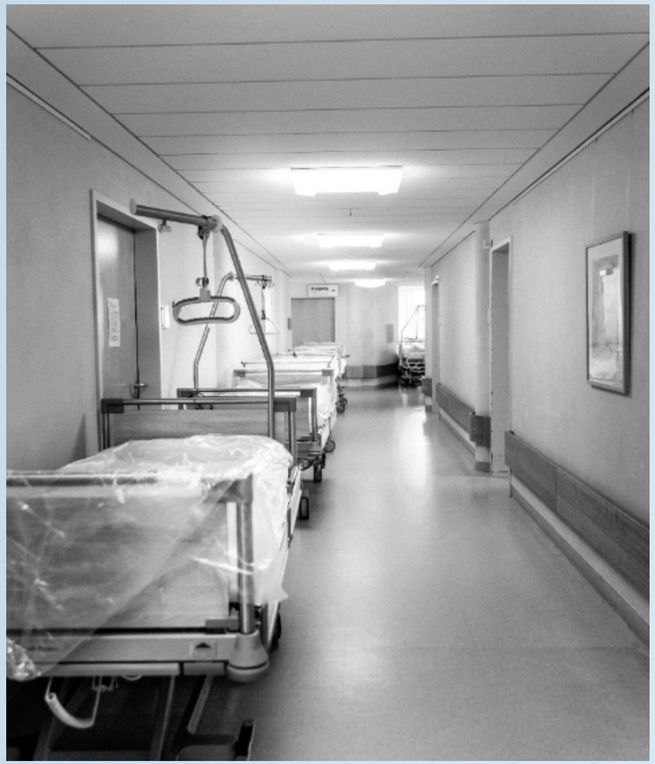
Primary care is the perfect setting to introduce palliative principles before crises occur.

Case Scenario 2

Primary Care NP: COPD, declining function

Fear: 'If I start oxygen, I'll become dependent.'

Opportunity: Normalize advance care planning & support



Case Scenario 3

Rural FNP: Advanced dementia, limited hospice

Fear: 'We don’t have resources here.’

Opportunity: Telehealth, partnerships, home palliative visits

Group Discussion

Choose one scenario:

1. What fears are present?

2. What palliative approach could help?

3. How would you start the conversation?

Key Takeaways

Fear is common—but manageable

Myths delay essential care

NPs are change agents

Palliative = More quality, more dignity, more peace

Hospice = Better quality, dignity with death, less suffering and more peace

Reflection Question

What’s one thing you’ll do differently in your practice this month?
(Live Poll)

Resources

- Center to Advance Palliative Care (CAPC)
- ELNEC (End-of-Life Nursing Education Consortium)
- NHPCO resources for providers and families

Closing Remarks

Palliative care is not giving up; it’s showing up differently.

Hospice is not giving up hope; it’s giving the patient something else to hope for.