OPEN ACCESS

Saudi Journal of Medical and Pharmaceutical Sciences

Abbreviated Key Title: Saudi J Med Pharm Sci
ISSN 2413-4929 (Print) | ISSN 2413-4910 (Online)
Scholars Middle East Publishers, Dubai, United Arab Emirates
Journal homepage: https://saudijournals.com

Review Article **Medicine**

Family Physicians Managing Multimorbidity Through a Palliative Care Prespective

Omar Atallah O Alatawi[1]*, Fawaz Hassan H Alamri[2], Rawan Mohammad Alhayyan[3], Ghada Sulaiman Saleh Alfaleh[3]

[1]Consultant Family Medicine, King Salman Armed Forces Hospital, Tabuk, Saudi Arabia
[2]Consultant Palliative Care, Prince Sultan Oncology Center, King Salman Armed Forces Hospital in the Northwest Region, Tabuk City, Saudi Arabia
[3]Consultant of Family Medicine, Family Medicine Department, Prince Sultan Military MedicalCity, Riyadh, Saudi Arabi

DOI: https://doi.org/10.36348/sjmps.2025.v11i12.018 | **Received:** 08.11.2025 | **Accepted:** 22.12.2025 | **Published:** 30.12.2025

***Corresponding author:** Omar Atallah O Alatawi
Consultant Family Medicine, King Salman Armed Forces Hospital, Tabuk, Saudi Arabia

Abstract

Family physicians occupy a pivotal role in managing multimorbidity, a situation where patients simultaneously deal with multiple chronic conditions, by incorporating a palliative care perspective into their practice. This approach is particularly beneficial as it emphasizes the importance of improving the overall quality of life for patients rather than simply focusing on curing individual diseases. When family physicians adopt a palliative care framework, they can create personalized treatment plans that address the complex interplay of various health issues, ensuring that each patient's unique circumstances and preferences are acknowledged. This holistic approach encompasses not only physical health but also addresses emotional, psychological, and social factors that significantly impact well-being. Engagement with patients in shared decision-making fosters trust and empowers individuals to take an active role in their healthcare journey. By prioritizing symptom management and addressing the goals of care with sensitivity, family physicians can alleviate distressing symptoms associated with chronic illnesses, such as pain, fatigue, and depression. Furthermore, these physicians serve as coordinators of care, collaborating with specialists, nurses, and mental health professionals to provide comprehensive support. This teamwork is essential in navigating the complexities of multimorbidity, particularly as patients may face numerous treatment regimens and potential medication interactions. Ultimately, the integration of palliative care principles within family medicine promotes compassionate care, enhances patient satisfaction, and leads to improved outcomes by ensuring that care is aligned with the patients' values and lifestyle preferences, providing a more meaningful and dignified healthcare experience.

Keywords: Family Physicians, Multimorbidity, Palliative Care, Patient-Centered Care, Chronic Conditions, Quality of Life, Holistic Care.

INTRODUCTION

The epidemiological transition from acute, infectious diseases to chronic, non-communicable conditions has fundamentally altered the practice of medicine in the twenty-first century. Family physicians, who serve as the first point of contact for patients within healthcare systems, now face a patient population characterised increasingly by multimorbidity the concurrent presence of two or more chronic conditions within the same individual [1]. This shift is not merely a statistical curiosity but represents a profound clinical challenge that demands a re-evaluation of traditional disease-oriented paradigms. As populations age globally, the prevalence of multimorbidity rises exponentially, affecting over 65% of adults aged 65 years and older, and this proportion continues to grow [2]. The management of these patients is complicated by the interactions between coexisting conditions, the cumulative burden of treatments, and the fragmentation inherent in specialist-driven care models [3].

Concurrently, the discipline of palliative care has evolved considerably from its origins in terminal cancer care to a broader, more inclusive philosophy focused on alleviating suffering and improving quality of life for patients with serious, life-limiting illnesses, regardless of diagnosis [4]. The World Health Organization explicitly defines palliative care as an

approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual [5]. This definition intentionally does not restrict palliative care to the final weeks or months of life, thereby creating a conceptual bridge to the management of chronic multimorbidity.

The integration of a palliative care lens into the routine management of multimorbidity by family physicians represents a paradigm shift of considerable significance. Traditional disease-specific guidelines, such as those for hypertension, diabetes, or heart failure, often provide conflicting recommendations when applied concurrently to the same patient, leading to treatment burden, polypharmacy, and potential harm [6]. Moreover, these guidelines rarely account for the patient's overall prognosis, functional status, or personal values [7]. A palliative care approach shifts the focus from disease-centred metrics to person-centred outcomes, emphasising symptom control, functional independence, and the alignment of medical interventions with the patient's expressed goals and preferences [8].

Family physicians are ideally positioned to lead this integration. Their longitudinal relationships with patients and families provide unparalleled insight into the patient's life context, social support structures, and evolving priorities [9]. This continuity of care enables family physicians to recognise subtle changes in functional status, detect the transition to a more palliative phase, and initiate timely conversations about prognosis, values, and advance care planning [10]. Furthermore, their role as coordinators of care across multiple specialists and community services positions them to ensure that palliative principles permeate all aspects of the patient's care journey [11].

Multimorbidity and Palliative Care

Understanding the theoretical intersection between multimorbidity and palliative care is essential for family physicians seeking to apply a palliative lens in their daily practice. Multimorbidity is not simply the sum of individual diseases; it is a complex state characterised by synergistic interactions between conditions, compounded by the psychosocial and economic consequences of chronic illness [12]. The cumulative burden of multiple diagnoses often results in reduced physical function, psychological distress, social isolation, and diminished quality of life domains that are central to the palliative care philosophy [13].

The conventional trajectory of care for patients with multimorbidity often follows a linear, curative model until a sudden terminal event occurs, leaving little opportunity for palliative preparation. However, many patients with multimorbidity experience a gradual decline punctuated by acute exacerbations, representing a more appropriate model for palliative integration [14]. The palliative care lens reframes this trajectory by recognising that palliative needs may emerge long before death and that interventions aimed at improving quality of life should be introduced early, concurrently with disease-modifying treatments [15].

Several conceptual models have been proposed to guide the integration of palliative care into multimorbidity management. The "Palliative Approach in Primary Care" model posits that primary palliative care skills, including basic symptom assessment, goals of care conversations, and advance care planning, should be core competencies for all family physicians [16]. The "Serious Illness Conversation Guide," adapted for primary care, provides a structured framework for discussing prognosis, values, and priorities, facilitating a shift from disease-focused to person-focused care [17]. Additionally, the "Chronic Care Model," when integrated with palliative principles, emphasises the importance of self-management support, decision support, and community resources in enhancing outcomes for patients with complex needs [18].

A critical conceptual distinction lies between "primary palliative care," delivered by generalist clinicians such as family physicians, and "specialist palliative care," provided by interdisciplinary teams for complex cases [19]. Primary palliative care encompasses the fundamental skills required to identify and address the physical, psychological, social, and spiritual needs of patients with serious illness. For the vast majority of patients with multimorbidity, primary palliative care delivered by their family physician, supported by appropriate community resources, is not only sufficient but preferable, as it leverages the established therapeutic relationship and continuity of care [20].

Family Physicians in Palliative-Oriented Multimorbidity Care

Family physicians occupy a distinctive and indispensable position within healthcare systems, characterised by several attributes that uniquely equip them to manage multimorbidity through a palliative lens. First and foremost is the principle of continuity of care the enduring therapeutic relationship that develops over years or decades of ongoing clinical encounters [21]. This longitudinal relationship fosters a deep understanding of the patient as a whole person, encompassing their medical history, personality, family dynamics, cultural background, and life experiences. When a patient with multimorbidity begins to decline, the family physician can detect subtle changes in function, cognition, or mood that might escape the notice of episodic or specialist providers [22].

This continuity also builds a foundation of trust that is essential for sensitive conversations about

prognosis, treatment limitations, and end-of-life preferences. Patients are more likely to engage in advance care planning and disclose their true concerns and fears when guided by a clinician they know and trust [23]. Moreover, the family physician often serves as the primary point of contact for family members and informal caregivers, who play a vital role in supporting patients with multimorbidity. Understanding the caregiver's perspective and addressing their needs is an integral component of palliative care, and the family physician's relationship with the family unit enhances the effectiveness of this support [24].

The comprehensiveness of family medicine is another critical asset. Family physicians are trained to manage the full spectrum of health conditions across the lifespan, providing care that integrates physical, psychological, and social dimensions. This broad expertise is essential for patients with multimorbidity, whose conditions span multiple organ systems and require complex, coordinated management [25]. Family physicians are adept at synthesising information from multiple specialists, reconciling conflicting recommendations, and developing an integrated care plan that reflects the patient's overall health status and priorities. This integrative function is particularly valuable in palliative care, where the goal is not to treat each disease in isolation but to optimise overall function and comfort [26].

Furthermore, family physicians are deeply embedded within their communities and are familiar with local resources, including community palliative care services, home care agencies, social work supports, and spiritual care providers. This knowledge enables them to facilitate seamless transitions between care settings and to ensure that patients receive appropriate support in their preferred environment, often the home [27]. The ability to coordinate care across the primary-secondary-tertiary interface is a hallmark of effective family practice and is essential for delivering palliative-oriented care to patients with multimorbidity [28].

Symptom Assessment and Management in Multimorbidity

Symptom management is a cornerstone of palliative care and assumes particular importance in patients with multimorbidity, who frequently experience a high symptom burden that is often under-recognised and under-treated. Common symptoms in this population include pain, dyspnoea, fatigue, depression, anxiety, nausea, and constipation, each of which may arise from multiple underlying conditions or their treatments [29].

Family physicians can employ validated screening tools such as the Edmonton Symptom Assessment System (ESAS) or the Integrated Palliative Care Outcome Scale (IPOS) to quantify symptom severity and track changes over time [30]. These tools, designed for ease of use in routine clinical practice, enable the physician to identify priority symptoms and to evaluate the effectiveness of interventions. However, symptom assessment in multimorbidity extends beyond checklists; it requires a narrative understanding of what symptoms mean to the patient and how they impact daily life and cherished activities [31]. The family physician's longitudinal relationship facilitates this deeper exploration, allowing for personalised goal-setting around symptom control.

Pharmacological management of symptoms in patients with multimorbidity is fraught with challenges. Polypharmacy, defined as the concurrent use of five or more medications, is highly prevalent in this population and is associated with adverse drug events, drug-drug interactions, and medication non-adherence [32]. A palliative lens emphasises the principle of "start low, go slow" for new medications, but also critically the principle of deprescribing, or the systematic discontinuation of medications that are no longer indicated or that cause more harm than good [33]. For example, in a patient with advanced heart failure, chronic kidney disease, and diabetes, the family physician might consider deprescribing statins or glucose-lowering agents with limited prognostic benefit in the context of a limited life expectancy, while prioritising symptom-relieving medications such as opioids for dyspnoea or diuretics for fluid overload [34].

Non-pharmacological approaches are equally important and often under-utilised. Simple interventions such as physical therapy, occupational therapy, nutritional support, and psychological counselling can substantially improve symptom control and quality of life. Family physicians can facilitate access to these services through their knowledge of community resources and their role as care coordinators [35]. Moreover, addressing the social determinants of symptom burden such as financial insecurity, social isolation, and inadequate housing falls within the purview of the family physician, who can connect patients and families with appropriate social supports.

Pain management deserves particular emphasis, given that pain is one of the most feared and prevalent symptoms in serious illness. In patients with multimorbidity, pain may be nociceptive (from tissue damage), neuropathic (from nerve injury), or mixed, and its management requires a multimodal approach. Family physicians should be proficient in the use of analgesics, including non-steroidal anti-inflammatory drugs, acetaminophen, and opioids, with careful attention to renal and hepatic function, drug interactions, and the risk of adverse effects [36]. The principles of opioid titration, breakthrough pain management, and the prevention of constipation are essential skills. Additionally, the judicious use of adjuvant therapies such as antidepressants, anticonvulsants, and corticosteroids can enhance pain control and address comorbid depressive and anxiety symptoms [37].

Prognostic Uncertainty and Triggers for Palliative Transition

One of the greatest challenges in managing multimorbidity through a palliative lens is prognostic uncertainty. Unlike patients with a single, well-defined terminal diagnosis such as advanced cancer, patients with multimorbidity often have unpredictable trajectories of decline, with periods of stability interrupted by acute decompensations, from which they may partially recover [38].

Family physicians can employ several strategies to navigate this uncertainty. The use of prognostic tools, such as the "Surprise Question" "Would I be surprised if this patient died in the next 12 months?" has been validated as a simple and effective trigger for initiating palliative considerations [39]. When the answer is "no," indicating that death is not unexpected within the year, the family physician is prompted to assess for palliative needs, engage in goals of care discussions, and consider referrals to specialist palliative care if indicated.

Other clinical triggers that should prompt a palliative-oriented assessment include: frequent hospitalisations or emergency department visits; progressive functional decline, such as difficulty with activities of daily living (ADLs) or instrumental activities of daily living (IADLs); weight loss, malnutrition, or sarcopenia; deteriorating cognitive function; refractory symptoms despite conventional treatment; and patient or family requests for limitation of interventions or discussion of end-of-life preferences [40]. The family physician's awareness of these triggers is enhanced by continuity of care, as they can recognise a change from the patient's baseline that might be overlooked in episodic care.

The concept of "candidacy" for palliative care has been proposed as a framework for identifying patients with multimorbidity who would benefit from a palliative approach. This framework considers not only clinical criteria but also the patient's perceptions, willingness to engage, and social circumstances [41]. Family physicians are uniquely positioned to assess candidacy through their understanding of the patient's values, health literacy, and support network, and to tailor the approach accordingly.

Goals of Care and Advance Care Planning:

Several structured communication frameworks have been developed to guide family physicians in these discussions. The SPIKES protocol (Setting, Perception, Invitation, Knowledge, Empathy, Strategy/Summary) provides a stepwise approach to delivering bad news and discussing prognosis, which can be adapted for goals of care conversations [42]. The "Ask-Tell-Ask" technique encourages the physician to first ask the patient about their understanding, then provide information in small chunks, and finally ask about their understanding and feelings, fostering a patient-centred dialogue. The "NURSE" acronym (Name, Understand, Respect, Support, Explore) offers a framework for responding to emotions, which inevitably arise in these discussions.

Advance care planning (ACP) is a key component of goals of care conversations and involves the process of reflecting on, discussing, and documenting a patient's values, goals, and preferences for future medical care, in the event that they become unable to make decisions for themselves [43]. ACP extends beyond the completion of legal documents (such as advance directives or health care proxies) to encompass a process of communication that should be revisited over time as the patient's condition evolves. The family physician is ideally suited to initiate and continue this process, often revisiting it at key junctures, such as after a hospitalisation or a significant decline in function.

A practical approach to ACP in family practice involves the "Four Questions" model: (1) What is your understanding of your health situation? (2) What are your goals and what matters most to you? (3) What are you worried about or afraid of? (4) What are you willing to accept or sacrifice, and what are you not willing to accept? [44].

Cultural competence is paramount in these conversations, as values and preferences are shaped by cultural, religious, and ethnic backgrounds. Family physicians must be sensitive to variations in health beliefs, family decision-making dynamics, and preferences for disclosure of prognosis [45]. Engaging family members and caregivers in the process, with the patient's permission, is often essential, as they will play a pivotal role in providing care and, potentially, in surrogate decision-making.

Documentation is a crucial final step in the ACP process. The family physician should ensure that the patient's expressed preferences are clearly recorded in the medical record, ideally using standardised formats such as "Physician Orders for Life-Sustaining Treatment" (POLST) or similar portable orders that can be respected across care settings [46]. This documentation facilitates communication with other providers and reduces the risk of unwanted interventions during acute events.

Polypharmacy and Deprescribing as Palliative Interventions

Polypharmacy is a near-ubiquitous feature of multimorbidity, with patients often accumulating medications from multiple specialists, each treating a single condition without comprehensive review [47]. The burden of polypharmacy extends beyond drug-drug and drug-disease interactions to include the practical burdens of taking multiple pills, financial costs, and the psychological impact of being "a sick person." The palliative lens reframes medication management by

prioritising the net benefit of each medication in the context of the patient's overall prognosis, functional status, and goals [48]. Deprescribing the planned, systematic discontinuation of medications that are no longer indicated or that may be causing harm is a fundamental skill for family physicians managing multimorbidity through a palliative lens [49].

Several tools are available to assist family physicians in deprescribing. The STOPP/START criteria (Screening Tool of Older Persons' Prescriptions/Screening Tool to Alert to Right Treatment) provide evidence-based guidelines for potentially inappropriate prescribing in older adults [50]. The Beers Criteria, developed by the American Geriatrics Society, identify medications that should generally be avoided in older adults due to high risk of adverse effects. Deprescribing algorithms are available for specific medication classes, including proton pump inhibitors, benzodiazepines, statins, antidiabetic agents, and antihypertensives [51].

A palliative approach to deprescribing requires careful communication with the patient and, where appropriate, family members. Patients may have misconceptions about the benefits of certain medications, may have been taking them for years, and may fear that deprescribing means "giving up." The family physician should explain the rationale for deprescribing, highlight the potential for harm reduction, and frame the change as a positive step toward simplifying the regimen and improving comfort [52]. Reassurance and close follow-up are essential, as symptoms may arise during deprescribing that require additional management.

The deprescribing process should be individualised and iterative. Starting with the medication most likely to cause harm or least likely to provide benefit, the physician can reduce or discontinue one medication at a time, monitoring for adverse effects, symptom recurrence, and the emergence of withdrawal symptoms [53]. The goal is not to eliminate all medications but to achieve a regimen that is aligned with the patient's goals and optimises quality of life.

Psychosocial Dimensions of Multimorbidity Care

Patients with multimorbidity face significant psychosocial and spiritual challenges that extend beyond biomedical symptom management. The cumulative burden of chronic illness often leads to social isolation, as functional decline and the demands of treatment limit social participation and connection [54]. Financial strain from medical expenses, loss of employment, and the need for caregiving can compound distress. Furthermore, the experience of living with multiple serious conditions often raises existential questions about meaning, purpose, and mortality spiritual concerns that are integral to holistic palliative care [55].

Family physicians, with their comprehensive training and longitudinal relationships, are well positioned to address these psychosocial and spiritual dimensions. Screening for depression and anxiety using validated instruments, such as the Patient Health Questionnaire-9 (PHQ-9) or the Generalized Anxiety Disorder-7 (GAD-7), can identify patients who would benefit from pharmacological or psychological interventions [56].

The family physician should be aware of community resources for psychosocial support, including mental health professionals, social workers, support groups, and spiritual care providers [57]. Referrals to these resources should be offered proactively and framed as integral to comprehensive care. For patients who are open to spiritual exploration, the family physician can engage in conversations about meaning and purpose, spirituality, or religious beliefs, with the goal of understanding how these factors can support or challenge the patient's coping [57].

Caregiver burden is a critical issue, often overlooked, that intersects with psychosocial and spiritual dimensions. Informal caregivers usually family members provide the vast majority of care for patients with multimorbidity. Caregiver burnout, depression, and financial strain are common and can compromise both caregiver and patient outcomes [58].

The social determinants of health, including poverty, housing instability, food insecurity, and lack of social support, exert a powerful influence on the health and well-being of patients with multimorbidity. Family physicians can address these determinants through practical interventions, such as referral to social work, advocacy for financial assistance, or connections to community resources [59].

Care Coordination and Interprofessional Collaboration

The complexity of multimorbidity demands a coordinated, interprofessional approach that extends beyond the capabilities of any single clinician. Care coordination the deliberate organisation of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of healthcare services is an essential competency for family physicians [60]. The family physician's role as coordinator is amplified in a palliative approach, where seamless communication and collaboration across settings and specialties are vital for ensuring that care is aligned with the patient's goals and preferences.

The core elements of care coordination for patients with multimorbidity include: (1) establishing a shared care plan that incorporates the patient's goals and priorities; (2) ensuring that all providers are aware of the patient's advance care preferences; (3) facilitating timely communication among specialists, primary care, and community services; (4) managing transitions between

care settings, such as hospital discharge; (5) maintaining a current medication reconciliation; and (6) providing timely information to patients and families [61].

Family physicians can leverage several strategies to enhance coordination. The use of care coordinators or case managers, often nurses or social workers embedded in primary care teams, can provide dedicated support for patients with complex needs [62]. Regular team meetings, including the family physician, nursing staff, social workers, pharmacists, and other allied health professionals, provide a forum for reviewing high-risk patients, discussing care plans, and identifying gaps in services. These meetings, which are increasingly supported by electronic health record (EHR) systems with tracking and alert functions, facilitate proactive, coordinated care.

Electronic communication tools have become essential for care coordination. The EHR can facilitate the sharing of advance care plans, medication lists, and symptom assessments. Patient portals can allow patients and caregivers to communicate with the care team, share updates, and access educational resources [63]. Telehealth visits, particularly for homebound patients, can enhance access to care and facilitate family involvement in care planning.

Transitions of care are high-risk junctures where fragmentation of care is most evident. After a hospitalisation, the patient's condition may have changed, medications may have been altered, and new specialists may be involved. The family physician should conduct a follow-up visit promptly after discharge (ideally within 48 to 72 hours), performing a comprehensive medication reconciliation, assessing the patient's functional status, and ensuring that the care plan is still aligned with the patient's goals [64]. Communication with the hospital team and community services should be proactive and documented.

Palliative Care into Routine Family Practice

Moving from theory to practice, the integration of a palliative lens into routine family practice requires systematic changes in clinical workflows, documentation, and team culture. Rather than viewing palliative care as an additional burden on already busy practices, it should be reframed as an efficient and person-centred approach that can reduce unnecessary testing, hospitalisations, and polypharmacy [65].

Several implementation models have been demonstrated to enhance the integration of primary palliative care into family practice. The "Palliative Care in Primary Care" (PCPC) model emphasises the provision of palliative care by primary care providers, with support from specialist palliative care consultants for complex cases [66]. The "Early Palliative Care" model, pioneered in oncology, has been successfully adapted to primary care, showing benefits in quality of life and reduced healthcare utilization. These models emphasise proactive identification of patients with palliative needs, using the "Surprise Question" and other triggers.

The integration process should begin with education and training for the entire primary care team, including physicians, nurses, and administrative staff. This training should cover the basic principles of palliative care, symptom assessment, goals of care conversations, and use of ACP documentation. Practice-based quality improvement initiatives, such as audit and feedback on ACP documentation rates or symptom management, can support continuous improvement [67].

Clinical workflows can be designed to embed palliative principles into routine care. For example, standardised assessment of symptoms and functional status could be incorporated into annual check-ups or chronic disease management visits. The annual wellness visit for Medicare patients, which includes a health risk assessment, provides an opportunity to introduce advance care planning [68]. Electronic templates for goals of care conversations and ACP documentation can reduce variability and improve completeness of documentation.

Barriers and Facilitators

At the policy level, the predominant fee-for-service reimbursement model often does not adequately reimburse for the cognitive and communication time required for thorough goals of care conversations, advance care planning, or care coordination [69]. These activities are time-intensive and are frequently undervalued relative to procedural or laboratory services. The result is a perverse incentive that rewards interventions over conversations, potentially undermining the palliative approach. Alternative payment models, such as value-based care or capitation, that reward outcomes and patient satisfaction, are more conducive to palliative care [70].

Access to specialist palliative care services is highly variable, with significant shortages in rural and underserved areas. Even where services exist, referral pathways may be unclear, and waiting lists may be long. The family physician may feel isolated in managing patients with complex palliative needs without adequate support from specialist consultants. Innovative models, such as telehealth-based specialist palliative care consultations, can mitigate this barrier [71].

The EHR, while potentially a facilitator, often functions as a barrier, with fragmented information, poor interoperability between systems, and cumbersome documentation requirements. Decision support tools for symptom assessment or deprescribing are often absent. Enhanced EHR functionalities, including integrated ACP modules, medication reconciliation tools, and clinical decision support for palliative triggers, could significantly facilitate implementation [72].

Clinician-level barriers include lack of confidence in palliative care skills, discomfort with prognosis discussions, and time constraints. Many family physicians report limited training in palliative care during residency and fellowship [73]. This lack of confidence can lead to avoidance of essential conversations. Mentorship, peer support, and access to specialist consultation can build confidence. Practice redesign, such as team-based care with dedicated time for complex patients, can address time constraints.

Patient and family factors also present barriers, including denial of prognosis, unrealistic expectations about cure, and cultural or religious beliefs that may conflict with palliative principles. The family physician's longitudinal relationship can facilitate honest conversations, but cultural and health literacy considerations must be addressed. Patients may also face social and economic barriers to accessing palliative care, such as transportation difficulties, lack of caregiver support, or financial constraints [74].

Ethical Considerations

Respecting patient autonomy is central to goals of care discussions and advance care planning. The family physician must ensure that decisions are truly informed and voluntary, and that patients are not coerced by clinicians, family members, or systemic pressures. This requires assessment of the patient's decision-making capacity and, when capacity is impaired, engagement with designated surrogate decision-makers, informed by the patient's previously expressed values and preferences. Advance directives, including living wills and health care proxies, are legal tools that support autonomy but should be part of a broader process of ongoing communication [75].

Beneficence acting in the patient's best interest in the context of multimorbidity requires a balanced assessment of the benefits and risks of interventions. The family physician must consider whether a specific treatment, such as a procedure or medication, will truly benefit the patient in terms of their own goals and quality of life, or whether it may cause more harm than good. The application of evidence-based guidelines must be tempered by individualised clinical judgment, considering the patient's prognosis, functional status, and values [76].

Non-maleficence do no harm is particularly relevant to the management of multimorbidity, where the treatment burden itself can cause iatrogenic harm. Polypharmacy, excessive testing, and interventions that are not aligned with the patient's goals are forms of medical futility that can cause harm. Deprescribing and limitation of interventions are expressions of non-maleficence, protecting the patient from burdensome, ineffective care [77].

Justice fairness in the distribution of healthcare resources arises in the context of access to palliative care and the allocation of healthcare resources. Family physicians should advocate for equitable access to palliative care services, particularly for underserved populations who may face barriers due to geography, socioeconomic status, or discrimination [78].

End-of-life ethical issues, including decision-making about CPR, mechanical ventilation, artificial nutrition and hydration, and withholding or withdrawing treatments, are particularly challenging. The family physician must be competent in these discussions and in applying legal and ethical frameworks, which may vary by jurisdiction [79].

Conclusion

Managing multimorbidity through a palliative lens is about returning to the heart of family medicine: caring for the whole person in the context of their family and community, honouring their values and preferences, and accompanying them through the entirety of their health journey from wellness through serious illness to the end of life. In doing so, family physicians fulfil their fundamental commitment to healing, even when cure is no longer possible.

References

1. Bijnsdorp F.M., Onwuteaka-Philipsen B.D., Boot C.R. Combining paid work and family care for a patient at the end of life at home: Insights from a qualitative study among caregivers in the Netherlands. BMC Palliat. Care. 2021;2021 93:20.
2. Kingston A., Robinson L., Booth H., Knapp M., Jagger C. MODEM Project. Projections of multi-morbidity in the older population in England to 2035: Estimates from the Population Ageing and Care Simulation (PACSim) model. Age Ageing. 2018;47:374–380.
3. Wiese M., Stancliffe R.J., Balandin S., Howarth G., Dew A. End-of-life care and dying: Issues raised by staff supporting older people with intellectual disability in community living services. J. Appl. Res. Intellect. Disabil. 2012;25:571–583.
4. Bandieri E., Sichetti D., Romero M., Fanizza C., Belfiglio M., Buonaccorso L., Artioli F., Campione F., Tognoni G., Luppi M. Impact of early access to a palliative/supportive care intervention on pain management in patients with cancer. Ann. Oncol. 2012;23:2016–2020.
5. McLaughlin D., Barr O., McIlfatrick S., McConkey R. Developing a best practice model for partnership practice between specialist palliative care and intellectual disability services: A mixed methods study. Palliat. Med. 2014;28:1213–1221.
6. Goodman C., Evans C., Wilcock J., Froggatt K., Drennan V., Sampson E., Iliffe S. End of life care for community dwelling older people with dementia: An integrated review. Int. J. Geriatr. Psychiatry. 2010;25:329–337.
7. Davies N., Maio L., Vedavanam K., Manthorpe J., Vernooij-Dassen M., Iliffe S., IMPACT Research

Team Barriers to the provision of high-quality palliative care for people with dementia in England: A qualitative study of professionals' experiences. Health Soc. Care Community. 2014;22:386–394.
8. Bloomer M.J., Botti M., Runacres F., Poon P., Barnfield J., Hutchinson A.M. Cultural considerations at end of life in a geriatric inpatient rehabilitation setting. Collegian. 2019;26:165–170.
9. Pennbrant S., Hjorton C., Nilsson C., Karlsson M. "The challenge of joining all the pieces together" Nurses' experience of palliative care for older people with advanced dementia living in residential aged care units. J. Clin. Nurs. 2020;29:3835–3846.
10. Connor S.R., Bermedo M.S. Global Atlas of Palliative Care at the End of Life.
11. Sarti A.J., Bourbonnais F.F., Landriault A., Sutherland S., Cardinal P. An Interhospital, Interdisciplinary Needs Assessment of Palliative Care in a Community Critical Care Context. J. Palliat. Care. 2015;31:234–242.
12. Bajwah S., Higginson I.J., Ross J.R., Wells A.U., Birring S.S., Riley J., Koffman J. The palliative care needs for fibrotic interstitial lung disease: A qualitative study of patients, informal caregivers and health professionals. Palliat. Med. 2013;27:869–876.
13. Virdun C., Luckett T., Davidson P., Phillips J. Dying in the hospital setting: A systematic review of quantitative studies identifying the elements of end-of-life care that patients and their families rank as being most important. Palliat. Med. 2015;29:774–796.
14. Hall S., Kolliakou A., Petkova H., Froggatt K., Higginson I.J. Interventions for improving palliative care for older people living in nursing care homes. Cochrane Database Syst. Rev. 2011;3:CD007132.
15. Hui D., Kim Y.J., Park J.C., Zhang Y., Strasser F., Cherny N., Kaasa S., Davis M.P., Bruera E. Integration of oncology and palliative care: A systematic review. Oncologist. 2015;20:77–83.
16. Livingston G., Pitfield C., Morris J., Manela M., Lewis-Holmes E., Jacobs H. Care at the end of life for people with dementia living in a care home: A qualitative study of staff experience and attitudes. Int. J. Geriatr. Psychiatry. 2012;27:643–650.
17. Simon J., Porterfield P., Bouchal S.R., Heyland D. 'Not yet'and 'Just ask': Barriers and facilitators to advance care planning A qualitative descriptive study of the perspectives of seriously ill, older patients and their families. BMJ Support. Palliat. Care. 2015;5:54–62.
18. Lenherr G., Meyer-Zehnder B., Kressig R., Reiter-Theil S. To speak, or not to speak-do clinicians speak about dying and death with geriatric patients at the end of life? Swiss Med. Wkly. 2012;142:w13563.
19. Arksey H., O'Malley L. Scoping studies: Towards a methodological framework. Int. J. Soc. Res. Methodol. 2005;8:19–32.
20. Boersma I., Jones J., Coughlan C., Carter J., Bekelman D., Miyasaki J., Kutner J., Kluger B. Palliative care and Parkinson's disease: Caregiver perspectives. J. Palliat. Med. 2017;20:930–938.
21. Ke L.-S., Huang X., Hu W.-Y., O'Connor M., Lee S. Experiences and perspectives of older people regarding advance care planning: A meta-synthesis of qualitative studies. Palliat. Med. 2017;31:394–405.
22. WHO . Noncommunicable Diseases. WHO; Geneva, Switzerland: 2017.
23. Fleming R., Kelly F., Stillfried G. 'I want to feel at home': Establishing what aspects of environmental design are important to people with dementia nearing the end of life. BMC Palliat. Care. 2015;14:26.
24. Geiger K., Schneider N., Bleidorn J., Klindtworth K., Jünger S., Müller-Mundt G. Caring for frail older people in the last phase of life The general practitioners' view. BMC Palliat. Care. 2016;15:52.
25. Gott M., Ingleton C., Bennett M.I., Gardiner C. Transitions to palliative care in acute hospitals in England: Qualitative study. BMJ. 2011;342:d1773.
26. Siouta N., Clement P., Aertgeerts B., Van Beek K., Menten J. Professionals' perceptions and current practices of integrated palliative care in chronic heart failure and chronic obstructive pulmonary disease: A qualitative study in Belgium. BMC Palliat. Care. 2018;17:103.
27. Poole M., Bamford C., McLellan E., Lee R.P., Exley C., Hughes J.C., Harrison-Dening K., Robinson L. End-of-life care: A qualitative study comparing the views of people with dementia and family carers. Palliat. Med. 2018;32:631–642.
28. Maddalena V., O'Shea F., Barrett B. An Exploration of Palliative Care Needs of People with End-Stage Renal Disease on Dialysis: Family Caregiver's Perspectives. J. Palliat. Care. 2018;33:19–25.
29. Abbas S.Q., Dein S. The difficulties assessing spiritual distress in palliative care patients: A qualitative study. Ment. Health Relig. Cult. 2011;14:341–352.
30. Kwak J., Ko E., Kramer B.J. Facilitating advance care planning with ethnically diverse groups of frail, low-income elders in the USA: Perspectives of care managers on challenges and recommendations. Health Soc. Care Community. 2014;22:169–177.
31. Weber M., Claus M., Zepf K.I., Fischbeck S., Pinzon L.C.E. Dying in Germany Unfulfilled needs of relatives in different care settings. J. Pain Symptom Manag. 2012;44:542–551.
32. Prince M.J., Wu F., Guo Y., Robledo L.M.G., O'Donnell M., Sullivan R., Yusuf S. The burden of disease in older people and implications for health policy and practice. Lancet. 2015;385:549–562.
33. Carvalho G.A.F.D.L., Menezes R.M.P.D., Enders B.C., Teixeira G.A., Dantas D.N.A., Oliveira D.R.C.D. Meanings attributed to palliative care by health professional in the primary care context1. Texto Contexto Enferm. 2018;27:e5740016.

34. Haun M.W., Estel S., Rücker G., Friederich H., Villalobos M., Thomas M., Hartmann M. Early palliative care for adults with advanced cancer. Cochrane Database Syst. Rev. 2017;6:CD011129.
35. Sealey M., O'Connor M., Aoun S.M., Breen L.J. Exploring barriers to assessment of bereavement risk in palliative care: Perspectives of key stakeholders. BMC Palliat. Care. 2015;14:49.
36. Mason B., Epiphaniou E., Nanton V., Donaldson A., Shipman C., Daveson B.A., Harding R., Higginson I., Munday D., Barclay S., et al. Coordination of care for individuals with advanced progressive conditions: A multi-site ethnographic and serial interview study. Br. J. Gen. Pract. 2013;63:e580–e588.
37. Selman L., Brighton L., Sinclair S., Karvinen I., Egan R., Speck P., Powell R., Deskur-Smielecka E., Glajchen M., Adler S., et al. Patients' and caregivers' needs, experiences, preferences and research priorities in spiritual care: A focus group study across nine countries. Palliat. Med. 2018;32:216–230.
38. Bone A.E., Morgan M., Maddocks M., Sleeman K.E., Wright J., Taherzadeh S., Ellis-Smith C., Higginson I.J., Evans C.J. Developing a model of short-term integrated palliative and supportive care for frail older people in community settings: Perspectives of older people, carers and other key stakeholders. Age Ageing. 2016;45:863–873.
39. Thai J.N., Barnhart C.E., Cagle J., Smith A.K. "It Just Consumes Your Life": Quality of Life for Informal Caregivers of Diverse Older Adults With Late-Life Disability. Am. J. Hosp. Palliat. Med. 2016;33:644–650.
40. Den Herder-van der Eerden M., van Wijngaarden J., Payne S., Preston N., Linge-Dahl L., Radbruch L., Van Beek K., Menten J., Busa C., Csikos A., et al. Integrated palliative care is about professional networking rather than standardisation of care: A qualitative study with healthcare professionals in 19 integrated palliative care initiatives in five European countries. Palliat. Med. 2018;32:1091–1102.
41. Wong M., Ho L., Hui E., Miaskowski Y. Burden of living with multiple concurrent symptoms in patients with end-stage renal disease. J. Clin. Nurs. 2020;29:2589–2601.
42. Udo C., Neljesjö M., Strömkvist I., Elf M. A qualitative study of assistant nurses' experiences of palliative care in residential care. Nurs. Open. 2018;5:527–535.
43. Saunders C. End of Life Care Strategy: Quality Markers and Measures for End of Life Care. Department of Health; London, UK: 2009.
44. Gallagher R., Krawczyk M. Family members' perceptions of end-of-life care across diverse locations of care. BMC Palliat. Care. 2013;12:25.
45. Cimino N.M., Lockman K., Grant M., McPherson M.L. Knowledge, Skills, and Attitudes in Caring for Older Adults with Advanced Illness among Staff Members of Long-Term Care and Assisted Living Facilities: An Educational Needs Assessment. Am. J. Hosp. Palliat. Med. 2016;33:327–334.
46. Fan S., Lin I., Hsieh J., Chang C. Psychosocial care provided by physicians and nurses in palliative care: A mixed methods study. J. Pain Symptom Manag. 2017;53:216–223.
47. Gardiner C., Cobb M., Gott M., Ingleton C. Barriers to providing palliative care for older people in acute hospitals. Age Ageing. 2011;40:233–238.
48. Klindtworth K., Oster P., Hager K., Krause O., Bleidorn J., Schneider N. Living with and dying from advanced heart failure: Understanding the needs of older patients at the end of life. BMC Geriatr. 2015;15:125.
49. Waldron M., Kernohan W.G., Hasson F., Foster S., Cochrane B. What Do Social Workers Think about the Palliative Care Needs of People with Parkinson's Disease? Br. J. Soc. Work. 2013;43:81–98.
50. Broom A., Kirby E., Good P., Wootton J., Adams J. Specialists' experiences and perspectives on the timing of referral to palliative care: A qualitative study. J. Palliat. Med. 2012;15:1248–1253.
51. O'Brien M.R., Kinloch K., Groves K.E., Jack B.A. Meeting patients' spiritual needs during end-of-life care: A qualitative study of nurses' and healthcare professionals' perceptions of spiritual care training. J. Clin. Nurs. 2019;28:182–189.
52. Low J., Pattenden J., Candy B., Beattie J., Jones L. Palliative care in advanced heart failure: An international review of the perspectives of recipients and health professionals on care provision. J. Card. Fail. 2011;17:231–252.
53. Wang T., Molassiotis A., Chung B.P.M., Tan J.Y. Unmet care needs of advanced cancer patients and their informal caregivers: A systematic review. BMC Palliat. Care. 2018;17:96.
54. Tan H.M., O'Connor M.M., Miles G., Klein B., Schattner P. GP and nurses' perceptions of how after hours care for people receiving palliative care at home could be improved: A mixed methods study. BMC Palliat. Care. 2009;8:13.
55. Mayland C.R., Mulholland H., Gambles M., Ellershaw J., Stewart K. How well do we currently care for our dying patients in acute hospitals: The views of the bereaved relatives? BMJ Support. Palliat. Care. 2017;7:316–325.
56. Krug K., Ballhausen R.A., Bölter R., Engeser P., Wensing M., Szecsenyi J., Peters-Klimm F. Challenges in supporting lay carers of patients at the end of life: Results from focus group discussions with primary healthcare providers. BMC Fam. Pract. 2018;19:112.
57. Blackwell R.W., Lowton K., Robert G., Grudzen C., Grocott P. Using Experience-based Co-design with older patients, their families and staff to improve palliative care experiences in the Emergency Department: A reflective critique on the process and outcomes. Int. J. Nurs. Stud. 2017;68:83–94.

58. Tallman K., Greenwald R., Reidenouer A., Pantel L. Living with advanced illness: Longitudinal study of patient, family, and caregiver needs. Perm. J. 2012;16:28.
59. Scheerens C., Deliens L., Van Belle S., Joos G., Pype P., Chambaere K. "A palliative end-stage COPD patient does not exist": A qualitative study of barriers to and facilitators for early integration of palliative home care for end-stage COPD. NPJ Prim. Care Resp. Med. 2018;28:23.
60. Johnston M., Crilly M., Black C., Prescott G.J., Mercer S. Defining and measuring multimorbidity: A systematic review of systematic reviews. Eur. J. Public Health. 2019;29:182–189.
61. Lewis E.T., Harrison R., Hanly L., Psirides A., Zammit A., McFarland K., Dawson A., Hillman K., Barr M., Cardona M. End-of-life priorities of older adults with terminal illness and caregivers: A qualitative consultation. Health Expect. 2019;22:405–414.
62. Handley M., Goodman C., Froggatt K., Mathie E., Gage H., Manthorpe J., Barclay S., Crang C., Iliffe S. Living and dying: Responsibility for end-of-life care in care homes without on-site nursing provision A prospective study. Health Soc. Care Community. 2014;22:22–29.
63. MacLeod A., Skinner M.W., Low E. Supporting hospice volunteers and caregivers through community-based participatory research. Health Soc. Care Community. 2012;20:190–198.
64. Ryan T., Ingleton C., Gardiner C., Parker C., Gott M., Noble B. Symptom burden, palliative care need and predictors of physical and psychological discomfort in two UK hospitals. BMC Palliat. Care. 2013;12:11.
65. Bolt E., Pasman H., Willems D., Onwuteaka-Philipsen B. Appropriate and inappropriate care in the last phase of life: An explorative study among patients and relatives. BMC Health Serv. Res. 2016;16:655.
66. Tricco A.C., Lillie E., Zarin W., O'Brien K.K., Colquhoun H., Levac D., Moher D., Peters M.D., Horsley T., Weeks L., et al. PRISMA Extension for Scoping Reviews (PRISMAScR): Checklist and Explanation. Ann. Intern. Med. 2018;169:467–473.
67. Grudzen C.R., Richardson L.D., Morrison M., Cho E., Morrison R.S. Palliative care needs of seriously ill, older adults presenting to the emergency department. Acad. Emerg. Med. 2010;17:1253–1257.
68. Brueckner T., Schumacher M., Schneider N. Palliative care for older people Exploring the views of doctors and nurses from different fields in Germany. BMC Palliat. Care. 2009;8:7.
69. Downar J., Chou Y.C., Ouellet D., La Delfa I., Blacker S., Bennett M., Petch C., Cheng S.M. Survival duration among patients with a noncancer diagnosis admitted to a palliative care unit: A retrospective study. J. Palliat. Med. 2012;15:661–666.
70. Lloyd A., Kendall M., Starr J.M., Murray S.A. Physical, social, psychological and existential trajectories of loss and adaptation towards the end of life for older people living with frailty: A serial interview study. BMC Geriatr. 2016;16:176.
71. You J.J., Dodek P., Lamontagne F., Downar J., Sinuff T., Jiang X., Day A.G., Heyland D.K. What really matters in end-of-life discussions? Perspectives of patients in hospital with serious illness and their families. CMAJ. 2014;186:E679–E687.
72. Higginson I.J., Daveson B.A., Morrison R., Deokhee Y., Meier D., Smith M., Ryan K., McQuillan R., Johnston B., Normand C. Social and clinical determinants of preferences and their achievement at the end of life: Prospective cohort study of older adults receiving palliative care in three countries. BMC Geriatr. 2017;17:271.
73. Fleming J., Farquhar M., Brayne C., Barclay S., Cambridge City over-75s Cohort (CC75C) Study Collaboration Death and the oldest old: Attitudes and preferences for end-of-life care-qualitative research within a population-based cohort study. PLoS ONE. 2016;11:e0150686.
74. Chang E., Bidewell J., Hancock K., Johnson A., Easterbrook S. Community palliative care nurse experiences and perceptions of follow-up bereavement support visits to carers. Int. J. Nurs. Pract. 2012;18:332–339.
75. Smallwood N., Currow D., Booth S., Spathis A., Irving L., Philip J. Attitudes to specialist palliative care and advance care planning in people with COPD: A multi-national survey of palliative and respiratory medicine specialists. BMC Palliat. Care. 2018;17:115.
76. Chang E., Daly J., Johnson A., Harrison K., Easterbrook S., Bidewell J., Stewart H., Noel M., Hancock K. Challenges for professional care of advanced dementia. Int. J. Nurs. Pract. 2009;15:41–47.
77. Lee R.P., Bamford C., Exley C., Robinson L. Expert views on the factors enabling good end of life care for people with dementia: A qualitative study. BMC Palliat. Care. 2015;14:32.
78. Sneesby L., Satchell R., Good P., van der Riet P. Death and dying in Australia: Perceptions of a Sudanese community. J. Adv. Nurs. 2011;67:2696–2702.
79. Buckingham S., Kendall M., Ferguson S., MacNee W., Sheikh A., White P., Worth A., Boyd K., Murray S.A., Pinnock H. HELPing older people with very severe chronic obstructive pulmonary disease (HELP-COPD): Mixed-method feasibility pilot randomised controlled trial of a novel intervention. Npj Prim. Care Respir. Med. 2015;25:15020.