Improving Quality of Life in Terminal Illness by Palliative Care: Global Perspectives, Multidisciplinary Approach, Advances and Future Directions

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Abstract

It is an evolutionary form of health care, where care for the whole being comes first. This is aimed at treating the physical symptoms such as pain and dyspnoea but designed to tackle emotional, psychological, social, and spiritual concerns as well. Evidence demonstrates that palliative care improves control of symptoms when started early in treatment, improves patient and family satisfaction, and assists in tailoring medical interventions to a patient's values and preferences. But beyond clinical outcomes, there is great support to families for counselling, bereavement assistance, and strategies to manage the emotional burden of caregiving. Cultural misconceptions and geographic disparities and lack of access to trained professionals are other barriers to the widespread practice of palliative care. Innovations in telemedicine and wearable health monitoring and a community-led approach are some of the things changing the face of delivery, making care more inclusive and accessible. This paper engages with the principles and practice of palliative care; its impact on quality of life; and its critical role in promoting dignity, autonomy, and comfort at the end. Systemic challenges can be addressed by emerging technologies, leading to palliative care being universally established as an integral part of compassionate and equitable health care systems.

Keywords: Palliative care, Terminal illness, Pain management, Quality of life, Interdisciplinary approach, Symptom management, Spiritual care.

1. Introduction

Palliative care is a specialized medical approach aimed at improving the quality of life for patients with serious, often terminal illnesses. It focuses on providing relief from symptoms, pain, and stress, regardless of the stage of the disease or the need for other therapies. This care is holistic, so it will touch on the symptom, and it will touch on your emotional and social and spiritual symptom, hence patients and families can be able to live well with their sicknesses (Kavalieratos et al., 2016). Palliative care is different from curative care. This is the care that mainly involves cure of disease but also extends life. While curative care would seek to treat an underlying illness, for instance, palliative care is meant to provide comfort and quality of life, often in addition to curative treatments (Temel et al., 2010). For instance, there is emerging evidence that even the integration of early palliative care into treatment may improve the control of symptoms and patient satisfaction despite curative interventions (Temel et al., 2010; Hui et al., 2014).

Palliative care does not mean hospice care even though it falls under the palliative care, that specifically targets patient's at end of their life usually at the phase when curative treatments are not only not effective, but no longer desired at all. It focuses on comfort and support and for patients in their ultimate stages of life, frequently offered at a patient's home or even in these specialized hospice facilities (Lindley, 2016). Although all hospice care is palliative, not all palliative care is hospice care, and even though palliative care can start at diagnosis and continue with curative treatments, hospice care is only for patients with less than six months to live (Flieger et al., 2020). Palliative care integration has been shown to improve both healthcare utilization and patient outcomes in diverse healthcare settings. For example, studies showed that palliative care patients are hospitalised less often and incur a lower cost of health resources because the treatment is near to the individual goals and preference of patients (Chettiar et al., 2018; Morrison et al., 2011). The timing of implementing palliative care impacts quality end-of-life care. In many cases, earlier palliative care referrals are associated with less aggressive treatments and more use of hospice (Hui et al., 2014; Liao, 2023).

One of the main reasons that palliative care is an integral part of the treatment for dying patients is the fact that it improves the quality of life. These studies have found that the very early implementation of palliative care greatly enhanced the patients' mood, pain, and overall quality of life. One notable landmark study, for instance, established that palliative care in a terminal case of lung cancer enhanced control over the symptoms while on average extended life by three months than a similar group who had no such care instituted during their illness (Temel et al., 2010). This is further backed by other studies that mention the effect of palliative care on aggressive end-of-life treatments so that patients spend their last days in a more dignified and comfortable way (Temel et al., 2010; Chung et al., 2021).

Palliative care also meets the complex physical, psychological, and social needs of patients. It is not only the cancer patients who benefit a lot, but also those who have terminal non-cancer illnesses as well. According to Kennedy et al. (2019), the holistic nature of palliative care includes not only symptom management and psychological support but also in making treatment decisions. Such an intervention is important to patients and their families during the final stages of terminal illness. Zhao et al. (2019) and Etkind et al. (2017) refer to this. This is an important model of care because the patient is usually experiencing a host of distressing symptoms such as pain, anxiety, and depression, which are efficiently managed through palliative care strategies (Zhao et al., 2019; Zimmermann et al., 2016).

Access to palliative care services remains a key issue, and inequalities are seen between cancer and non-cancer patients. It has been established that patients with non-cancer terminal illnesses face barriers in access to palliative care, thus leading to poor symptom management and quality of life (Seow et al., 2018). Thus, it becomes essential to bridge these disparities in order to provide the end-of-life support and care to all patients, irrespective of the diagnosis.

Palliative care also provides benefits to the family in many ways, other than the advantages in patient outcomes. The burden on the mind and psychological state of the family of a terminally ill patient can be huge, and these services include counseling and supporting the caregiver, thereby helping the caregiver to come to terms with the problem of dealing with a loved one who is dying (Wang, 2024). This aspect of palliative care is significant as it not only benefits the patient but also alleviates stress and anxiety that family members feel in these trying moments.

2. Core Components of Palliative Care

Pain management is one of the pillars of palliative care. Effective pain control is crucial for improving the quality of life of patients with chronic and terminal illnesses. Studies show that uncontrolled pain can cause a lot of distress and decrease the quality of life for patients (Fraser et al., 2018). The World Health Organization asks for pain relief as a minimum right and supports the use of analgesics, among which opioids, to guarantee effective control of pain (Fraser et al., 2018). In palliative care, the approach to management of pain must take account of the particular needs for effective management of each patient, ranging from the specific nature of the illness to the overall health and individual preferences of the patient themselves (Kim et al., 2021). Additionally, pain control in palliative care has resulted in the decreased use of aggressive treatments near the end of life and has become more in line with a patient's desires (Temel et al., 2010).

Palliative care also incorporates psychological support aimed at the emotional and mental health well-being of the patient and the family. Research has also proven that psychological distress exists among many patients with serious illnesses; managing the distress can largely improve overall well-being (Ann-Yi et al., 2018). The integration of clinical psychologists into palliative care teams has been proven to promote the psychological support of patients, thus offering improved mechanisms for coping and greater emotional resilience (Ann-Yi et al., 2018). Furthermore, psychological interventions are said to enhance patient outcomes, such as decreased anxiety and depression, which are common in this population (Kozlov et al., 2017). Psychological support is very much in demand during the COVID-19 pandemic, where healthcare workers have identified the need for the integration of mental health care into palliative services to meet the heightened emotional needs of patients (Singh et al., 2021).

Spiritual care is also an essential part of palliative care, acknowledging the need to address the spiritual and existential concerns of patients suffering from life-limiting illnesses. Spirituality may play a significant role in how patients cope with their illness and the dying process, thus affecting their quality of life (Laabar et al., 2021). Palingual care teams often have chaplains or spiritual care providers who join medical professionals in providing integrated care that reaches the spirit of the patients (Laabar et al., 2021). Indeed, existing evidence has established that higher satisfaction in care in general as well as better peacefulness and acceptance of one's state of affairs are associated with spiritual care (Miranda et al., 2019). These measures also help address spiritual issues that allow for better end-of-life preferences and care goals discussions, enhancing treatment concordance with the patient's values and beliefs (Kavalieratos et al., 2017).

These three major elements of palliative care-pain management, psychological support, and spiritual care-must be brought together in the delivery of palliative care to achieve a comprehensive and compassionate service. Studies have reported that the involvement of a multitude of health care professionals brings more efficacy to palliative care treatment interventions (Kim et al., 2021). For example, multidisciplinary collaboration between the physician, nurse, psychologist, and spiritual care provider allows more holistic assessment of the patient needs, hence tailored interventions that address the physical, emotional, and spiritual aspects of care (Kavalieratos et al., 2017). Moreover, education of doctors and other healthcare professionals should be conducted in the principles of palliative care so they can provide quality care that addresses the various requirements of patients and their relatives (Spetz et al., 2016).

Some of the key roles of ACP in palliative care include being able to offer anticipatory guidance such that patients and their families appreciate the course of their illness, which will affect future decision-making on care. For example, Brizzi et al. emphasize that palliative care specialists support patients in understanding the function of hospice care and meet bereavement needs, which also signifies the necessity of proactive conversations about end-of-life care (Brizzi et al., 2019). Similarly, Hafer et al. point out that ACP is usually the most frequently cited reason for referral to palliative care specialists, especially for patients with neurological conditions, highlighting the need to have special skills in this kind of discussion (Hafer et al., 2021).

In addition, research showed that patients who participate in ACP are better placed to receive appropriate palliative interventions.This means ACP does not only benefit from improvement of patients' autonomy but also helps with greater symptom management and also their satisfaction with care overall. For instance, instead, Kastbom et al. found that prescriptions for palliative medication among ACP participants were much higher when compared to non-A PCP participants (Kastbom et al., 2022). Moreover, the COVID-19 pandemic has made the launch of ACP conversations important, as it was soon realized that the comprehension of the values and preferences that a patient holds is integral in care planning during emergency episodes (Dujardin et al., 2021).

Moreover, ACP effectiveness is further confirmed through its effects on cost and resource use within health care. Evidence-based studies reveal that early integration of palliative care, such as ACP, leads to a reduced amount of aggressive treatment at the end stages of life and overall lower costs for healthcare (Temel et al., 2010). The application of early palliative interventions in oncology is more relevant because early interventions are reported to result in better documentation of resuscitation preferences and reduced unnecessary interventions (Temel et al., 2010). In addition, there has been evidence of increasing advance care plan completion rates where discussions are facilitated by trained facilitators, further supporting the need for a structured approach to such discussions (Detering et al., 2010).

3. Role of Palliative Care in Terminal Illnesses

It has been shown, in the context of cancer, that early initiation of palliative care significantly improves the quality of life. Such an example is the evidence obtained from patients with advanced NSCLC, who experienced improved quality of life and reduced aggressive end-of-life interventions and even improved survival when included in early palliative care compared to standard care (Zhuang et al., 2018; Temel et al., 2010). The systematic review by Kavalieratos et al. further supports this, showing that palliative care not only improves outcomes for patients but also that of caregivers (Kavalieratos et al., 2016). The qualitative study showed that, in comparison to those patients who did not receive palliative care, those who received such care were more likely to have advance care planning discussions-things that are very necessary for aligning treatment to patient preferences (Ahmed et al., 2020).

Palliative care benefits advanced cardiovascular disease. Palliative care indeed reduces the disturbing symptoms like pain and dyspnea that are very prevalent in patients with heart failure. From the literature review, patients who had consultations with a palliative care specialist noticed a reduction in symptom burden and improved quality of life (Hnyda & Avadhani, 2017; Kavalieratos et al., 2014). Advance care planning is also an area of significant need in the management of heart failure; that is, many patients would have to make choices, for example, at times as regards being aggressively treated or being comfort focused. Implementing palliative care as part of the treatment process enhances patient satisfaction and reduces hospital stays for an improved quality of overall care. Such is indicated through studies such as those made by Hnyda and Avadhani in 2017 and Kavalieratos et al. 2014.

For patients suffering from end-stage respiratory diseases, palliative care is important in the management of chronic symptoms and improvement of life quality. Palliative care intervention research shows that interventions could cut across significant symptoms in most palliative care conditions such as those faced in COPD cases (Hnyda & Avadhani, 2017). Home-based intervention among respiratory patients showed a decrease in their level of symptoms, such that quality of life improves during intervention (Maetens et al., 2019). Furthermore, holistic care in palliative care settings promotes psychological support, which is an important aspect of dealing with the emotional distress associated with chronic respiratory illnesses (Hnyda & Avadhani, 2017).

Neuro degenerative diseases, like ALS, Parkinson's disease, and dementia, are those problems that palliative care best can address. Teams of palliative care can offer holistic support that includes symptom management, psychosocial support, and assistance with decision-making regarding care preferences (Kavalieratos et al., 2016; Zimmermann et al., 2016). As in such diseases as Alzheimer's, for example, based on the evidence of many studies, patients with palliative care show improvements and a reduction in burden placed on caregivers (Kavalieratos et al., 2016). Again, early interventions of neurodegenerative diseases using the approach of palliative medicine showed improved control of symptoms by the patients and satisfaction concerning received care (Zimmermann et al., 2016).

The underlying theme of these many conditions is that palliative care plays a crucial role in improving the quality of life by alleviating symptoms, providing psychosocial support, and making advance care planning. Evidence therefore strongly supports the concept that end-of-life care should not be considered as a stand-alone modality but rather an integral part of the treatment plan from the time of diagnosis (Meffert et al., 2016). This not only benefits the patients but also saves the caregivers from the stresses of psychological and physical strain and contributes to better general family experience with the health service (Ahmed et al., 2020; Kavalieratos et al., 2016).

Palliative care has been established to dramatically increase the satisfaction of patients as well as families during the end stage through a plethora of mechanisms. One of the ways it does this is by giving respect and integrating patients' preferences and values into their care plans. For example, the research by Temel et al. illustrated that patient with metastatic lung cancer, receiving early palliative care, had more documented resuscitation preferences-very essential to respect patient's preferences at the end of life (Temel et al., 2010). This is a proactive approach in which, besides clarifying what the patient wants, reduces the aggressive interventions so that they could have a dignified death (Temel et al., 2010). Indeed, early integration of palliative care during treatment has been linked with improved quality of life and higher satisfaction rates among both patients and their families (Huen et al., 2019).

It is also important to note that emotional and psychological support provided by palliative care teams enhances satisfaction. There is evidence that effective palliative care may relieve symptoms of depression and anxiety and improve the quality of life generally for the patient and their family (Temelli & Cerit, 2019). It is this very same research study that has shown a more elevated level of satisfaction through supporting and educating the family caregivers about the process of palliative care, where it gives them better skills to take responsibility and tackle their emotional loads (Galatsch et al., 2017). Furthermore, an environment of highly specialized palliative care professionals has been linked to an environment that possesses open communication; this then opens the environment to effective discussion of complex needs the patients and their families have in mind (Aboshaiqah et al., 2016).

In addition, home-based palliative care has been associated with high satisfaction levels by providing care within a well-known environment. Patients under home-based palliative care experienced a better quality of life and comfort than those in the hospital setting and can be associated with lower anxiety and depression levels among family members (Kerr et al., 2014; Balasubramanian et al., 2021). The same home-based environment also allows families to be more participative in the care process, which enhances their perceived control and satisfaction with the care received (Biswas et al., 2022). Besides, research has established that home-based palliative care reduces the cost of treatment while at the same time improving the outcomes for patients, which increases patient and family satisfaction (Lindayani & Maryam, 2017; Gomes et al., 2013).

4. Multidisciplinary Approach in Palliative Care

Usually, the physicians remain at the center of coordination for palliative care and take charge of medical treatment ensuring proper relief of symptoms that may be affecting the patient; they coordinate with other members in creating a comprehensive care plan tailored to the medical and psychosocial needs of their patients. Communication between members of the care team has been shown to be key in ensuring effective utilization of patients in a palliative care setting as demonstrated in studies by Spetz et al. 2016; Hui et al. 2010. Physicians play an essential role in educating the patient and the family on the expectations of the goals of palliative care hence ensuring that the misconceptions and fear associated with this process are reduced (Taels et al., 2023).

Nurses are part of the multidisciplinary team that provides care for palliative care and therefore may be the first point of access for patients and their loved ones. They provide continual care and support, managing symptoms and advocating for their patients' needs. Research has suggested that nurses frequently provide emotional support and counseling, helping people cope with the challenging experience of severe illness (Guan, 2024; Damen et al., 2018). Their presence is crucial in building a relationship of trust with patients, and this will have a wide impact on the experience of care (Brinkman-Stoppelenburg & Heide, 2015). Furthermore, nurses take the responsibility of coordinating among disciplines to ensure that all facets of a patient's care are met (Koper & Pasman, 2018).

Social workers also play an important role in palliative care by addressing the psychosocial aspects of care for patients. They offer counselling and support to patients as well as their families on the emotional and social issues precipitated by severe illness (Guan, 2024; Taels et al., 2023). Social workers can be useful for the process of having family meetings, resolving conflicts and directing the families to any relevant resource within the community-activities that may boost the quality of life in a patient's life (Taels et al., 2023; Damen et al., 2018). Especially in terms of the intricate family dynamics, and in ensuring that patients' wishes are respected and honored (Guan, 2024).

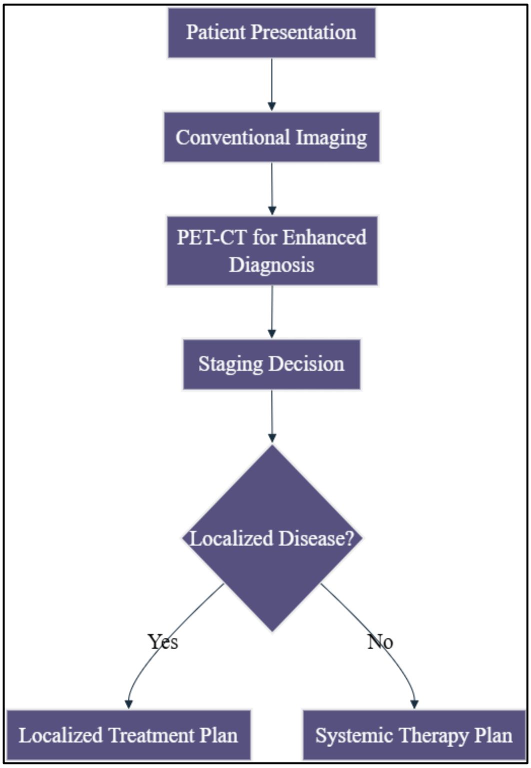

Figure 1. This flowchart illustrates the core framework of palliative care, emphasizing its multidisciplinary approach to addressing physical symptoms, emotional well-being, and spiritual needs to improve patients' quality of life and achieve holistic care.

Chaplains add another dimension to the care provided by bringing an element of addressing the spiritual needs of the patient as well as the family. Spiritual care is a relevant element in holistic palliative care. It can become important to the emotional well-being of the patient and quality life of the patient because studies have showed this to be the case (Gijsberts et al., 2019; Goldberg et al., 2021). A chaplain's practice would include spiritual care assessment, crisis intervention, and even decisions for dying to provide for hope and meaning in patient and family suffering (Olsman, 2020; Fitchett et al., 2011). Having chaplains’ part of the interdisciplinary team would help improve communication and enhance the appreciation of what other members of the team are trying to say. Sometimes, they can produce something that is not easily understandable when viewed only medically (Galchutt & Connolly, 2020). In studies, patients often request spiritual care, indicating the need for chaplains in palliative care (Flannelly et al., 2012; Howard et al., 2021).

One of the very foundational elements of successful interdisciplinary collaboration is shared understanding and mutual respect among team members. A review of literature indicates that successful teamwork is supported by shared mental models, trust, and effective communication strategies, which are significant in ensuring that all the team members are aligned toward their goals and approaches to the care of patients (Weaver et al., 2014; Weller et al., 2014). It has been determined that structured communication techniques and training programs for teams do much to improve teamwork, particularly in high-stakes situations, such as emergency care and surgery (Weaver et al., 2014; Aaberg et al., 2019). Most training programs plan and assess readiness prior to team member participation to ensure seamless effective working (Weaver et al., 2014).

Moreover, interprofessional education in healthcare training is important for developing teamwork skills in future healthcare providers. The earlier students are exposed to collaborative practices, the better prepared they are to function in an interdisciplinary team when they start work (Bridges et al., 2011; Rajadurai, 2021). Not only does this kind of education enhance individual competencies but also a culture of collaboration that is required to deliver patient-centered care (Baek, 2023). Teamwork impact on outcomes in patients is also well articulated. Research work implies that effective collaboration among healthcare professionals ensures a decrease in medical errors and patient dissatisfaction among many others and improvement in the quality of care provided (Costello et al., 2021; Skoogh et al., 2022). For example, a systematic review showed that greater teamwork levels are related to safer patient outcomes, and therefore the cohesive team dynamics are essential for risk minimization (Schmutz et al., 2019; Kalisch et al., 2010).

Moreover, the supportive team environment is related to the job satisfaction of healthcare workers, which leads to a lower turnover rate and improved patient care (Bakht, 2024). However, the barriers to the effective teamwork of the healthcare setting include hierarchical structures, communication failure and variance in professional cultures. To address these barriers will require targeted strategies: fostering inclusivity and democracy within teams and implementing regular team-building activities (Sanford, 2024). Understanding each team member's unique roles and contributions is important for maximizing the strengths of the interdisciplinary team (Morley & Cashell, 2017).

Most of the home-based palliative care is provided by family caregivers, and it has been estimated that they are the ones providing 75% to 90% of care to patients approaching the end of life, making them the bedrock of the palliative care workforce (Gardiner et al., 2019). This can create a high-level emotional attachment, but it causes caregivers much burden as they become helpless and guilty in coping with the end-of-life process, hence causing emotional anxiety to them as well (Gomes et al., 2013; Hudson et al., 2010). The emotional and physical pressures of caregiving may lead to negative health effects for caregivers: fatigue, anxiety, and depression (Hudson et al., 2010; Hudson & Payne, 2011).

Optimizing care delivery requires communication between healthcare providers and family caregivers. Poor communication among families who received end-of-life care was revealed in studies as the primary reason for complaint, raising importance for healthcare professionals to involve caregivers in discussions about care plans and preferences of the patient (Zadeh et al., 2018; Woodman et al., 2015). This involvement is also advantageous for caregivers as it increases their feelings of being supported. In addition, it guarantees quality care for patients since it provides the services in conformity with the wishes and needs of the patients (Ornstein et al., 2017; Ateş et al., 2018).

Caregivers also sometimes need support systems for themselves. Study results show that caregivers have unresolved support needs that can be met using interventions focused on structured support and resources aimed at their situation (Bijnsdorp et al., 2020; Demiris et al., 2019). Tools have been designed through systematic approaches- such as the Carer Support Needs Assessment Tool (CSNAT)-to assess caregivers' support needs systematically, thereby supporting them in executing their caregiving roles successfully (Ewing & Grande, 2012; Becqué et al., 2021). In addition, interventions about grief counseling and psychological support have been used to reduce some of the burden associated with caregiving, especially in terminal illness cases like cancer (Wu et al., 2020; Wong et al., 2022).

5. Pain and Symptom Management

Managing pain in the terminally ill is a rather complex challenge that calls for the implementation of a comprehensive method to ensure effective relief of pain and improvement of the quality of life. The major use of opioids is to control pain; it has been proved to be the most effective analgesic for severe pain conditions related to terminal illnesses. Weidner and Plantz emphasize that opioids are not only the best choice for pain relief but also recommended for managing dyspnea at the end of life, highlighting their critical role in palliative care (Weidner & Plantz, 2014). Besides this, Zhao et al. pointed out that pain in cancer patients is multidimensional and multi-factorial and thus should be dealt with in an integrative model involving physical, psychological, social, and spiritual aspects of the patient (Zhao et al., 2019).

Non-pharmacological strategies are also required, besides pharmacological interventions. According to Cerit et al., there is an increase in the overall well-being of the terminally ill when they are given effective medical care together with emotional and spiritual support (Cerit et al., 2021). This is also what Tang et al. had pointed out where most patients and their families find that the pain management provided is lacking and hence should be done more profoundly through both pharmacological and supportive treatments (Tang et al., 2010).

Moreover, the use of adjuvant medications, such as pregabalin, can be beneficial in managing neuropathic pain, which is often prevalent in terminally ill patients (Bhawna et al., 2022). This opioid adjuvant combination is capable of treating more types of pain than opioids alone. Kennedy et al. assert the need for individualized approaches to pain management for each group of patients (Kennedy et al., 2019). There are also advanced methods in intrathecal analgesia for patients with refractory pain, which are not relieved by systemic analgesics. According to Whyte and Lauder, intrathecal infusion of analgesics shows better control of pain with fewer adverse effects than with conventional interventions (Whyte & Lauder, 2011). Such a technique is not without its invasive approach but might be justified if all other measures have failed.

Table 1: Benefits of Early Palliative Care Integration.

Aspect	Outcome	Citations
Symptom Management	Improved control of pain, nausea, and dyspnea.	Zhao et al. (2019); Zimmermann et al. (2016)
Patient Satisfaction	Higher satisfaction rates due to tailored interventions.	Chung et al. (2021); Ahmed et al. (2020)
Healthcare Utilization	Reduced hospitalizations and aggressive treatments.	Hui et al. (2014); Morrison et al. (2011)

Effective communication between health care professionals and patients is also an important element in pain management. According to Wu, hospice care providers need to be communicative to talk to their patients about not just physical but psychological and spiritual pain and distress as well (Wu, 2020). This way, the approach ensures that patients are being heard and catered to properly throughout their journey.

Nausea is a very common symptom in palliative care, often from the illness itself or side effects from treatments like chemotherapy. Nausea has been proven to impair the quality of life in patients, which makes controlling it a concern in any palliative environment (Hansen et al., 2022; Glare et al., 2011). There are several pharmacological methods to treat nausea, and the antiemetics include haloperidol and ondansetron. They have proven to be highly effective in managing nausea and vomiting in patients who receive palliative care (Murray-Brown & Dorman, 2015; McLean et al., 2013; Prommer, 2011). Moreover, non-pharmacological treatments, including aromatherapy, have recently been reported. In that context, peppermint oil was found to relieve nausea due to its effects on serotonin and dopamine receptors (Mariyana, 2024). Nausea is usually multifactorial and hence needs to be addressed appropriately while devising the treatment plans, as mentioned in the case of Hansen et al., (2022).

Another very disturbing symptom of palliative care is dyspnea, or shortness of breath. Dyspnea is generally associated with cancer or heart failure in its late stages of disease (Årestedt et al., 2021). There are pharmacologic interventions for managing dyspnea, for example opioids, which serve to relax the patient not only by abolishing pain but also assuaging their dyspnoeic feeling due to soothing effect (Skjoedt et al., 2020; DeVader et al., 2012). Non-pharmacological interventions, such as supplemental oxygen and breathing techniques, are also part of the management of this symptom (Wu et al., 2015). The holistic approach of palliative care emphasizes that the management of dyspnea should involve both medical and supportive measures to improve patient comfort.

Anxiety is common among patients receiving palliative care, and it often worsens because of the unknown nature of their illness and the dying process (Taylor et al., 2022). Pharmacological management could include benzodiazepines or antidepressants that could be helpful in reducing anxiety and symptoms (Skjoedt et al., 2020; Hansen et al., 2019). In addition, psychological interventions in the form of counseling and mindfulness practice are essential when dealing with palliative care in which psychological and emotional needs are addressed (Sarmento et al., 2017; White et al., 2017). With these approaches, an atmosphere of relaxation and support will be provided to improve the feelings and comfort of patients.

6. Psychological and Emotional Support

Importance of therapeutic communication is reduced anxiety and tension of patients; a good amount of research has proven to reduce significantly due to therapeutic communication; there is one study that demonstrated its positive sign, that good communication practice decreased the anxiety of the treated child by 10.7 times more than poor communication practices (Ridho, 2023). Similarly, therapeutic communication by nurses can help patients deal with anxiety in critical situations, such as pre-operative preparations, through calm and empathetic interactions (Mahyuvi, 2023). Such a reduction in anxiety is not only helpful for immediate coping but also helps in long-term psychological resilience.

Furthermore, therapeutic communication raises the awareness of self-care for patients and skills to meet their physical and emotional needs. A study reveals that patients who experienced successful therapeutic communication recorded greater satisfaction and coping skills, which are essential in recovery (Abdolrahimi et al., 2017). This is even more relevant in the field of palliative care because clear and honest communication by healthcare providers has been documented to improve patient satisfaction and promote better coping among seriously ill patients and their families (SeccarecciaDori et al., 2015). The setting of an open and supportive relationship with therapeutic communication leads to allowing patients to express their views and emotions, which forms the key to the patients' emotional recovery.Besides this, health care providers are closely linked to patients due to the application of therapeutic communication; hence it provides them with proper health care results. For instance, nurse therapeutic communications are viewed as more support and care giving, a characteristic that will enable them in building patients' trust and help the patients become more alert in their care. This in turn is very important toward building successful coping skills because with supportive care, patients stand higher chances of expressing the need for them, thereby achieving an overall improved treatment process (Prasasta et al., 2022). Further, the active listening and empathic response from healthcare practitioners enhance a therapeutic relationship that strengthens the patients' capacity to live with the condition (Harianthy, 2023).

7. Spiritual and Cultural Dimensions

Palliative care is a crucial aspect in treating the spiritual needs and many questions about existence among terminal patients. This model is concerned with the realization of the fact that spirituality should form part of total holistic care, which encompasses dimensions concerning physical, psychological, social, and spiritual (Best et al., 2023). Effective palliative care always enhances the quality of lives for patients and their family members while working on these tough problems with life-threatening conditions as put by the World Health Organization (Best et al., 2023).

Spiritual care in such palliative environments is very much about learning to search for meaning, connections and hopes in themselves and in their lives for patients (Gijsberts et al., 2019). Questioning the meaning of death and life is the core issue that terminally ill patients deal with, which can lead to spiritual distress (Wang et al., 2023). Only through the humane attitude of healthcare professionals can such needs be met; for instance, such professionals will be able to gain the trust of patients and thus hold open conversations with them on their spiritual concerns (O'Callaghan et al., 2019). The human relationship is the basis that provides a context where the patients feel comfortable in sharing their fears and doubts, and thus, becomes an indispensable requirement to spiritual care (O'Callaghan et al., 2019).

Table 2: Key Components of Palliative Care.

Component	Description	Citations
Pain Management	Addresses chronic pain using opioids, adjuvants, and non- pharmacological strategies.	Fraser et al. (2018); Kim et al. (2021)
Psychological Support	Manages emotional distress, enhances coping mechanisms, and reduces anxiety and depression.	Kozlov et al. (2017); Ann-Yi et al. (2018)
Spiritual Care	Provides existential support to improve acceptance and alignment of care with patient values.	Kavalieratos et al. (2017); Miranda et al. (2019)

On the contrary, the biopsychosocial-spiritual model of care also encourages the provision of spiritual care in the context of psychological and medical treatments (Rêgo & Nunes, 2016). This theoretical model indicates that spiritual well-being is very associated with a patient's quality of life, when he or she faces his or her terminal condition (García-Navarro et al., 2021). Studies have evidenced the fact that if the spiritual care given is meeting the needs of a patient, then in most ways, the patient will generally accept their situation and feel at peace with it, thereby leading towards end-of-life care (Wisesrith et al., 2021). For instance, terminally ill cancer patients who received spiritual care had dignity in their last days (Wisesrith et al., 2021).

Despite its acknowledged importance, spiritual care still faces challenges in its implementation in palliative care. Most healthcare professionals feel unprepared to address spiritual concerns that could hinder their ability to give holistic care (Mahilall & Swartz, 2021). In addition, spiritual care is generally the most underdeveloped aspect of palliative care. This is usually manifested through inconsistencies in meeting spiritual needs from one healthcare environment to another (Sutarta & Ariani, 2022). This therefore requires urgent improvement in the level of training and resource to prepare the health professionals adequately for effective work with spiritual dimensions of care in patient management (Espinel et al., 2022).

8. Challenges in Providing Palliative Care

Lack of infrastructure and trained personnel remains a significant challenge to access palliative care in resource-poor settings. A lot of low- and middle-income countries either have a few established or no palliative care services at all. More than half of low-income countries have no known hospice or palliative care activity (Sleeman et al., 2019). The shortage of trained palliative care healthcare professionals then amplifies the unavailability of infrastructures, which is essential for efficient service provision (Salikhanov et al., 2023). An example is in the Philippines, where poor availability of the palliative care workforce and out-of-pocket health expenditure that is too high add to the problem of access (Ho et al., 2023). The lack of formal education about palliative care among providers leads to poor provision and lacks awareness of why it is given (Salikhanov et al., 2023).

Cultural factors have greatly hindered access to palliative care. Cultural beliefs and practices often lead to misconceptions in many communities about what palliative care is all about. In most cases, people associate it with end-of-life care rather than a comprehensive management of serious illnesses (Law, 2024). For instance, religious fatalism and the value of family-oriented relationships may affect patients' and families' readiness to embrace palliative care, preferring instead to rely on more traditional or familial care (Ho et al., 2023). There is also the communication barrier where people have different languages or health literacy levels that affect the effective dialogue between providers and patients, thereby complicating the access to necessary services (Esmaili et al., 2018).

Geographic disparity contributes to unequal access to palliative care. The literature has documented significant regional variability within countries such as Colombia regarding the accessibility of palliative care services. Many regions lack resources to provide for their population needs (Vargas-Escobar et al., 2022). Socioeconomic factors worsen this geographic imbalance, particularly for marginalized populations, who suffer from more than just access problems due to financial restrictions and the unavailability of public transport (Vargas-Escobar et al., 2022). The World Health Organization emphasizes recognition of such geographic disparities as critical factors in access to palliative care, according to Vargas-Escobar et al., 2022.

Table 3: Barriers to Palliative Care Access.

Barrier	Impact	Citations
Cultural Misconceptions	Delays in seeking care due to associations with end- of-life treatment only.	Law (2024); Ho et al. (2023)
Geographic Disparities	Limited access in rural and underserved areas.	Vargas-Escobar et al. (2022)
Resource Limitations	Insufficient trained personnel and infrastructure in low-income settings.	Sleeman et al. (2019); Salikhanov et al. (2023)

Systemic factors such as bureaucratic obstacles and poor policymaking can further limit integration of palliative care services into LMICs' present health systems. In all LMICs, palliative care is not given its rightful priority in health policies, and hence there has been insufficient funding and capacity for the implementation of palliative care projects (Brant & Silbermann, 2021). A confused strategy to integrate palliative care services into primary healthcare can lead to fragmented care and missed chances for early intervention (Radfar, 2022).

9. Advances and Innovations in Palliative Care

Telemedicine is an integral element in the delivery of palliative care, as the pace set by the COVID-19 pandemic has enhanced its growth and adoption. Recent studies have revealed that telehealth service provision permits healthcare practitioners to maintain proximity to the patients, thus carrying out quick evaluation and intervention without requiring them to come physically. Telehealth is possible and acceptable as an option for palliative care delivery, mainly for isolated communities where the access to high-level care may be low, as reported by a systematic review by Gordon et al. (2021). The best feature of virtual models of care lies in optimizing existing digital health technologies with bi-directional communication systems which can respond quickly to ever-changing patient needs (Disalvo et al., 2021). This is the dynamism of palliative care, where the symptoms vary very significantly.

The wearables are also crucial for upgrading the delivery of the care. They can keep tabs on the patient's vital signs and symptoms in real time and hence have a lot of precious data to shape up the care plans according to individual needs. Studies have demonstrated that mobile devices and wearables support various dimensions of palliative care, such as telemonitoring of physical activity and symptomatology, which leads to the improvement of patient conditions (Nwosu et al., 2022). The enhanced capacity of these devices to collect and store health-related data is of great potential for enabling proactive management of patient care (Mills et al., 2021). These technologies can also be integrated into practice and enhance safety of the patient, as well as improve communication between healthcare providers and patients (May et al., 2022).

Digital health technologies integrated into palliative care also remove several important barriers to care, such as geographical restrictions and the need for continuous support. A national study further indicates that healthcare providers regard digital health as the future order of the day that will continue to increase its relevance in palliative care due to increased accessibility and convenience for both patients and service providers (Stanley, 2024). Further, there is the incorporation of electronic health records and the uptake of telehealth that healthcare professionals have strongly supported as indicators of future care delivery models that entailed a lot of integration of technology (May et al., 2022).

10. Global Perspectives and Policies

Explicit national policies are among the major determinants of palliative care quality: they set the basis upon which a foundation for service in palliative care shall be erected. This ensures that essential medicines are provided, routine education for all healthcare workers is available and that palliative care is implemented widely (Clelland et al., 2020). Countries with better policies for palliative care, such as those in Europe, are better integrated into their health care systems than regions with less structured approaches, such as parts of the Asia-Pacific (Yamaguchi et al., 2014; Beek et al., 2013). The effectiveness of palliative care can be enhanced through education and training of health care providers. For instance, a comparative study established that although European countries have progressed in incorporating palliative care into cancer care, there is still a need to pay attention to non-cancer care as well (Beek et al., 2013). A pan-European survey indicated that palliative care education at the postgraduate level is insufficient and thus lacks competent professionals who can offer quality palliative care (Paal et al., 2019). Moreover, undergraduate-level education in palliative care is increasingly being called for since healthcare professionals have ethical and legal mandates to provide quality care along the continuum of care (Pereira & Hernández-Marrero, 2016). For example, in Africa, more has been done to improve training on palliative care, while much remains to be desired to ensure that all who deliver health care are adequate and prepared (Fraser et al., 2018).

Cultural perspectives and societal views on dying and death greatly impact practice on palliative care. In many cultures, especially in the Global South, there is a shyness about talking about death, which can delay acceptance and implementation of palliative care services (Clark et al., 2020; Schill, 2019). The World Health Organization has been emphasizing culturally sensitive approaches in palliative care, advocating for practices respectful of the beliefs and values of diverse populations (Froggatt et al., 2017). For instance, culturally safe practice is required to ensure that the palliative care is rendered in a respectful and effective manner among indigenous communities (Schill, 2019). There is also an imbalance in the resources provided across countries in terms of the availability of palliative care beds and specialized services. For example, the number of palliative care services in the Asia-Pacific region is much lower than that of Western Europe, thus indicating a lack of access to care (Yamaguchi et al., 2014). The scarcity of resources is further worsened by inadequate funding and political will, which are critical for sustaining palliative care programs (Clelland et al., 2020; Motlana et al., 2023).

11. Role of Palliative Care in Caregivers' Well-being

Palliative care helps greatly in supporting the emotional and physical well-being of the caregiver who often faces such various tasks, both emotionally and physically, while caring for patients with serious illnesses. It keeps them away from anxiety, sadness, and even exhaustion due to the burdens they have to endure. According to studies, family caregivers of patients diagnosed with incurable cancer reported declining mental and physical health that may predict poor quality of life in the future (Shaffer et al., 2016). This suggests that timely intervention of palliative care directed toward caregivers is required in the early stages of the disease process.

More so, palliative care expands its advantages to not only patients but also their caregivers. Most particularly, it will involve chronic conditions such as Parkinson's disease. A complete approach is significant in the process of preparing a caregiver to prepare himself emotionally and physically in order to handle the complex demands of the caregiving activity. Educating and resourcing may make better strategies for coping of caregivers in palliative care. Their general welfare will thus improve (Zhang, 2023). The availability of practical support and psychosocial resources is related to reduced burden among caregivers and thus results in enhanced perceived health outcomes (Zomerdijk et al., 2022).

Secondly, caregivers are known to often prepare less than they should for the emotional and physical demands that they endure in caring for terminally ill patients in their home environment. There would be increased feelings of isolation as well as stress without professional support (Zhang, 2023). The same feelings could be mitigated with the help of palliative care services, because these services also provide critical support and counseling for the emotional well-being of the caregivers. In fact, interventions that deal with psychological distress and existential issues have proven to reduce significantly anxiety and depression symptoms in caregivers (Oechsle, 2019).

Furthermore, the literature emphasizes the need for bereavement support. According to Aoun et al. (2018), if caregivers are actively engaged during the pre-bereavement period, then it enhances their coping mechanism and emotional resilience. This is a very important proactive approach since it offers caregivers an opportunity to ventilate their grief and gain enough support before the loss. This way, in the long run, their emotional health will be better improved (Aoun et al., 2017).

12.Future Directions in Palliative Care

For example, studies have illustrated that embedding palliative care into community health systems is associated with better patient results. Early initiation of community-based palliative care will reduce hospitalization and emergency room visits (Wright et al., 2018). The approach allows more effective management of symptoms while also honoring the patient's preferences regarding end-of-life treatment, increasing the likelihood of death at home (Lin et al., 2021). The fact that the model based on interprofessional teams is community-based, unique, and the same in developing it that Hawkins-Taylor et al. (2020) propose, and thereby was important to overcome the barriers related to access in delivering such palliative care services holistically and with a more accessible affordable price tag especially within a rural setting. The model under development is that of paramedic roles in the provision of community-based palliative care. The increasing acuity of older populations makes it imperative that community-based provision of palliative care be provided by paramedics to elicit timely and preventative action to the manifestation of illnesses (Juhrmann et al., 2022). This approach addresses the urgent care requirements while providing continuity of care by giving a patient the opportunity to be at home but accessing medical assistance.

The rapid progress caused by the COVID-19 pandemic in further evolving the models of palliative care has seen that most health care systems have adapted virtual care strategies. This shift has allowed the palliative services to continue uninterrupted in a manner that avoids transmission risks, thereby underlining flexibility in delivery in palliative care. Virtual home-based palliative care has emerged as a viable alternative because it is flexible and accessible for the patient and the caregiver themselves (Vincent et al., 2022). Integration of psychiatric services into palliative care teams has been seen as one approach to psychosocial aspects of patient care, especially in crises (Shalev et al., 2020).

Community-led models of palliative care, as established in Kerala, India, are sustainable and effective in resource-poor settings. Such models require active involvement by trained volunteers and the community, where home-based care is offered to patients free of charge (Azeez & Selvi, 2019). These programs show the possibility of enhancing the delivery of palliative care through community engagement, especially in low-resource settings.

Conclusion

Palliative care is a very important, patient-centered approach in healthcare that focuses on the overall needs of people with terminal diseases while extending support to the families. It ensures comprehensive treatment by focusing on dignity, comfort, and quality of life, integrating the physical relief of symptoms, emotional and psychological care, and spiritual support. Evidence always directs people to the benefits of curbing unnecessary medical intervention, optimal usage of healthcare, and raising the overall satisfaction of both the patients and the caregivers. In fact, this has the huge barriers of cultural taboo, geographic disparities, as well as inadequate infrastructure, especially those regions that are not adequately provided for these reasons demand systemic changes, such as integrating policies, training in workforces, and appropriate provision of resources.

Innovation in telemedicine, wearable technology, and community-based care models have huge potential to fill gaps in access and equity so that timely and appropriate care is delivered. Such obstacles require collaboration between policymakers, health providers, and the communities to overcome the hurdles of delivering palliative care everywhere. Evolving demographics and a mounting burden of chronic disease require palliative care as a component of treatment, underpinning principles of compassion, equity, and respect for human dignity. Its universal application will not only reduce suffering but will be an ethical foundation of health care itself in attention to patients' needs and wishes in the most vulnerable stages of life.

Author Contributions

All authors reviewed the final paper and gave their approval for submission, pledging to accept responsibility for all aspects of the work to ensure accuracy and integrity. The first author generates the concept and composes the text's first draft, and the corresponding author supervises the entire work and makes important critical adjustments.

Conflict of Interest

The authors declare no conflicts of interest related to this study.

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