International Research Journal of Multidisciplinary Scope (IRJMS), 2026; 7(1): 1092-1111 IRJMS

Review Article | ISSN (O): 2582-631X DOI: 10.47857/irjms.2026.v07i01.08581

The Odd One Out: A Review of Palliative Medicine in Modern Healthcare

María Teresa García-Baquero Merino[1,2]*, Micaela Menárguez[3], Ignacio Segarra[4]

[1]Catholic University of Murcia (UCAM), Murcia. 30107, Spain, [2]St Margaret of Scotland Hospice, E Barns St, Clydebank G811EG. Scotland UK, [3]Faculty of Medicine, Catholic University of Murcia (UCAM), Murcia 30107, Spain, [4]Department of Pharmacy, Faculty of Pharmacy and Nutrition, Catholic University of Murcia (UCAM), 30107 Murcia, Spain. *Corresponding Author's Email: mtgarcia@ucam.edu

Abstract

Western Healthcare systems primarily focus on cure and life extension, while Palliative care (PC) and Palliative medicine (PM) maintain a distinctive, marginalized position. The paper aims to analyze the specific features within PC that prioritize dignity and quality-of-life-enhancing approaches, focusing on the role of multidisciplinary teams and their core communication practices and comprehensive care. Such an approach emphasizes compassion, empathy, and respect for patient autonomy, ensuring that care aligns with individual values and preferences. Systemic biases, cultural death stigmas, alongside structural inefficiencies, restrict the complete integration of patient and caregiver satisfaction benefits, cost reduction measures, and ethical patient-centred healthcare initiatives. The dominance of curative medicine limits awareness of PC and PM's holistic benefits. Using a narrative review approach, this research examines the historical development of PC and PM, in conjunction with existing system problems and new strategies, to establish these fields as core value-based healthcare practices. It further highlights the growing need for training programs, policy reform, and interprofessional collaboration to strengthen palliative frameworks. Healthcare institutions must eliminate misunderstandings as they transition to new payment structures and educate staff to integrate these fields more effectively, which may support patients with serious pathologies, life-threatening illnesses, individuals with longstanding conditions and chronic diseases, including children, and aging populations. Ultimately, embracing PC and PM can redefine healthcare success through compassion, dignity, and improved quality of life.

Keywords: Caregiver Satisfaction, Healthcare Costs, Holistic Care, Palliative Medicine, Quality of Life.

Introduction

In modern times, Western healthcare focuses on curative solutions rooted in sophisticated technologies, pharmaceutical developments, and life-extending therapies that control the medical field. Within such systems, palliative medicine (PM) operates under a different ethos, even independently, to deliver quality-of-life care through symptom management and psychosocial interventions, rather than focusing solely on disease-altering therapy. There is also experience from medical disciplines that shows that pain-relief actions play an equivalent role in life expectancy as they do in conventional healthcare systems (1). Current research investigates PM in contemporary health by examining its unique practices that counteract traditional medical systems, as its absence highlights how healthcare frequently promotes treatments that aim to save lives at the expense of those that seek to comfort and maintain, or improve, quality of life. The paper follows a narrative review method to address the historical development, conceptual differences, and universal issues of PM in contemporary healthcare. It is also narrowed to the organizational, policy, and interdisciplinary facets of PM, rather than disease-specific clinical trials or systematic outcome analyses. The review identifies ways in which PM can transform success in healthcare by integrating PM into healthcare structures, training frameworks, and value-based models, focusing on the desired outcomes of compassion, dignity, and improved quality of life. The purpose of this method is to synthesize conceptual, historical, and policy viewpoints on PM rather than a systematic assessment of quantitative outcomes or a scoping review of all available literature. The method enables the incorporation of diverse sources, such as clinical guidelines,

(Received 08th October 2025; Accepted 31st December 2025; Published 28th January 2026)

historical records, and policy documents, to provide an overall picture of the development and current challenges facing PM. In comparison, systematic or scoping reviews would be more suitable for highly specific clinical queries or evidence-based mapping, and the current study is more focused on the conceptual analysis and cross-disciplinary synthesis. The theoretical framework used in this review incorporates three concepts found to be central to PM. To start with, Dame Cicely Saunders's total pain principle offers a comprehensive perspective that, by considering the physical, emotional, social, and spiritual aspects of suffering, has become a holistic approach to suffering. Second, patient-centered care theory emphasizes autonomy, dignity, and shared decision-making, ensuring that treatment is based on personal values and preferences. Third, healthcare models that emphasize value-based care highlight the need to balance clinical outcomes with quality of life, caregiver satisfaction, and cost-efficiency. All these theoretical foundations are combined to inform the analysis contained in this review, and palliative medicine is viewed as a multidimensional field that redefines healthcare success by embracing compassion and dignity. PCs in low and middle-income countries (LMICs) also experience huge challenges despite the high rate of need due to an abundance of noncommunicable diseases, as well as life-limiting illnesses. Most of the world's need for Palliative care (PC) is in these countries, yet the service is primarily accessible in high-income nations. Various hindrances, including insufficient resources, the unavailability of skilled professionals, and cultural beliefs about PC, fuel the inequality. There is, however, evidence of successful integration, as well as inspiring examples of innovative strategies that can serve as inspiration for other LMICs (2).

In countries where 80% of the world's need for PC is in LMICs, only a small proportion of these patients get proper care. Inadequate healthcare systems, shortages of trained personnel, and the unavailability of fundamental medications such as opioids compound this. For children, it is even worse, as 98% of them who require PC remain in LMICs, but also experience wide gaps in accessing and quality of care (3).

The World Health Organization (WHO) describes PC as an interdisciplinary approach that aims to improve the quality of life for patients with serious or life-threatening conditions (4).

PC is described as the active, holistic care of individuals across all ages with serious health-related suffering (ShRS) due to severe illness, and especially of those near the end of life. It aims to improve the quality of life of patients, their families, and their caregivers (5). PM emerged from the hospice movement, which sought to address deficiencies in the traditional biomedical model of care by emphasizing symptom management, psychosocial support, and end-of-life ethics. PM scope approaches, interventions, and therapeutic strategies involve managing physical symptoms of pain, dyspnea, and fatigue, while simultaneously ensuring the

interdisciplinary delivery of psychological help, social assistance, and spiritual care that operate in parallel to medical curative treatments (6). The interdisciplinary teams of PC care include physicians, pharmacists, social workers, psychologists, chaplains, and therapists, demonstrating a patient-centered, holistic approach (7). In some countries, PM may function as a physician-directed symptom management practice and decision-making expertise that needs specialized training and board certification under the American Academy of Hospice and PM (8). Whereas in countries such as the UK, nurses play an essential role as independent prescribers and clinicians. In these scenarios, specialist nurses consult physicians and other team members as required. PM also relies on pharmacological and procedural therapeutic methodologies for complex and refractory symptoms, including, but not only, pain and delirium, while PC delivers comprehensive psychosocial and existential family-focused care (9). Together, the PC and PM base their practice on core values, including alleviating suffering and promoting patient autonomy within a team-based model of patient and family care (10). PM can also be described through its medical interventions—such as symptom management and treatment planning—it also addresses broader aspects of patient care. PC, in turn, adopts a whole-person approach that includes emotional, social, and spiritual support, often extending beyond clinical treatment alone. Furthermore, PM physicians may offer interventions in a variety of settings (11). These distinctions stem in part from their unique philosophical values, economic frameworks, and

cultural origins, which can differ from those of conventional medical practice. PC and PM place more emphasis on dignity and symptom relief than medicine, which equates success with longevity and cure. The conflicting mindsets between curative and non-curative approaches delay patient referrals, as patients wait until they exhaust all curative options, yet research shows that early intervention yields better results (12). PM discourses are often misunderstood as abandonment rather than as the necessary treatment. It happens due to the cultural stigma that continues to affect death and unhealing treatments. Furthermore, in countries where healthcare is not free at the point of need, reimbursement systems favour high-intensity interventions (e.g., surgeries, chemotherapy) over time-intensive palliative consultations. The fee-for-service payment method discourages essential discussions about goals of care, and the delivery of PC and primary medicine differs widely across countries, depending on income levels. Society must face death through PC/PM despite cultural preferences that prefer medical treatment for aging. When end-of-life communication skills exceed their expertise, clinicians tend to select aggressive treatments that conflict with patients' wishes (13). Medical interventions during the dying process become overused because patients end up in ICU settings. The necessity of tracing PM's historical development and its role in contemporary healthcare is highlighted by these systemic challenges, which run counter toits.

This study aims to differentiate PM from general PC, although the two are related. It reviews the underlying causes that result in PM being often overlooked in care plans, where it could really help patients. The paper examines the challenges to including PM services across society, the market, and structures, while also discussing notable achievements and worldwide differences in access to these services. In calling for PM to help achieve value-based healthcare and focus on better patient outcomes in serious illness, the authors dispute the current medical approach, primarily based on curing, and encourage hospitals to recognize and fully include PM as a primary medical specialty.

Search Strategy

This narrative review was shaped by a thorough search of PubMed, Scopus, and Google Scholar using keywords such as “palliative care,” “palliative medicine,” “quality of life,” “policy frameworks,” and “healthcare costs.” The research focused on English-language literature published from 1998 to 2025. Studies were included if they addressed clinical practice, policy, or educational aspects of PM.

Review Analysis

Historical Context

Origins of PC and PM: PC and PM originated in terminal care, focused on comfort and spiritual readiness, often provided by families or clergy. Terminal. At the beginning of the 20th century, there were no standardized guidelines for terminal care, and the medical field often overlooked it. The introduction of the modern hospice movement in the mid-20th century brought a clear, gentle, and comprehensive approach to caring for the dying. Dame Cicely Saunders led the way in this change by integrating her clinical, social work, and theological education to develop the concept of “total pain,” which brings together physical, emotional, social, and spiritual pain. In 1967, St. Christopher’s Hospice was founded in London by her, becoming the first institution to provide both care, research, and training in hospice care (14).

PC was designed to improve quality of life, starting with the early management of symptoms, providing emotional and social support, and ensuring that the family is involved in care (5). As patient requirements and healthcare systems became more complex, PM evolved into a distinct area of medicine. PM ensured that PC was treated as a physician-led area focused on effective symptom control, teamwork, and ethical guidance. In 1987, the Royal College of Physicians in the UK recognized PM as a subspecialty, and the American Board of Medical Specialties (ABMS) followed suit in 2006 (15). The change from terminal care to hospice, to PC, and finally to PM has dramatically changed how medicine thinks about caring for people, their suffering, and their quality of life.

The Evolution of the Modern Hospice Movement: The grass-roots hospice movement steadily grew into a nationwide healthcare organization throughout the later years of the twentieth century. In their early years, hospice facilities focused on providing care only to cancer patients until their services expanded to serve people with HIV/AIDS, advanced organ failure, and neurodegenerative diseases (16). On Death and

Dying, by Elisabeth Kübler-Ross, published in 1969, catalyzed the rapid growth of the hospice movement by exposing medical death avoidance and uncovering patients' emotional needs.

The modern hospice movement in the United States expanded during the 1970s and 1980s through advocacy efforts and new legislation, laying the groundwork for modern palliative approaches. The Medicare Hospice Benefit (1982) introduced federal funding for hospice services across the United States and established national service requirements. The policy modification established home-based care as a practical substitute to hospital deaths, which cut down on aggressive treatment needs and increased patient choice. International hospice programs spread throughout the 1990s through cultural modifications where Japanese family caregiving practices went hand in hand with South African community care models for HIV/AIDS patients (15).

The importance of PCs is steadily rising in LMICs, as these nations must address their growing aging populations. The requirement for complete patient-centered care has substantially increased in regions where people face life-threatening diseases**.** The development of PC services within LMICs, including India and across Africa, emerged because these nations recognized that pain management, alongside supportive services, constitutes a human rights principle. Healthcare professionals, in collaboration with community organizations and international partners, have established PC programs to address cultural, economic, and healthcare access barriers affecting these populations. The ongoing population aging in middle-income countries requires the development of local PC to maintain dignity, comfort, and quality of life for patients with life-limiting conditions (2).

The Modern HM encountered two main barriers, which involved delayed patient admission stemming from doctors' reluctance to determine terminal conditions, while also struggling to provide equal access to rural and disadvantaged communities. Its growth reflected society's shift toward valuing dignity in death over aggressive interventions. This evolution is well-documented in the primary medical literature, which brings together the clinical, ethical, and organizational aspects of PM (17).

The Emergence of PM as a Recognized Medical Specialty: PM was recognized as a specialty in 1987 and defined as 'the study and management of patients with active, progressive, far-advanced disease. The nursing model of hospice care evolved into PM as a medical discipline providing broad support for serious illnesses across all stages of the disease. The process of turning PM into an official medical subspecialty in the United Kingdom took about 4 decades, with key efforts beginning in the 1970s and culminating in 2010. When the Royal College of Physicians gave this designation, it confirmed that radiology was a unique and fully independent medical specialty with its own high standards in clinical, ethical, and educational matters (18). The subspecialty status confirmed advanced skills and knowledge needed to deliver quality End of Life Care (EoLC). Not only did this enhance the professional status of PC providers, but it also facilitated advanced training and research within the discipline (19). Hospice and Palliative Medicine (HPM) attained subspecialty status approval from the American Board of Medical Specialties in 2006. Subsequently, they received recognition in the UK, Canada, and Australia in the following years (15).

PM's role in symptom management and end-of-life ethics was acknowledged. Specialized training programs and certification systems for doctors led them to learn communication skills in addition to pharmacological skills and multidisciplinary collaboration (20). WHO included PM into its world health strategies, treating cancer and long-term illnesses, and medical organizations from every part of the world supported its utility (21).

Mainstream healthcare faced obstacles when integrating PM into clinical practice. Healthcare systems that use fee-for-service reimbursement systems discouraged long PC consultations, which led to continued resistance against abandoning curative treatments. Scientific research proved that starting PC services early improves patient health outcomes because it lowers hospital readmissions and delivers better life quality, and extends survival periods (12). Although PM exists as a crucial healthcare element, it shows uneven distribution throughout the global healthcare sector during the 21st century. Dame Cicely Saunders started PM at St. Christopher's Hospice in the UK to develop core principles for delivering compassionate, complete EoLC (22). The British

approach to PC unified medical support with emotional and spiritual care to form worldwide palliative models. The United States introduced PC institutionalization throughout hospital systems, which powered research and education and shaped policies (15). Through its approach, the United States established PM as an official specialty, which gained strength from strong academic and clinical frameworks. The availability of PC services shows extreme disparities between different regions because health infrastructure inequalities persist across low- and middle-income countries, which prevents them from providing fundamental medical services (23). The pioneering work of the British PC and the American broad clinical model serves as a model to help close worldwide access deficits in PC.

What Makes PM 'Odd'? From the World's Oldest Profession (Caring for Each Other) to A New Medical Specialty: The modern healthcare system often fails to recognize the unconventional role of PM. PM creates distinctions from typical medical practices because it prioritizes comfort and dignity alongside quality of life over curative treatment, while operating within healthcare structures where such person-centered treatments remain outside standard practices. The following section provides an overview of the critical features of PM, based on current research findings, to support our analysis.

The primary characteristic of PM is its unique approach to care, which involves caring for patients with complex needs based on diagnosis or age, from birth to the end of life. PM's holistic method differs from other medical specialties in that it provides patients of any age group in more than one setting of health care in hospitals of every describable type and hospices, as well as public PC and intensive care as well as maternity and tertiary oncology and nursing homes, and long-term care, and emergency (5). PM became the first medical practice to establish treatment approaches that view patients alongside their families as unified care units because it understands how physical, emotional, social, and spiritual distress interconnect (24). The comprehensive treatment model of PM functions as a distinct anomaly because most health systems focus primarily on specific disease interventions instead of the whole person, although modern healthcare depends on this revolutionary therapeutic approach.

Comparisons with critical care medicine have resulted from this unorthodox scope. PM is increasingly compared to intensive care medicine because of its shared focus on managing patients with critical and complex health needs, albeit with distinct goals. While often used interchangeably in casual discussion, PC and PM differ significantly in scope. PC is a broad, interdisciplinary approach that addresses the physical, emotional, psychosocial, and spiritual needs of individuals facing serious illnesses, irrespective of diagnosis or prognosis (24). In contrast, PM refers specifically to the specialized, physician-led medical discipline that provides expert symptom management and complex decision-making support, typically within hospital, outpatient, or specialized clinic settings (20). Intensive care medicine, traditionally centered on aggressive, life-sustaining therapies for critically ill patients in ICUs, has increasingly integrated PC principles, especially around communication, symptom control, and end-of-life decision-making (25). This convergence underscores the evolving recognition that quality of life and dignity must be prioritized even within the most technologically advanced areas of medicine. Table 1 highlights key differences between PM and traditional medical specialties, including goals, ethics, and methods of care.

Table 1: Key Distinctions between PM and Traditional Medical Specialties.

Characteristic	Palliative Medicine (PM)	Traditional Medical Specialties	Reference
Primary Goal	Enhance comfort, dignity, and quality of life by optimizing symptom control	Prolong survival and eliminate the disease	(26, 27)
Approach	Holistic, interdisciplinary, patient- and family-centered	Disease-specific, physician-led	(20)
Timing of Care	Early integration is recommended throughout the illness	Often starts at diagnosis, continues until cure or death	(28)
Care Setting	Hospitals, homes, ICUs, hospices, long-term care facilities	Hospitals, outpatient clinics, specialized centers	(9, 24)
Ethical Framework	Based on autonomy, non-maleficence, and dignity	Often leans toward a curative, interventionist ethos	(29, 30)

PM needs to be recognized beyond its status as a mere symptom control specialty because it possesses deeper healing capabilities at the personal level. Far from being second-class medicine, PM offers scientifically grounded care. The practice of genuine PC requires practitioners to maintain dual levels of observance since they need to treat both physical symptoms and emotional-spiritual distress simultaneously. Healing occurs independently from curing at the end of life because genuine care that builds trust and acknowledges patients' complete humanity leads to recovery. Comprehensive patient care requires physicians to improve their clinical skills and develop inner strength through personal growth, enabling them to support patients in their suffering. The dedication to complete patient-care understanding remains essential because PM might otherwise become another specialty boxed within narrow medical frameworks. Through the revival of timeless healing principles in present-day healthcare, PM provides comprehensive change for caregivers, patients, and their families, and healthcare practitioners and medical protocols. Instead of focusing on organ-specific pathology, PM is unique in that it addresses suffering across ages and conditions. It aims to alleviate serious health-related suffering, as established more recently in Redefining PC—a new consensus-based definition. Its focus is neither dying, although much suffering is experienced within the dying Process, nor death, because when this comes, the sick person no longer needs care. Moreover, true to its commitment to patients' meaningful others, it is a specialty that offers bereavement care as part of the attention PC delivers when the family needs to live after their loved one has died. They're left with issues that need support (17).

Not Focused on Cure – Centered Comfort, Dignity- Preserving, and Quality of Life-Enhancing: PC and PM differ from traditional medical specialties in prioritizing comfort, dignity, and quality of life over curative treatments. Modern hospital rescue practices clash with patient-focused approaches because they perceive death as a medical failure instead of a natural occurrence (29). This philosophical gap emerged because traditional medical education and practice focused on technological interventions and disease elimination for many decades. Studies show that integrating PC early yields superior patient outcomes and reduces psychological burden, potentially increasing survival rates for metastatic cancer patients. Numerous patients experienced improved quality of life and mood while undergoing fewer aggressive final-stage treatments during concurrent palliative and oncology care (31). Clinical practitioners often shy away from PC referrals, despite being aware of the documented advantages, because they believe the process amounts to surrendering treatment (26). Palliative services become inaccessible to patients when referrals are made too late, thereby reducing their ability to utilize a holistic care approach. Palliative and curative care approaches should be delivered simultaneously, as per modern medical models, because the combined approach improves patient health while reducing hospital admissions during chemotherapy treatments (26, 32). Medical organizations face challenges in transforming fundamental beliefs about PC, which still associate it with end-of-life strategies when they should recognize its value in comprehensive, whole-person healthcare. The PM collaborates with patients, families, and other professionals to identify issues that are problematic for the patient.

Interdisciplinary Nature - Team-Based Approach to Whole-Person Treatment: To give answers to such a polyhedral cohort of care needs, PC and PM, understandably, need to engage in interdisciplinary work. The patient´s multidimensional needs require comprehensive treatment through palliative teams that include physicians, nurses, social workers, chaplains, and therapists (20). Contrary to other fields of study, PC depends on genuine team collaboration. The research confirms that team-based PC is effective in reducing hospital admissions and enhancing caregiver mental health (33). The total pain theory, which Saunders coined as "total pain," has found acceptance through the inclusion of psychosocial and spiritual professionals in healthcare teams. The implementation of this model encounters operational obstacles because current reimbursement systems reward procedures over the extended time required for interdisciplinary care (34). The traditional medical hierarchy functions as an obstacle to authentic interdisciplinary teamwork, creating operational barriers that teams must overcome through cultural transformations (35). The expanding research

evidence demonstrates that team-based PC could represent a model that addresses patients' diverse chronic diseases beyond EoLC, including children and young people born with Low-prevalence diseases (LPDs) and their caregivers (36).

Research findings demonstrate that team PC has evolved into a necessity for addressing the complex needs of patients with various chronic diseases at every stage of illness, extending beyond end-of-life care. The global expansion of PM has significant potential due to this transformation. Palliative principles are incorporated earlier in the disease process using this method, allowing patients with long-term conditions to receive symptom relief and holistic care before end-of-life treatment (23). Secondly, it supports the development of interdisciplinary healthcare teams to foster better collaboration among physicians, nurses, social workers, and chaplains for comprehensive care delivery (20). Implementing team-based models would help alleviate strain on the worldwide healthcare system, particularly in low- and middle-income countries, by improving disease management, thereby advancing the WHO's Universal Health Coverage objectives (24). A collaborative approach offers enduring solutions that replace conventional, overmedicalized processes by putting patient worth and dignity at its core, and delivers holistic treatment that includes family and meaningful others. These findings are consistent with the theoretical framework supporting this review, especially the concepts of total pain and patient-centered care, as well as Saunders's premise that interdisciplinary work is imperative for managing the multidimensionality of suffering.

Significance for Educational Planners and Professional Organizations: The modern PC demands intentional effort on the part of educational planners and professionals to integrate these principles throughout the training of health care practitioners. It has been shown that structured educational programs enhance competence in communication, ethical decision-making, and symptom management among health and social care professionals (37). The training needs to be not only specialized but also involve nurses, primary care providers, hospitalists, and other generalists who commonly care for patients with serious illness (38). Professional organizations are vital for establishing standard practice, accrediting programs, and advancing continuing education that embraces PM into practice (39). The interdisciplinary ethos of PM enables the alignment of educational strategies, thereby enhancing workforce capacity, reducing care disparities, and promoting the integration of PM into mainstream health care delivery (40). Such a focus on education ensures that PM is not merely a clinical specialty; it is also a supporting element of value-based healthcare systems.

Complexity Management: PM physicians now spend a significant amount of time managing complex medical needs, especially among patients with multiple health issues. Research indicates that complex needs necessitate multidimensional management, which involves combining various therapeutic, psychological, and spiritual interventions. Multiple specialists are needed to address the symptoms, objectives, and social context of complex needs. The PC team engages patients and families to evaluate and handle multiple healthcare demands through collaborative work (41). PC is designed to care for patients' health, emotional, social, and spiritual needs in any situation. At times, patients, caregivers, teams, and institutions are connected in ways that are not always balanced. This approach shows that care decisions should adapt over time and depend on what is most important. Figure 1 shows how the system's elements are linked.

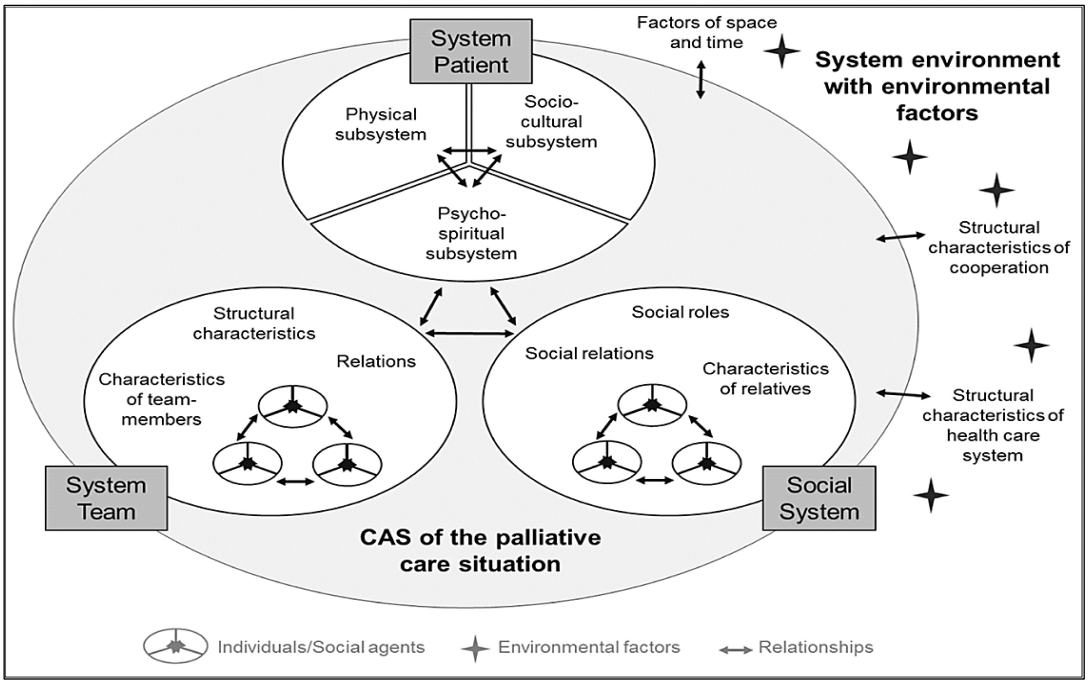

Figure 1: Understanding Complexity, the PC Situation is a Complex Adaptive System (42)

Medical practitioners specializing in PM dedicate their efforts to provide assertive care management for patients who require complex interventions for their physical and therapeutic needs, particularly in cases of COPD and interstitial lung disease (ILD) (43). The scope of pediatric PC has evolved to include international standards of care across different age levels, approaching managing complexity, and is adaptable to diverse populations (44). The growing recognition of complexity leads to demands for comprehensive healthcare models that unite medical specialists to improve patient outcomes (45). The example of complex needs management is another application of value-based healthcare principles, as successful PM must balance clinical and quality-of-life outcomes for patients and caregivers.

Policy and Frameworks Across Jurisdictions: Clinical practice is not the only determinant of PC development; policy environments and organizational structures also play a role. The jurisdictions vary in their approaches to controlling access, reimbursing for PC, and incorporating PC into mainstream healthcare. As an illustration, the United Kingdom has incorporated PC into its National Health Service (NHS), which provides shared access and specialist training bypasses. In contrast, the United States has introduced the Medicare Hospice Benefit, which has increased coverage but remains subject to qualification requirements that may delay early adoption. Conversely, most low- and middle-income nations lack effective policies, leading to limited access to needed medications and substandard workforce development (46, 47). East Asian and Australian comparative research has shown that the national law and equity-oriented policies have a significant impact on the range and quality of services (48, 49). The Canadian stakeholder perspective indicates that local resources, funding mechanisms, and barriers to collaboration influence the implementation of the national framework (50). International communities have provided guidelines on universal health coverage, equity, and multidisciplinary education issued by organizations such as the WHO and the European Association of Palliative Care. Still, these concepts are unequally applied across regions (51). These disparities show that policy environments may either promote or retard PC integration, which in turn determines workforce capacity, service delivery models, and patient outcomes. Enhancing policy alignment across jurisdictions remains necessary to promote PC as a universal health concern.

Impeccable Communication Skills: Prioritizing Goals of Care and Planning: One of the most relevant instruments that PM uses is impeccable communication. Good time management assists families with difficult situations. Only by working with teams that can effectively manage time and resources can families accept and confront the

situation. It has been shown that this forward-thinking strategy operates differently from traditional medical approaches, as discussions about values and patient preferences typically occur after treatment options have been exhausted (13). Research findings demonstrate that patients who discuss their treatment preferences with clinicians receive care that aligns with their values and avoid receiving unwanted, aggressive medical procedures. The lack of formal training about serious illness communication affects physicians. Research shows that inadequate communication between doctors and patients causes patient and family frustration, medical resource misuse, and healthcare provider moral distress. Medical practitioners who participate in the Serious Illness Care Program and VitalTalk gain greater confidence through structured communication frameworks that connect medical options with patient values (13). The programs provide instruction for medical staff on managing emotions during interactions, explaining diagnostic information with compassion, and matching treatments to patient priorities. The COVID-19 pandemic highlighted the fundamental value of these communication techniques, as medical staff worldwide engaged in numerous challenging discussions regarding life support and EoLC. Medical education now focuses on incorporating communication training at all levels, from undergraduate programs to ongoing professional development. The VOICES (Views of Informal Carers Evaluation of Services) survey has been instrumental in understanding bereaved families' experiences in the UK through extensive research. The survey collects data about those who have experienced a loss to reveal the difficulties they encounter in both their emotional state and psychological well-being, as well as their practical needs. The VOICES survey assesses the quality of EoLC while also highlighting the importance of palliative healthcare services, including comprehensive patient needs assessments, which are vital to families. The research findings inform the development of new services that focus on patient and family needs, thereby enhancing the quality of end-of-life and post-death care (52, 53).

Philosophical Grounding: Challenging the Biomedical Model: PM, like Hospice Care, PC, and EoLC, breaks away from the biomedical Framework. Traditionally, Medicine has a strong humanist base, which often promotes treating the illness rather than the patient. PC philosophy prioritizes patients' needs over aggressive medical interventions, upholding the fundamental principle of 'head and heart always together' as outlined by Saunders. Medical practitioners address patients using scientific evidence, clinical guidelines, and personal compassion for their values (heart) when making treatment decisions. PM professionals develop their unique approach to working by incorporating a humanistic philosophy, with ancient roots, and an assertive attitude towards the suffering they observe and alleviate, allowing the patient to determine which problems they want the team to focus on first. This is known as palliative problematization. Such personalized care helps create individualized plans that account for personal preferences, including cultural, emotional, and spiritual needs. This form of medicine is often perceived as unorthodox, different, and odd to those who don't understand the ethos of PM. However, those same professionals have their interest piqued by observing the reality that surfaces, in which patients gain control, content, and acceptance.

Medical technology exceeds our capacity to match treatments with patients' quality-of-life goals; thus, the philosophical foundation emerges from this observation. The different viewpoints reach their peak tension when patients get intensive medical care that runs against their expressed end-of-life wishes. Previous literature reported that Medicare beneficiaries with advanced cancer received intensive treatments in their last month, even though most patients expressed desires for comfort-focused care (30). The moral framework within PC ensures essential protection against unhelpful, unwanted, or troublesome treatment and medical technology by using principles of autonomy, beneficence, and non-maleficence to question both our capability and ethical duty to intervene (54). In medical philosophy, practition-ers must evaluate patients as complete entities rather than focusing solely on their illnesses when making treatment decisions, and should include a quality-of-life assessment. Medical practitioners need to recognize both diagnostic uncertainties and therapeutic limitations, as well as medical solutions that meet traditional certainty standards (55). Several healthcare systems now promote "realistic medicine" as an emerging movement

because healthcare professionals better understand palliative principles, leading to shared decision-making that combines benefit assessment with treatment burdens and patient values alignment.

Paradoxically, collaboration is often required from PM to help manage the struggle with maintaining hope for a cure in the face of a life-threatening illness. In all these circumstances, the health care team must combine elements of PC with life-sustaining therapy to maximize the patient's quality and quantity of life" (56).

Care Beyond for Supporting Families and Existential Needs: Supportive care and PM go beyond medical procedures by recognizing the importance of addressing the entire patient's and family's needs. Serious illness disrupts whole family systems, so the comprehensive approach treats families as the primary unit of care (57). It has been demonstrated that seriously ill patients' family caregivers face substantial emotional stress, financial hardship, and physical health deterioration (58). Under the guidance of palliative teams, healthcare professionals deliver ongoing bereavement care and caregiver support services together with respite care for families following the patient's death (59). The existential aspects of PC specifically address questions of meaning and purpose, and how individuals want to be remembered when serious illness strikes (60). The existential aspects of PC specifically address questions about meaning and purpose, as well as how individuals want to be remembered when a serious illness strikes (60). Spiritual care remains a decisive component of comprehensive care for total pain, yet it is often misunderstood by many (61). All team members provide Spiritual Care. Not every team has a chaplain (62). Many healthcare systems provide inadequate reimbursements for psychosocial services, creating organizational obstacles to delivering whole-person care despite its documented positive effects (63). Insufficient funding leads healthcare institutions to prioritize procedural treatments over cognitive and emotional support services. The COVID-19 pandemic revealed how it exacerbated existing healthcare issues while underscoring the vital importance of PC and PM in managing complex symptoms. The specialists in PC demonstrated active symptom management throughout this global emergency, utilizing their advanced skills in symptom regulation alongside end-of-life support. Their extensive therapeutic expertise enabled them to provide worldwide guidance, assisting medical staff in performing both life-saving and peaceful dying procedures. During this time, PM demonstrated its dual effect by helping to save critical patients while also allowing peaceful deaths, which proved the value of the "judicious use of medication" as a core principle of PC. The pandemic highlighted the essential value of these support systems, as families required PC to maintain their dignity when traditional medicine failed to provide additional support during their isolated illness experience (64). The experiences have led to demands for healthcare reform to establish proper funding mechanisms for comprehensive PC services.

Systemic and Cultural Challenges

Misunderstanding and Stigma Around Dying and Death: Hesitance towards death that exists deeply within cultures acts as an obstacle against integrating PC. It has been observed that modern medical practice often interprets death as a therapeutic failure, rather than recognizing it as an inevitable phase of life. It has also been reported that end-of-life discussions happen only 33 days before death for patients with cancer (13). Family beliefs in superstitions about death prevention and the continued pursuit of all-out treatments make advanced care planning avoidance even more challenging. The pandemic heightened awareness of death, but this increased attention failed to create lasting improvements in death acceptance across the healthcare system (65).

Marginalization Within Medical Education: The provision of PC is severely underrepresented throughout medical educational programs worldwide. It has been reported that 25% of U.S. medical schools offer dedicated PC rotations (66). Participating trainers from 59 nations achieved a 71% success rate in improving clinical care for seriously ill children at their institutions, according to the EPEC-Pediatrics survey (2011-2019). However, the self-reported outcomes may be limited by the 22% response rate among 172 trainers out of 786 total trainers (67). The specialty board requirements evaluate medical expertise through procedural skills rather than symptom management, leading medical professionals to select aggressive treatments rather than value-based practice methods.

Resource and Funding Gaps: The Global Atlas of PC (2023) indicates that low- and middle-income countries reach fewer than 20% of their populations, whereas high-income countries reach 80% of their populations. The availability of PC services remains unbalanced because of multiple factors, including racial and geographic differences, societal economic status, and healthcare system fragmentation. Tragically, in the UK, independent non-mainstream public healthcare providers, which receive varying percentages of their budgets from local authorities, are seeing these percentages decrease, forcing reductions in services and leading to highly trained professionals losing their jobs. The successful elimination of health system inequalities requires policy organizations to team up with trained health workers who will work together with communities to develop inclusive healthcare systems. Research into hospice, and PC has not yet met the increasing demand because significant gaps exist across clinical practice methods, access to systems, caregiving models, and research methodologies. Research gaps create an obstacle to North America's use of evidence to guide policy development, educational initiatives, and service delivery systems (68). Table 2 shows the barriers to PC integration and potential solutions.

Table 2. Barriers to PC Integration and Potential Solutions

Barrier	Description	Potential Solution	Reference
Death stigma and denial	Death is viewed as a failure in care, avoided in conversations	Public education and clinician training in death literacy	(13)
Misconceptions about PM/PC	Seen as end-of-life only, or "giving up."	Rebranding and education on early integration benefits	(69)
Reimbursement limitations	Time-intensive care is not rewarded under fee-for-service models	Shift to value-based care reimbursement structures	(70, 71)
Inadequate training	Few medical schools require PC rotations	Mandated training (e.g., SB 294 in California)	(66)
Access disparity in LMICs	Infrastructure, drug regulation, and workforce shortages	Policy reforms and WHO-endorsed national strategies	(4, 23)

WHO recognizes PC as a fundamental human right that should be integrated into national health systems. The provision of appropriate care remains restricted, particularly in low- and middle-income countries (LMICs), with only 14% of those who need it able to access suitable services. Restricted drug regulations like those affecting morphine supply, along with missing nationwide policies, prevent access to PC. Only eight European countries have established PC laws, while most lack independent national plans and physician accreditation systems to support PC practice (4).

Emerging Solutions: Various new policies present practical solutions to address these challenges. The California state legislation, SB 294, requires physicians to receive PC education, while value-based payment systems encourage healthcare providers to integrate this care approach early (70). Similarly, in the UK, the NHS launched "Ambitions for Palliative and End of Life Care" to enhance patients' access to PC at the right time and to provide high-quality services (72). Spanish regions have established specific policies that focus on healthcare professional training and on integrating palliative services into primary care to improve access to PC nationwide. The implementation of automatic triggers in clinical systems for metastatic cancer conditions has led to faster patient consultations, according to recent system developments. The introduced systemic changes aim to align clinical practice with proven data demonstrating that early PC produces better results (73, 74).

PM Contributions and Strengths

Improved Patient and Caregiver Satisfaction: It has been demonstrated that whiteboards, along with provider photographs displayed at patients' bedsides, enhance both patient satisfaction and caregiver satisfaction levels throughout hospital stays (75). The collected studies demonstrated improved satisfaction levels, with whiteboards producing universal positive results (2/2 studies) and picture-based tools showing positive outcomes in 2 of 3 studies. Patient satisfaction scores increased after whiteboards were implemented, and caregiver identification of providers rose by 480% using photographs (76, 77). The identified tools fill essential gaps in provider recognition and role comprehension, as these factors strongly influence patient-centered care satisfaction.

Reduced Unnecessary Hospital Admissions: The implementation of PC offers terminally ill cancer patients better quality of care alongside reduced hospital stays and related expenses. Medical research shows that integrating PC services results in a 40%–66% decrease in ICU admissions and leads to hospital cost reductions of 24%–32% during the first two days of hospital admission. Patients under PC experience 57%–59% lower costs when they die in hospitals compared to standard care, because PC avoids unnecessary treatments and reduces ICU stay duration (78-81,71). It has been demonstrated that patients under PC spent 32% less on healthcare costs during the six months following hospital discharge. It has also been found that patients who underwent end-of-life discussions experienced a 36% decrease in healthcare expenses during their last week of life (82, 83). Better patient outcomes, including increased hospice admission rates and improved quality of death, accompany these savings (84).

Alignment with Ethical, Patient-Centered Care Models: The principles of PC mirror ethical, patient-centered models by focusing on patient decision autonomy while supporting co-decision-making and treating both medical accomplish-ments and complete well-being. Healthcare providers indicate that PC upholds key ethical principles through delivering personalized care plans and empathetic communication that respects patient choices and cultural values (85). Research indicates PC reduces aggressive treatments that bring no benefit to patients while maintaining treatment consistency with personal treatment objectives (86).

Cultural Sensitivity, Literacy, and Holistic Approaches: Holistic medical approaches that incorporate cultural sensitivity will determine the success of PC by addressing pain, other problematic symptoms for the patient, suffering through physical and psychological aspects, social networking, and spiritual needs, including cultural and faith (religious)-related issues. Brant stresses that cultural differences produce vast variations in how people perceive and handle pain because Asian patients tend to normalize pain based on their beliefs. In contrast, African American patients experience greater pain sensitivity and encounter discriminatory healthcare treatment from providers (87). The integration of cultural nuances in holistic care involves creating personalized interventions that incorporate individual beliefs, including involving spiritual leaders for patients who perceive pain as a spiritual test, and culturally adapted communication that addresses stigma (88). Through this method, doctors enhance both symptom control and patients' trust in their care plan and their willingness to adhere to treatment protocols, especially when treating diverse communities. The presence of opioid distribution gaps, together with unconscious bias, requires comprehensive system modifications that will establish global, equitable medical care.

Toward Integration: Rethinking The 'Oddity'

Western healthcare systems may marginalize PM due to systemic biases, cultural attitudes, and structural inefficiencies rather than any inherent value limitations. A complete transformation of medical perspectives is required because PC and PM should be recognized as integral parts of comprehensive healthcare, given their benefits to all stakeholders. The upcoming section outlines practical approaches to incorporate PC and PM into standard medical care, with a special emphasis on their importance in elderly care and the management of chronic diseases.

Reframing Palliative Disciplines as Essential: Healthcare professionals should transition PC and PM from EoLC to whole-person care that spans the entire illness duration. Key steps include:

Terminology and Perception: The current terminology used for PC/PM functions is a significant obstacle that prevents timely integration (34). Clinical discussions continue to employ stigmatizing terminology, which includes "last resort" as well as "giving up" thus delaying patient referrals and creating anxiety among patients (89). Scientific research provides evidence about the effectiveness of changing this specific narrative. One study found that PC administered within 3 weeks of metastatic non-small-cell lung cancer diagnosis simultaneously improved patient quality of life and prolonged survival by 2.7 months (69). The research establishes an urgent requirement to educate both the public and medical professionals about PC/PM because these interventions should be positive preventative treatments instead of negative indicators of treatment failure. Adequate conceptualization of terms and expressions used in

situations in which patients, their families, and treating professional teams would benefit from a palliative approach, intervention, or inclusion in a Specialist PC program is of great importance (90).

Value-Based Metrics: The current medical performance metrics examine survival statistics and procedure effectiveness, but do not fully capture the advantages of PC/PM approaches. Value-based medicine (VBM) in PC establishes medical decisions based on patients' values and preferences, as well as quality-of-life measures, rather than solely on clinical outcomes and costs. Evidence-based medicine combined with patient-centered care and cost-effectiveness enable VBM patients to obtain treatment strategies that safeguard their quality-of-life goals and dignity during the treatment of severe ailments. The goal of PC is to provide holistic symptom management, which aligns with VBM because it focuses on treating physical and psychosocial needs and spiritual support without performing unnecessary treatments. The application of this strategy leads to improved patient comfort and empowerment, as well as reduced unnecessary procedures and end-of-life treatments. The perspective highlights the importance of value metrics in cancer treatment, particularly in PC, where patient-centered outcomes, cost-effectiveness, and timely treatment are relevant. Emphasis on reducing treatment delays and costs in cancer treatment also benefits PC by promoting patient choice through the removal of unnecessary procedures and by managing physical and psychological discomfort. The application of value-based decision-making strategies, encompassing safety, equity, and patient-centered approaches, enables PC to enhance patient welfare by optimizing resource allocation. Through joint efforts among professional organizations, these principles should be implemented in PC to deliver comprehensive, dignified medical support to patients with terminal illnesses (91).

Calls for Better Integration into Primary and Specialist PC: The process of integration needs comprehensive changes to occur across various organizational levels.

Policy and Reimbursement: Healthcare policies, together with reimbursement systems, act as essential components for determining how accessible and high-quality PC services become across the world. WHO now understand financial systems must provide incentives for prolonged activities like advanced care planning services while symptom management sessions, and comprehensive patient care rather than focusing on expensive procedures. The Australian Medicare Benefits Schedule (MBS) provides item numbers dedicated to advanced care planning sessions to promote essential discussions between doctors and their patients. Through NHS funding models in the United Kingdom, PC receives integration within primary care to enable general practitioners to deliver palliative services throughout community settings (92). Canada and other nations have integrated PC funding into provincial healthcare budgets, which makes home-based palliative services sustainable. Global organizations prove the universal recognition that healthcare systems need adequate reform in policies and payments to move from intervention-based services to quality-focused patient care. Organize support for payment systems that reward time-consuming PC discussions, such as advance care planning, rather than procedures with a high intensity level. The implementation of California's SB 294 demonstrates policy progress by requiring physician education in PC (70).

Clinical Pathways: Medical organizations should establish automatic PC referral systems, based on trigger points for the different pathologies and life-threatening illnesses, ratified by all levels of care professionals, that activate when treating patients with metastatic cancer or advanced organ failure. The use of automated systems is successful in reducing time-related problems (73).

Interdisciplinary Collaboration: The global healthcare sector is moving toward an integrated PC design that enables generalists and specialists to collaborate in providing continuous, early support to patients with severe illnesses. Healthcare providers who are both generalists and specialists in oncology, cardiology, and geriatrics gain specialized expertise through this approach, enabling them to deliver fundamental palliative treatments at an early stage. Specialist teams then handle complex symptoms alongside psychosocial difficulties. The integration of generalist PC at an early stage has been shown to have positive effects, including enhanced patient outcomes, lower hospital admission rates, and improved quality of life (93, 94). The health systems in Europe, Australia, and Canada now integrate PC

competencies into their medical training programs because they support best practices for early interdisciplinary care delivery. A team of PC professionals should be incorporated into oncology, cardiology, and geriatrics units to provide simultaneous patient care. Through the "Generalist Plus Specialist" model (20), healthcare providers can implement palliative approaches early in care without placing excessive demands on specialists.

Medication Used by Palliative Medicine Professionals

The use of medications frequently prescribed in PM remains a source of debate, as it continues to palliate irreversibility in an increasing number of medical fields (95, 96). Current evidence on subcutaneous and off-label used drugs in hospice and PC is a common practice in PM. However, evidence on tolerability and effectiveness, particularly pharmacokinetic data, is limited. This work lays the groundwork for further research in this area (96). As more patients with various pathologies are treated by PM at E-o-L, interest in the pharmacokinetics of the most commonly used medications may increase due to potential comorbidities and physiological changes at the end of life. Oral drug absorption can be significantly affected by gastrointestinal symptoms, necessitating close monitoring and medication reassessment during the palliative phase. Drug volume distribution can fluctuate in terminally ill patients due to alterations in body composition and plasma proteins, potentially affecting the efficacy of rapidly acting drugs.

Drug metabolism may be compromised in cases of liver disease, dehydration, inflammation, or cachexia, requiring caregivers to monitor for signs of altered efficacy and side effects. Renally eliminated drugs can accumulate in the final days of life due to restricted fluid intake, potentially leading to adverse effects from drug or metabolite buildup. Given the complexity of drug interactions in terminal illness, pharmacological treatment should ideally be evaluated in a multi-disciplinary context, with input from pharmacists or clinical pharmacologists strongly advised (97). Furthermore, as places of PC and EoLC are increasingly provided in residential and Care home settings at patients' preferences, best symptom control via different routes is gaining interest (98). Finally, the importance of treating infections in the latter stages of life without requiring transfer to the acute setting become problematic, making it necessary for PM to strive to identify new routes of antibiotic therapies, which are gaining professional concern (99).

Role in Aging Populations and Chronic Disease Burden

As the global population ages and chronic illnesses become more common, the approaches of PC and PM are not just helpful; they are essential for creating sustainable health systems.

Chronic Disease Management: PC offers solutions for multiple aspects of suffering in patients with dementia and heart failure because treatment cures are improbable, but healthcare professionals can enhance their quality of life. PC decreases ICU mortality rates by 57%-59% per patient (86).

Caregiver Support: Comprehensive methods of PC help decrease the emotional problems experienced by caregivers who provide home-based care to their families. The study demonstrated that family-centered PC eliminates both financial pressures and emotional challenges on families (58).

Global Health Equity: The healthcare implementation in Rwanda incorporates practical PC functions in resource-limited areas, employing affordable public health approaches that align with local cultural practices (100).

The research revealed the multifaceted nature of PM, making it challenging for both non-PC healthcare professionals and the public to understand (41). Generally, only professionals who receive PM advice and support, and whose relatives have received PC, can advocate for it. Therefore, patients who might benefit from timely PC don´t receive it at all, or PC appears too late to benefit them fully (22). A comprehensive PC includes PM, which offers individualized clinical planning. Such personalized care helps potentiate patient autonomy, allowing consideration of personal preferences, including cultural, emotional, and spiritual needs (87).

This form of medicine is often perceived as unorthodox, different, and odd to those who don't comprehend the ethos of PM (34). However, those same professionals have their interest piqued by observing that well-informed patients achieve optimal control of their physical and psychological symptoms, are content, and accept their situation

(33). Families find themselves well-supported with the knowledge they need to ask for help 24 hours a day. These family members who receive bereavement support after the patient´s death often recognize how important PC support was while their loved one was dying and how they wish we had come earlier into the patient´s disease trajectory. Frequently, they refer to them in disbelief regarding the unusual funding for services that "do so much". Figure 2 shows a variation of a multicolored line graph by Dr Matt Doré, depicting some of the parameters that may contribute to the multidimensional complexity that PM physicians are expected to address, in relation to time and its evolution. It also demonstrates the increasing expectations and demands placed on PM Clinicians by other health and social care professionals (41).

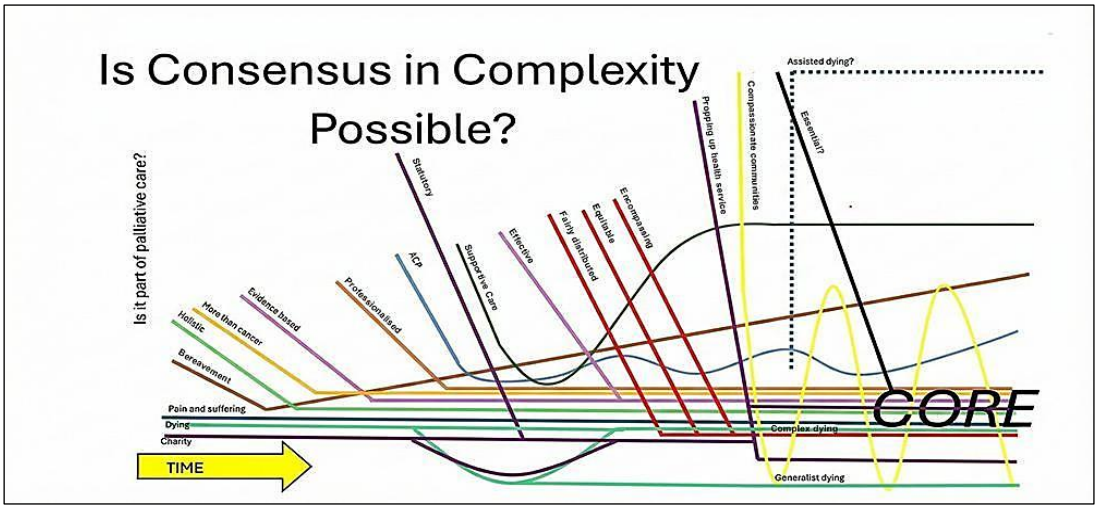

Figure 2: PM Addresses Multidimensional Complexity (Dr Matt Doré)

Indeed, PM offers a revolutionary approach to care practices that need to move beyond their marginal status in contemporary healthcare systems (22). The complete integration of PM continues to face barriers due to cultural stigmas, which are compounded by educational gaps and systemic barriers, even though research shows multiple benefits, including cost reduction, improved patient satisfaction, and better ethical alignment with patient values (33). Healthcare organizations should shift their perspective on PC and PM from terminal care-life interventions to fundamental core elements in patient care from diagnosis to survivorship or end of life (5). A comprehensive transformation to PC and medicine requires multiple intervention levels, including changing public and professional opinions, integrating palliative practices into primary care and specialty treatment, developing tailored insurance models, and developing accessible cultural models to advance health equity (87). The rise of chronic illnesses and aging populations worldwide demands that healthcare institutions and educators work with policymakers and clinicians to implement PC and PM principles that ensure dignity, quality of life, and compassionate care for all patients with serious illnesses (33). The creation of patient-centered value-driven healthcare depends on total acceptance of PC and PM's holistic vision, which focuses treatment on the core values of patients and their families (87). PM doctors and nurses' knowledge and use of medication is extensive, particularly given the few teams with pharmacist support, despite PC medical teams using those medications and treatments in various clinical and non-clinical care settings (34).

Future Research and Practical Implications

The review points out several crucial areas where we really need to focus our research efforts to enhance the role of PM in today's healthcare landscape. To start, we should conduct comparative studies across world regions to examine how different policy frameworks, reimbursement systems, and cultural contexts affect access to and integration of palliative care (PC) and palliative medicine (PM). Next, there's a pressing need for more empirical research to assess the effectiveness of interdisciplinary training programs for everyone involved, from

specialists to generalists, including nurses, primary care providers, and hospitalists. Lastly, we should investigate longitudinal studies that examine the long-term benefits of integrating PC early on, especially for chronic and non-cancer conditions, to gather solid evidence supporting wider adoption.

From these research priorities, we can draw some practical implications. Healthcare institutions ought to weave PM principles into everyday practice by promoting teamwork across disciplines, enhancing communication training, and aligning care models with what patients truly value. Educational planners and professional organizations need to ensure PM is a key part of curricula and ongoing education so our workforce is ready to provide holistic, dignity-preserving care. Policymakers should focus on ensuring fair access to essential medications, creating sustainable funding models, and establishing national frameworks that recognize PM as a vital part of value-based healthcare.

By merging thorough research with actionable strategies, we can elevate PM from a niche specialty to a fundamental element of healthcare systems worldwide, ultimately fostering compassion, dignity, and improved quality of life for patients and their families.

Conclusion

PM evolved from PC but remains distinct. The first having evolved from within the second. PM is often perceived as an unconventional medical specialty because of its unique focus on preserving and enhancing patients' quality of life with incurable conditions, rather than seeking a cure. This specialty emerged from the hospice movement, which sought to address deficiencies in the traditional biomedical model of care by emphasizing symptom management, psychosocial support, and end-of-life ethics. Despite its relatively recent recognition as a distinct specialty, PM has become essential in managing complex patient needs across various medical fields, including oncology, neurology, pediatrics, and geriatrics, among many. Its holistic, patient-centered approach distinguishes PM, reinforcing its perception as an 'odd' specialty. However, its growing importance and demand highlight its critical role in modern healthcare systems.

The numerous and varied activities associated with PC make it challenging to understand and accept within society. PC, in general, and PM, as a medical specialty, must find new and innovative ways to make themselves better known and publicize their results periodically and widely.

These insights confirm the theoretical foundations of PM, particularly total pain, patient-centered care, and value-based healthcare. In the immediate future, given actual demographics and PC's unique role in the COVID-19 pandemic, when it is said to have come of age, and its untiring work in LMIC and world-devastated areas, it must accept its place within Public Health, itself becoming an asset regarding quality of clinical complexity outcomes. PC humility is equally present in PM, which is incredibly important, as such a refreshing attitude is attractive. At times, PM is healthcare's Cinderella, allowing specialists to go beyond showing that best medical practice and compassion are robust pillars supporting SHrS.

Abbreviations

ABMS: American Board of Medical Specialties, EoLC: End-of-Life Care, HPM: Hospice and Palliative Medicine, ICU: Intensive Care Unit, ILD: Interstitial Lung Disease, LMICs: Low- and Middle-Income Countries, LPDs: Low-Prevalence Diseases, PC: Palliative Care, PM: Palliative Medicine, ShRS: Serious Health-Related Suffering.

Acknowledgment

None.

Author Contributions

María Teresa García-Baquero Merino: conception of the study, design of the study, interpretation, writing of the manuscript, Micaela Menarquez: research process of the manuscript, writing of the manuscript, critically reviewed the material for intellectual accuracy, Ignacio Segarra: intellectual work in the study, manuscript preparation, revision, final approval. The final version of the manuscript was reviewed and approved by all authors, and they are willing to take responsibility for all aspects of the work.

Conflict of Interest

No potential conflict of interest was reported by the author(s).

Declaration of Artificial Intelligence (AI) Assistance

No usage of AI.

Ethics Approval

Not Applicable.

Funding

The author(s) reported that there is no funding associated with the work featured in this article.

References

1. Sleeman K, Higginson I, Evans C. How do hospice and specialist palliative care services influence care, home staff confidence to provide palliative and end-of-life care? BMJ Support Palliat Care. 2024;14(4):86. https://doi.org/10.1136/spcare-2024-HUNC.105
2. Basu A, Mittag B, Miller K. Palliative care in low-and medium-resource countries. Cancer J. 2013;19(5): 410-3. doi: 10.1097/01.PPO.0000434392.18811.3c
3. Maher F, Mammas I, Spandidos D. Challenges and perspectives of palliative medicine: A webinar by the Paediatric Virology Study Group. Med Int (Lond). 2023;3(3):24. doi: 10.3892/mi.2023.84
4. WHO. World Health Organization. Palliative Care. 2023. https://www.who.int/europe/news-room/fact-sheets/item/palliative-care
5. Radbruch L, De L, Knaul F, *et al.* Redefining palliative care—a new consensus-based definition. J Pain Symptom Manage. 2020;60(4):754-64. doi: 10.1016/j.jpainsymman.2020.04.027
6. Jadhav U, Bhanushali J, Sindhu A, *et al.* Navigating compassion: A comprehensive review of Palliative Care in Respiratory Medicine. Cureus. 2023;15(12): e50613. doi: 10.7759/cureus.50613
7. Paice J, Malloy P, Mazanec P, *et al.* Virani-Cooksey RMJJoP, Management S. Dr. Betty Ferrell and the extraordinary pursuit of worldwide Palliative Nursing Education. J Pain Symptom Manage. 2025; 69(1): e7-e11. doi: 10.1016/j.jpainsymman.2024.10.008
8. Hearing PW. American Academy of Hospice and Palliative Medicine. 2023. https://scholar.google.com/scholar?hl=en&as_sdt=0%2C5&q=Hearing+PW.+American+Academy+of+Hospice+and+Palliative+Medicine.+2023.+&btnG=
9. Hui D, Paiva B, Paiva C. Personalizing the setting of palliative care delivery for patients with advanced cancer: "care anywhere, anytime". Curr Treat Options Oncol. 2023;24(1):1-11. doi: 10.1007/s11864-022-01044-1
10. Dzierżanowski T. Definitions of palliative care–narrative review and new proposal. Palliative Med. 2021;13(4):187–200. doi:10.5114/pm.2021.114495
11. Macken L, Corrigan M, Prentice, *et al.* Palliative long-term abdominal drains for the management of refractory ascites due to cirrhosis: A consensus document. Frontline Gastroenterol. 2022 Jun 10;13(e1): e116-e125. doi: 10.1136/flgastro-2022-102128
12. Temel J, Jackson V, El-Jawahri A, *et al.* Stepped palliative care for patients with advanced lung cancer: A randomized clinical trial. JAMA. 2024;332(6):471-481. doi: 10.1001/jama.2024.10398
13. Bernacki R, Paladino J, Neville B, *et al.* Effect of the serious illness care program in outpatient oncology: a cluster randomized clinical trial. JAMA Intern Med. 2019;179(6):751-759. doi: 10.1001/jamainternmed.2019.0077
14. Saunders C. The evolution of palliative care. J R Soc Med. 2001;94(9):430-432. doi: 10.1177/014107680109400904
15. Meier D. Increased access to palliative care and hospice services: opportunities to improve value in health care. Milbank Q. 2011;89(3):343-80. doi: 10.1111/j.1468-0009.2011.00632.x
16. Connor S, Pyenson B, Fitch K, *et al.* Comparing hospice and non-hospice patient survival among patients who die within a three-year window. J Pain Symptom Manage. 2007;33(3):238-46. doi: 10.1016/j.jpainsymman.2006.10.010
17. Hanks GW. Oxford textbook of palliative medicine. OUP Oxford, 21-Jul-2011 - Medical - 1666 pages. https://books.google.com.pk/books/about/Oxford_Textbook_of_Palliative_Medicine.html?id=Fk9uBAAAQBAJ&redir_esc=y
18. Hain R, Heckford E, McCulloch R. Paediatric palliative medicine in the UK: past, present, future. Arch Dis Child. 2012;97(4):381-4. doi: 10.1136/archdischild-2011-300432
19. Gunten C, Lupu D. Development of a medical subspecialty in palliative medicine: progress report. J Palliat Med. 2004;7(2):209-19. doi: 10.1089/109662104773709332
20. Quill T, Abernethy A. Generalist plus specialist palliative care—creating a more sustainable model. N Engl J Med. 2013;368(13):1173-5. doi: 10.1056/NEJMp1215620
21. WHO. It's time to walk the talk: WHO Independent High-level Commission on Noncommunicable Diseases-final report: WHO; 2019. https://www.who.int/publications/i/item/9789241517003
22. Clark D. From margins to centre: a review of the history of palliative care in cancer. Lancet Oncol. 2007;8(5):430-8. doi: 10.1016/S1470-2045(07)70138-9
23. Knaul F, Farmer P, Krakauer E, *et al.* Alleviating the access abyss in palliative care and pain relief—an imperative of universal health coverage: The Lancet Commission report. Lancet. 2018;391(10128):1391-1454. doi: 10.1016/S0140-6736(17)32513-8
24. WHO. World Health Organization. Palliative Care. 2020. https://www.who.int/news-room/fact-sheets/detail/palliative-care
25. Aslakson R, Curtis J, Nelson J. The changing role of palliative care in the ICU. Crit Care Med. 2014; 42(11):2418-28. doi: 10.1097/CCM.0000000000000573

26. Hui D, Bruera E. Models of palliative care delivery for patients with cancer. J Clin Oncol. 2020;38(9):852-865.
doi: 10.1200/JCO.18.02123
27. Temel J, Greer J, Muzikansky A, *et al.* Early palliative care for patients with metastatic non–small-cell lung cancer. N Engl J Med. 2010;363(8):733-42.
doi: 10.1056/NEJMoa1000678
28. Zimmermann C, Swami N, Krzyzanowska M, *et al.* Early palliative care for patients with advanced cancer: A cluster - randomised controlled trial. Lancet. 2014;383(9930):1721-30.
doi: 10.1016/S0140-6736(13)62416-2
29. Titko E, Dei M, Smalii O, *et al.* Impact of Palliative Care/Medicine on realization of "Right to Life" and "Right to Dignity" in the context of Human Rights Protection. J Hist Cult Art Res. 2020;9(1):49.
doi:10.7596/taksad.v9i1.2534
30. Teno J, Gozalo P, Trivedi A, *et al.* Site of death, place of care, and health care transitions among US Medicare beneficiaries, 2000-2015. JAMA. 2018; 320(3):264-271.
doi: 10.1001/jama.2018.8981
31. Rodin G, An E, Shnall J, *et al.* Psychological interventions for patients with advanced disease: implications for oncology and palliative care. J Clin Oncol. 2020 Mar 20;38(9):885-904.
doi: 10.1200/JCO.19.00058
32. Bakitas M, Elk R, Astin M, *et al.* Systematic review of palliative care in the rural setting. Cancer Control. 2015;(4):450-64.
doi: 10.1177/107327481502200411
33. Kavalieratos D, Lowers J, Moreines L, *et al.* Embedded specialist palliative care in cystic fibrosis: results of a randomized feasibility clinical trial. J Palliat Med. 2023;(4):489-496.
doi: 10.1089/jpm.2022.0349
34. Aldridge M, Hasselaar J, Garralda E, *et al.* Education, implementation, and policy barriers to greater integration of palliative care: a literature review. Palliat Med. 2016;30(3):224-39.
doi: 10.1177/0269216315606645
35. Meier D, Back A, Berman A, *et al.* A national strategy for palliative care. Health Aff (Millwood). 2017;36(7):1265-1273.
doi: 10.1377/hlthaff.2017.0164
36. Correa-Morales J, Umbacia M, Martinez C, *et al.* The paramount role of palliative care in low-prevalence diseases. Int J Palliat Nurs. 2025;31(4):181-188.
doi: 10.12968/ijpn.2023.0039
37. Wong K, Chow A, Chan I. Effectiveness of educational programs on palliative and end-of-life care in promoting perceived competence among health and social care professionals. Am J Hosp Palliat Care. 2022;39(1):45-53.
doi: 10.1177/10499091211038501
38. Dehghani F, Barkhordari - Sharifabad M, Sedaghati-Kasbakhi M, *et al.* Effect of palliative care training on perceived self-efficacy of the nurses. BMC Palliat Care. 2020 May 4;19(1):63.
doi: 10.1186/s12904-020-00567-4
39. Best M, Leget C, Goodhead A, *et al.* An EAPC white paper on multi-disciplinary education for spiritual care in palliative care. BMC Palliat Care. 2020;19(1):9.
doi: 10.1186/s12904-019-0508-4
40. Sullivan D, Iyer A, Enguidanos S, *et al.* Palliative care early in the care continuum among patients with serious respiratory illness: An official ATS/ AAHPM/ HPNA/ SWHPN policy statement. Am J Respir Crit Care Med. 2022;206(6): e44-e69.
doi: 10.1164/rccm.202207-1262ST
41. Carduff E, Johnston S, Winstanley C, *et al.* What does 'complex' mean in palliative care? Triangulating qualitative findings from 3 settings. BMC Palliat Care. 2018;17(1):12.
doi: 10.1186/s12904-017-0259-z
42. Hodiamont F, Jünger S, Leidl R, *et al.* Understanding complexity–the palliative care situation as a complex adaptive system. BMC Health Serv Res. 2019;19(1):157.
doi: 10.1186/s12913-019-3961-0
43. Janssen D, Bajwah S, Boon M, *et al.* European Respiratory Society clinical practice guideline: palliative care for people with COPD or interstitial lung disease. Eur Respir J. 2023;62(2):2202014.
doi: 10.1183/13993003.02014-2022
44. Benini F, Papadatou D, Bernadá M, *et al.* International standards for pediatric palliative care: from IMPaCCT to GO-PPaCS. J Pain Symptom Manage. 2022 May;63(5): e529-e543.
doi: 10.1016/j.jpainsymman.2021.12.031
45. Laura L. Holistic palliative care needs assessment in older patients with complex chronic conditions and their families: Challenges and opportunities for improved quality of care. 2024.
URL: https://hdl.handle.net/10550/100861
46. Clark D, Baur N, Clelland D, *et al.* Mapping levels of palliative care development in 198 countries: the situation in 2017. J Pain Symptom Manage. 2020; 9(4):794-807.e4.
doi: 10.1016/j.jpainsymman.2019.11.009
47. Samuels A, Dekker N, Practice S. Palliative care practices and policies in diverse socio-cultural contexts: aims and framework of the ERC globalizing palliative care comparative ethnographic study. Palliat Care Soc Pract. 2023;17: 26323524231198546.
doi: 10.1177/26323524231198546
48. Javanparast S, Anaf J, Tieman J. Equity consideration in palliative care policies, programs, and evaluation: an analysis of selected federal and South Australian documents. BMC Palliat Care. 2022;21(1).
doi:10.1186/s12904-022-00997-2
49. Osei E, Lee H, Kim S. Comparison of legislation, regulations, and national health policies for palliative care in three East Asian countries: A review of the literature. J Glob Health Sci. 2022;4(6).
doi:10.35500/jghs.2022.4.e3
50. Xiao J, Brenneis C, Fassbender K. Stakeholder perspectives towards implementing the national framework on palliative care in Canada. Health Policy. 2022;126(6):576-583.
doi: 10.1016/j.healthpol.2022.01.011
51. Payne S, Harding A, Williams T, *et al.* Revised recommendations on standards and norms for palliative care in Europe from the European Association for Palliative Care (EAPC): A Delphi study. Palliat Med. 2022 Apr;36(4):680-697.
doi: 10.1177/02692163221074547
52. Jordan R, ElMokhallalati Y, Corless L, *et al.* Quality of end-of-life care with non-malignant liver disease:

analysis of the VOICES National Survey of Bereaved People. Liver Int. 2023;43(2):308-316. doi: 10.1111/liv.15428
53. Gomes B, Calanzani N, Curiale V, *et al.* Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers. Cochrane Database Syst Rev. 2013;2013(6):CD007760. doi: 10.1002/14651858.CD007760.pub2
54. Dahlin C, Coyne P, Goldberg J, *et al.* Palliative care leadership. J Palliat Care. 2018 Aug 16: 825859718791427. doi: 10.1177/0825859718791427
55. Bhise V, Rajan S, Sittig D, *et al.* Defining and measuring diagnostic uncertainty in medicine: a systematic review. J Gen Intern Med. 2018;33(1): 103-115. doi: 10.1007/s11606-017-4164-1
56. Larson A, Curtis J. Integrating palliative care for liver transplant candidates: "too well for transplant, too sick for life". JAMA. 2006;295(18):2168-76. doi: 10.1001/jama.295.18.2168
57. Walsh F, McGoldrick M. A family systems perspective on loss, recovery and resilience. In: In: Sutcliffe P, Tufnell, G., Cornish, U. (eds) editor. Working with the Dying and Bereaved. Palgrave, London: Springer; 1998. p. 1-26. https://doi.org/10.1007/978-1-349-26222-9_1
58. Kent A. Nursing Care of family caregivers: Interventions and considerations regarding current issues facing family caregivers of persons with dementia relevant to nursing practice [Senior Honors Theses]. 2023. https://digitalcommons.liberty.edu/honors/1344
59. Stroebe M, Schut H. Bereavement in times of COVID-19: A review and theoretical framework. Omega (Westport). 2021;82(3):500-522. doi: 10.1177/0030222820966928
60. Fitchett G, Hisey A, Hoffmeyer C, *et al.* Development of the PC-7, a quantifiable assessment of spiritual concerns of patients receiving palliative care near the end of life. J Palliat Med. 2020;23(2):248-253. doi: 10.1089/jpm.2019.0188
61. Vivat B, Lodwick R, Merino MTG-B, *et al.* What do palliative care professionals understand as spiritual care? Findings from an EAPC survey. Religion. 2023, 14(3), 298. https://doi.org/10.3390/rel14030298
62. Puchalski C, Ferrell B, Battista V, *et al.* Interprofessional Spiritual Care. Handbook of Psychiatry in Palliative Medicine 3rd Edition: Psychosocial Care of the Terminally Ill2023. p. 396. 2022. doi:10.1093/med/9780197583838.003.0027
63. Aldridge M, Epstein A, Brody A, *et al.* Association between hospice spending on patient care and rates of hospitalization and Medicare expenditures of hospice enrollees. J Palliat Med. 2018;21(1):55-61. doi: 10.1089/jpm.2017.0101
64. Rolland J. COVID-19 pandemic: Applying a multisystemic lens. Fam Process. 2020;59(3):922-936. doi: 10.1111/famp.12584
65. Menzies R, Neimeyer R, Menzies R. Death anxiety, loss, and grief in the time of COVID-19. Behaviour Change. 2020;37(3):111-115. doi:10.1017/bec.2020.10
66. Sullivan D, Iyer A, Reinke L. Collaborative primary palliative care in serious illness: a pragmatic path forward. Ann Am Thorac Soc. 2023;20(3):358-360. doi: 10.1513/AnnalsATS.202206-556VP
67. Bernacki G, McDermott C, Matlock D, *et al.* Advance care planning documentation and intensity of care at the end of life for adults with congestive heart failure, chronic kidney disease, and both illnesses. J Pain Symptom Manage. 2022;63(2): e168-e175. doi: 10.1016/j.jpainsymman.2021.07.030
68. Antonacci R, Barrie C, Baxter S, *et al.* Gaps in hospice and palliative care research: a scoping review of the North American literature. J Aging Res. 2020 Nov 5: 2020:3921245. doi: 10.1155/2020/3921245
69. Persenaire C, Spinosa D, Brubaker L, *et al.* Incorporation of palliative care in gynecologic oncology. Curr Oncol Rep. 2023;25(11):1295-1305. doi: 10.1007/s11912-023-01457-7
70. Scheffler R, Bowers L, Fulton B, *et al.* A new vision for California's healthcare system: Integrated care with aligned financial incentives. Calif J Polit Policy. 2014;6(2). https://doi.org/10.5070/P2N019
71. Morrison R, Penrod J, Cassel J, *et al.* Cost savings associated with US hospital palliative care consultation programs. Arch Intern Med. 2008;168 (16):1783-90. doi: 10.1001/archinte.168.16.1783
72. Pask S, Mohamed A, Leniz J, *et al.* Better End of Life 2022. 2022. https://www.mariecurie.org.uk/globalassets/media/documents/policy/beol-reports-2022/better-end-of-life-report-2022.pdf
73. Ahmed S, Simon J, Biondo P, *et al.* Acceptability of automatic referrals to supportive and palliative care by patients living with advanced lung cancer: qualitative interviews and a co-design process. Res Involv Engagem. 2024;10(1):36. doi: 10.1186/s40900-024-00568-0
74. Kircher C, Hanna T, Tranmer J, *et al.* Defining "early palliative care" for adults diagnosed with a life-limiting illness: A scoping review. BMC Palliat Care. 2025;24(1):93. doi: 10.1186/s12904-025-01712-7
75. Goyal A, Tur K, Mann J, el al. Do bedside visual tools improve patient and caregiver satisfaction? A systematic review of the literature. J Hosp Med. 2017;12(11):930-936. doi: 10.12788/jhm.2871
76. Singh S, Fletcher K, Pandl G, *et al.* It's the writing on the wall: Whiteboards improve inpatient satisfaction with provider communication. Am J Med Qual. 2011; 26(2):127-31. doi: 10.1177/1062860610376088
77. Dudas R, Lemerman H, Barone M, *et al.* PHACES (Photographs of Academic Clinicians and Their Educational Status): A tool to improve delivery of family-centered care. Acad Pediatr. 2010;10(2):138-45. doi: 10.1016/j.acap.2009.12.006
78. Penrod J, Deb P, Luhrs C, *et al.* Cost and utilization outcomes of patients receiving hospital-based palliative care consultation. Palliat Med. 2010;13(8): 973-9.

doi: 10.1089/jpm.2010.0038
79. Smith T, Coyne P, Cassel B, *et al.* A high-volume specialist palliative care unit and team may reduce in-hospital end-of-life care costs. J Palliat Med. 2003; 6(5):699-705. doi: 10.1089/109662103322515202
80. May P, Garrido M, Cassel J, *et al.* Prospective cohort study of hospital palliative care teams for inpatients with advanced cancer: earlier consultation is associated with larger cost-saving effect. J Clin Oncol. 2015;33(25):2745-52. doi: 10.1200/JCO.2014.60.2334
81. May P, Garrido M, Cassel J, *et al.* Palliative care teams' cost-saving effect is larger for cancer patients with higher numbers of comorbidities. Health Aff (Millwood). 2016;35(1):44-53. doi: 10.1377/hlthaff.2015.0752
82. Zhang B, Wright A, Huskamp H, *et al.* Health care costs in the last week of life: Associations with end-of-life conversations. Arch Intern Med. 2009;169(5):480-8. doi: 10.1001/archinternmed.2008.587
83. Gade G, Venohr I, Conner D, *et al.* Impact of an inpatient palliative care team: A randomized controlled trial. J Palliat Med. 2008;11(2):180-90. doi: 10.1089/jpm.2007.0055
84. Groeneveld EI, Cassel JB, Bausewein C, *et al.* Funding models in palliative care: Lessons from international experience. Palliat Med. 2017;31(4):296-305. doi: 10.1177/0269216316689015
85. Piskorz-Ryń O, Olsen G, Karstensen V, *et al.* Healthcare providers' perspectives on the implementation of patient-centered care models in hospitals. Palliat Med. 2017;31(4):296-305. doi: 10.1177/0269216316689015
86. Dalal S, Bruera E. End-of-life care matters: Palliative cancer care results in better care and lower costs. Oncologist. 2017;22(4):361-368. doi: 10.1634/theoncologist.2016-0277
87. Brant J. Holistic total pain management in palliative care: Cultural and global considerations. Palliat Med Hosp Care Open J SE. 2017; 1(1): S32-S38. doi:10.17140/PMHCOJ-SE-1-108
88. Fang M, Sixsmith J, Sinclair S, *et al.* A knowledge synthesis of culturally-and spiritually-sensitive end-of-life care: Findings from a scoping review. BMC Geriatr. 2016;16(1):107. doi: 10.1186/s12877-016-0282-6
89. Strand M, Sjöstrand M, Lindblad A. A palliative care approach in psychiatry: Clinical implications. BMC Med Ethics. 2020;21(1):29. doi: 10.1186/s12910-020-00472-8
90. Merino MTG-B, Sánchez MVR, Pettus K, *et al.* The challenges facing palliative care advocacy: What is in a name? Chapters, in: Marco Cascella & Michael John Stones (ed.), Suggestions for Addressing Clinical Non-Clinical Issues in Palliative Care: IntechOpen; 2021:291. doi:10.5772/intechopen.97367
91. Sampaio S, Motta L, Caldas C. Value-based medicine and palliative care: how do they converge? Expert Rev Pharmacoecon Outcomes Res. 2019;19(5):509-515. doi: 10.1080/14737167.2019.1651645
92. NHS. NHS England. Commissioning guidance for palliative and end of life care services. 2024. https://www.england.nhs.uk/
93. Phelan C, Hammond L, Thorpe C, *et al.* A novel approach to managing thirst and dry mouth in palliative care: A prospective randomized cross-over trial. J Pain Symptom Manage. 2023;66(5):587-594.e2. doi: 10.1016/j.jpainsymman.2023.08.005
94. Gaertner J, Siemens W, Meerpohl J, *et al.* Effect of specialist palliative care services on quality of life in adults with advanced incurable illness in hospital, hospice, or community settings: Systematic review and meta-analysis. BMJ. 2017;4:357:j2925. doi: 10.1136/bmj.j2925
95. Masman A, van D, Tibboel D, *et al.* Medication use during end-of-life care in a palliative care centre. Int J Clin Pharm. 2015;37(5):767-75. doi: 10.1007/s11096-015-0094-3
96. Wernli U, Duerr F, Jean-Petit-Matile S, *et al.* Subcutaneous drugs and off-label use in hospice and palliative care: A scoping review. J Pain Symptom Manage. 2022;64(5): e250-e259. doi: 10.1016/j.jpainsymman.2022.07.006
97. Franken L, de Winter BM, Van Esch H, *et al.* Pharmacokinetic considerations and recommendations in palliative care, with focus on morphine, midazolam and haloperidol. Expert Opin Drug Metab Toxicol. 2016;12(6):669-80. doi: 10.1080/17425255.2016.1179281
98. Leong L, Crawford G. Residential aged care residents and components of end of life care in an Australian hospital. 2018;17:1-9. BMC Palliat Care. 2018;17(1):84. doi: 10.1186/s12904-018-0337-x
99. Datta R, Juthani-Mehta M. Burden and management of multidrug-resistant organisms in palliative care. Palliat Care. 2017; 10: 1178224217749233. doi: 10.1177/1178224217749233
100. Ntizimira C, Uhagaze B, Mukeshimana O, *et al.* Palliative care: Challenges and opportunities–A comparison of the fee-for-service system of the united states with rwanda's public health approach. In book: Palliative Care for Chronic Cancer Patients in the Community. 2021:281-292. doi:10.1007/978-3-030-54526-0_25

How to Cite: Merino MTGB, Menárguez M, Segarra I. The Odd One Out: A Review of Palliative Medicine in Modern Healthcare. Int Res J Multidiscip Scope. 2026; 7(1): 1092-1111.
DOI: 10.47857/irjms.2026.v07i01.08581