

INTEGRATED MANAGEMENT OF CHRONIC DISEASE IN PATIENTS WITH PALLIATIVE CARE NEEDS AS PERSON-CENTRED APPROACH

Dascalu Daciana -Nicoleta^{1*}

¹Lecturer, Medical Department- Faculty of Medicine, Lucian Blaga University, Sibiu, Romania.

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***Corresponding Author: Dascalu Daciana -Nicoleta**

Lecturer, Medical Department- Faculty of Medicine, Lucian Blaga University, Sibiu, Romania.

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ABSTRACT

Chronic diseases are a major cause of morbidity, disability, and mortality worldwide. As chronic conditions progress, many patients experience complex physical symptoms, psychological distress, social difficulties, and spiritual concerns that significantly affect their quality of life. Patients with advanced chronic diseases may therefore develop palliative care needs alongside their ongoing disease-directed treatment. The management of chronic disease in this population requires a shift from focusing exclusively on cure or disease control toward a comprehensive, person-centred approach that addresses comfort, function, autonomy and quality of life. The main objectives include effective symptom management, preservation of functional ability, psychological and social support, shared decision-making, advance care planning, coordination of care and appropriate use of medical treatments. Palliative care should be integrated early rather than reserved only for the final days of life. This paper discusses the principal objectives and approaches to the management of chronic diseases in patients with palliative care needs and emphasizes the importance of holistic, multidisciplinary and patient-centred care. Advance care planning and effective communication are also essential components of care, particularly as the patient's condition deteriorates.

KEYWORDS: chronic disease, palliative care, symptom management, quality of life, patient-centred care, advance care planning, end-of-life care, shared decision-making.

INTRODUCTION

Chronic diseases such as cardiovascular disease, chronic respiratory disease, cancer, neurological disorders, chronic kidney disease and advanced liver disease are frequently associated with prolonged illness, recurrent exacerbations, functional decline and increasing healthcare needs. As these diseases progress, patients may experience symptoms that cannot always be adequately controlled through disease-directed treatment alone.^[1]

Pain, breathlessness, fatigue, nausea, anxiety, depression, sleep disturbances, weakness, and loss of independence

can substantially reduce quality of life. The World Health Organization (WHO) identifies chronic diseases as a major population requiring palliative care, with cardiovascular disease, cancer, and chronic respiratory disease accounting for a substantial proportion of adults who need such care (World Health Organization [WHO], 2020).

Palliative care is an approach that aims to improve the quality of life of patients and their families facing serious illness. It addresses physical symptoms as well as psychological, social, and spiritual needs. Importantly, palliative care is not limited to patients who are

imminently dying. It can be introduced at different stages of a chronic illness and can be provided alongside treatments intended to control the underlying disease. (WHO, 2023)

The management of patients with chronic diseases and palliative care needs therefore requires a broader understanding of therapeutic goals and set of objectives. The purpose is not necessarily to prolong life at any cost, but to achieve the outcomes that are most important to the individual patient. This may include maintaining independence, reducing distressing symptoms, remaining at home, spending meaningful time with family or avoiding burdensome interventions that are unlikely to provide meaningful benefit. Care should balance disease-directed interventions with symptom relief, quality of life, functional ability, autonomy, and the patient's personal values.^{[2][3]}

1. Assessment of the Patient's Individual Needs

The first objective of management is to undertake a comprehensive assessment of the patient's condition and individual needs. Patients with advanced chronic diseases often have multiple symptoms and comorbidities, making isolated treatment of a single disease insufficient.

Assessment should include physical symptoms, functional status, psychological wellbeing, social circumstances, spiritual concerns, and the patient's understanding of their illness. Healthcare professionals should also assess the patient's goals, expectations, values, and preferences.

Regular reassessment is particularly important because palliative care needs can change rapidly. A patient who is relatively stable may develop significant symptoms following an exacerbation or hospitalization. Management should therefore remain flexible and responsive to changes in the patient's condition.^[3]

2. Effective Symptom Management

One of the central objectives of palliative care is the prevention and relief of suffering. Symptoms should be identified systematically and managed according to their severity, cause, and impact on daily life.

Common symptoms in advanced chronic disease include:

- pain
- breathlessness
- fatigue and weakness
- nausea and vomiting
- constipation
- loss of appetite and weight loss
- anxiety and depression
- insomnia
- confusion or delirium
- reduced mobility and functional dependence.

should combine appropriate pharmacological and non-pharmacological interventions. Medication must be reviewed regularly to determine whether each treatment continues to provide meaningful benefit. In patients with limited prognosis, medications intended primarily to prevent long-term complications may become less important than medications that provide immediate symptom relief.

Symptom management should consider potential adverse effects, interactions between medications, renal and hepatic function and the patient's ability to take medicines safely.

3. Preservation of Quality of Life

Improving and maintaining quality of life is a major objective of management for patients with palliative care needs. Quality of life is highly individual and may involve physical comfort, independence, relationships, emotional wellbeing, meaningful activities or the ability to remain in a familiar environment. (WHO, 2023)

Healthcare professionals should ask patients what matters most to them rather than assuming that prolongation of life is their primary objective. Treatment decisions will be evaluated according to whether they contribute to the patient's personally defined goals.^[4]

Maintaining dignity is also fundamental. Patients should be treated with respect, privacy, compassion, and consideration regardless of the severity of their illness or level of dependency.^{[5][6]}

4. Maintaining Functional Ability and Independence

Progressive chronic disease can lead to weakness, reduced mobility, dependence on caregivers, and loss of the ability to perform everyday activities. Preserving functional ability for as long as possible is therefore another important objective. Physiotherapy, occupational therapy, nutritional support, mobility aids, appropriate exercise, and environmental modifications may help patients remain independent. Even when complete recovery is not possible, rehabilitation can help patients maintain meaningful levels of activity and participation.^[7]

Management focuses on what the patient is still able to do and how those abilities can be preserved. Small improvements in mobility or self-care can have significant effects on confidence and quality of life.^{[3][6]}

5. Psychological and Emotional Support

Living with an advanced chronic disease can cause fear, uncertainty, grief, frustration, anxiety, and depression. Psychological distress may also worsen physical symptoms and reduce adherence to treatment.

Healthcare professionals may provide opportunities for patients to express their concerns and emotions. Active listening and clear communication can help patients

understand their condition and reduce feelings of isolation.

When appropriate, patients should have access to psychological counselling, social workers, mental health professionals, spiritual care providers or other support services. Emotional support should also extend to family members and caregivers.^[6]

6. Supporting Families and Caregivers

Chronic illness frequently affects not only the patient but also family members and informal caregivers. Caregivers may experience physical exhaustion, emotional distress, financial difficulties and uncertainty about how to provide appropriate care. An important objective of palliative care is therefore to assess caregiver needs and provide education and practical support. Families should receive understandable information about the patient's condition, expected progression, medication, symptom management, and what to do during deterioration.

Supporting caregivers can improve the patient's overall care and may help prevent caregiver burnout and unnecessary hospital admissions.

7. Shared Decision-Making and Respect for Autonomy-Patient centred approach

Patients with advanced chronic diseases should be actively involved in decisions concerning their treatment whenever possible. Shared decision-making involves communication between the patient and healthcare professionals about available options, expected benefits and burdens, and the patient's values and preferences.^[6]

Healthcare professionals should avoid presenting treatment decisions solely in terms of what is medically possible. Instead, they can discuss whether an intervention is consistent with the patient's goals. Respect for autonomy includes recognizing a competent patient's right to accept or refuse treatment. Communication should be honest but sensitive, particularly when discussing disease progression, prognosis and end-of-life issues.

8. Advance Care Planning

Advance care planning allows patients to discuss their future healthcare preferences before they become unable to communicate or make decisions. It may include preferences concerning hospitalization, resuscitation, artificial nutrition or hydration, place of care, and other treatments. Advance care planning begins ideally before a crisis occurs. Discussions will be revisited as the patient's disease progresses because preferences may change over time. The objective is not simply to complete documentation but to ensure that future care reflects the patient's values and wishes.^{[3][6][8][9]}

9. Appropriate Use of Disease-Directed Treatment

Palliative care does not necessarily mean stopping treatment for the underlying chronic disease. Disease-

directed and palliative treatments may be provided simultaneously when they remain beneficial. However, as disease progresses, the balance between benefit and burden should be reviewed regularly. Some interventions may have limited benefit while causing substantial discomfort, inconvenience or risk.^[3] Treatment decisions will therefore consider prognosis, treatment burden, potential benefits, patient preferences, and overall goals of care. In this moment of disease evolution, the focus is on proportional and appropriate treatment rather than treatment intensity for its own sake.

10. Coordination of Multidisciplinary Care

Patients with complex chronic diseases frequently require care from multiple professionals, including physicians, nurses, pharmacists, physiotherapists, dietitians, psychologists, social workers, and palliative care specialists.^{[3],[9]}

Effective coordination is essential to prevent fragmented care and conflicting treatment plans. Communication is occurring across primary care, hospital services, specialist clinics, community services or home-care providers. A coordinated approach can help patients receive the right care in the right setting and may reduce unnecessary emergency department visits and hospital admissions. NICE (2019) recommends coordinated communication between health and social care professionals so that there is a shared understanding of the patient's needs and care preferences. Good coordination can reduce fragmented care and support patients in receiving appropriate care in their preferred setting.

11. End-of-Life Care

When a chronic disease reaches an advanced stage and death becomes likely, the objectives of care will increasingly focus on **comfort and dignity**. During the final phase of life symptom control, emotional support, communication and family involvement become particularly important. Patients should receive appropriate management of pain, breathlessness, agitation, nausea, secretions or other distressing symptoms. Families should be informed about expected changes and supported throughout the process.

End-of-life care should respect the patient's cultural, spiritual, and personal preferences. The aim is to ensure that the patient experiences the final stage of life with as much comfort, dignity and respect as possible.^{[4],[5],[6]}

CONCLUSION

The management of chronic diseases in patients with palliative care needs requires a holistic and individualized approach. The primary objectives extend beyond controlling the underlying disease and include relieving symptoms, improving quality of life, preserving independence, addressing psychological and social needs, supporting families, respecting autonomy and ensuring appropriate treatment according to the patient's goals.

Palliative care should be considered an integral component of the management of serious chronic illness rather than exclusively an intervention for the final days of life. Early recognition of palliative care needs allows healthcare professionals to establish meaningful goals, improve communication, coordinate multidisciplinary services and avoid treatments that may provide limited benefit while imposing significant burdens.

Quality management is achieved when care is centred on the individual rather than solely on the disease. By combining appropriate medical treatment with compassionate communication, symptom control, psychosocial support and advance care planning, healthcare professionals can help patients with advanced chronic diseases live as well as possible for as long as possible while maintaining dignity and respecting their preferences.

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