



The role of palliative care in a dignified end of life

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Summary

Palliative care represents an active and comprehensive approach to patients with advanced and incurable illness, focused on improving quality of life and ensuring a dignified end of life. It does not imply giving up on treatment, but rather providing holistic support through symptom relief, clear and compassionate communication, and offering comprehensive support to the patient and their family through physical, psychological, social, and spiritual dimensions. Historically rooted in the hospice movement, palliative care has developed into a medical discipline. Its ethical ideal, described by the concept of a “good death”, implies a peaceful and dignified end of life in accordance with the values and wishes of the patient. As such, palliative care remains a fundamental expression of humanity and compassion in the face of the inevitable reality of death.

Keywords: holistic approach, palliative care, terminal illness

Uloga palijativne skrbi u dostojanstvenom završetku života

Sažetak

Palijativna skrb predstavlja aktivan, sveobuhvatan pristup osobama s uznapredovalom i neizlječivom bolešću usmjeren na poboljšanje kvalitete života i omogućavanje dostojanstvenog završetka života. Ona ne znači odustajanje od liječenja, nego pružanje cjelovite podrške: ublažavanje simptoma, razumljivu i suosjećajnu komunikaciju te sveobuhvatnu podršku bolesniku i njegovoj obitelji kroz tjelesnu, psihološku, socijalnu i duhovnu dimenziju. Povijesno utemeljena u hospicijskom pokretu, palijativna skrb razvila se u medicinsku disciplinu. Njezin etički ideal opisan pojmom „dobre smrti“ podrazumijeva miran i dostojanstven završetak života u skladu s vrijednostima i željama bolesnika. Kao takva, palijativna skrb predstavlja izraz humanosti i suosjećanja u suočavanju s neizbježnom stvarnošću smrti.

Ključne riječi: holistički pristup, palijativna skrb, terminalna bolest

1. Introduction

Birth and death are two unavoidable facts of human existence. While birth is frequently discussed and celebrated, death remains a topic that is rarely addressed openly. The topic of dying is often shrouded in silence and mystification and is perceived as a distant

phenomenon that primarily concerns others. A dying and powerless person often remains invisible to society – isolated and left to their own suffering.

Although about 10% of deaths are sudden and leave no time for preparation, as many as 90% of deaths are expected and provide an opportunity



for active decision-making and preparation for the patient and their family. People of all ages die, and the way a person experiences illness and death largely depends on their role in life, relationships, culture and individual values.

In palliative care, the way of communicating with the patient and family is also crucial – open, compassionate and understandable. Honesty does not exclude hope; on the contrary, clearly stated information helps the person to take control, express their wishes and prepare for the end of life. Proven communication models such as the SPIKES protocol (Setting, Perception, Invitation, Knowledge, Emotions, Strategy) are used to set the context, assess perceptions, provide information, express empathy, and plan together (1).

2. Social and demographic context

The extension of life expectancy and the aging of the population bring new challenges. The traditional family is disappearing, many elderly people are left alone, and a vital part of the population is leaving the country. There are fewer and fewer people who can care for the dying, which results in isolation and neglect.

Institutionalization of care and placement of the dying in various institutions are becoming a necessity. Experience in working with patients at the end of life shows that, whenever possible, they choose their own home as the place of care during their final days. Being surrounded by family and loved ones provides a sense of security and contributes to a better quality of life and dignity at its end.

The family represents a network of attachment, a link between the past and the future, and exists within a social and cultural context. However, family members are often unprepared for the demands of caregiving – psychologically, emotionally and organizationally. They need support, education and coordination. Societies have always paid special attention to the dying and, in accordance with their own culture and customs, have developed rituals, offered support to the dying, and provided comfort to their families.

3. Definition and goals of palliative care

Palliative care is active, comprehensive care for people with advanced and incurable illnesses who are facing imminent death. Palliative care and active oncological treatment are often provided in parallel, with the boundary between them not being clearly defined. The goal of palliative care is to improve the quality of life of patients and to enable a dignified death by alleviating pain and other severe symptoms: nausea, vomiting, dyspnea, anorexia, cachexia and others (2).

The approach is holistic – it includes the physical, psychological, spiritual and social dimensions of the person. Palliative care respects the autonomy of the patient, their values, wishes and choices. It neither hastens or postpones death, but accepts it as a natural, integral part of life. Palliative care also provides support to the family – both during the illness and after death, in the period of mourning. Numerous professionals are involved in the care: doctors, nurses, clergy, caregivers, pharmacists, physiotherapists, social workers, psychologists, and volunteers – all play an equally important role in supporting the patient and his family (3,4).

In practice, palliative care also encounters obstacles: uneven availability in Croatia, insufficient education of healthcare workers, organizational and financial shortcomings. However, progress is evident: the development of mobile teams, educational programs, and national strategies. The ideal we strive for is a “good death” (1,4).

4. Historical development and philosophy

The modern hospice movement that began in the 1960s arose from the need to listen to patients and to recognize and meet their need for comprehensive care. Palliative medicine as a specialized field, also developed from this movement.

Dame Cicely Saunders, the founder of modern hospice, introduced the concept of “total pain” which encompasses all dimensions of human



suffering: physical, emotional, social and spiritual (5–9). Palliative care seeks to address all of these dimensions – simultaneously and equally. In modern society, death is often medicalized and deprived of its personal and spiritual dimensions. Palliative care aims to restore dignity and a holistic approach to the human being. “Total pain” also requires a “total response”, which calls for a multidisciplinary and transdisciplinary approach. In Croatia, the pioneer of the hospice and palliative movement was Prof. Anica Jušić (1926–2021). In addition to her specific education in palliative-hospice care, she strongly advocated for the establishment of hospices – special institutions dedicated to caring for patients at the end of life (3,10,11).

5. Case report

The case of a 68-year-old patient named Marija, diagnosed with advanced cancer, clearly illustrates the value of palliative care. Although all treatment options had been exhausted, her family insisted on continuing oncological therapy, as they found it difficult to accept the imminent end of Marija's life. Marija was exhausted from previous aggressive treatments, felt they were no longer helping her, and made it clear that she did not wish to continue. She did not want to go to the hospital anymore, she wanted peace. After repeated discussions with the palliative care team, the family members finally accepted her wish.

Palliative care then provided her with what was most important: preservation of dignity, effective symptom control, inner peace, and continuous support until the very end. She had people by her side, not just medication. Compassionate healthcare professionals, a clergyman, family members, and volunteers together enabled her to decide for herself how she wanted to spend the final days of her life.

6. The concept of a “good death” as an ethical ideal

“Good death” implies relief of symptoms, respect for the patient's will and values, the possi-

bility of choosing the place of death, and the involvement of the family throughout the entire process of dying and terminal care. The patient and family are the center of care. Respect for autonomy, avoidance of unnecessary interventions, and equitable access to resources are the fundamental ethical principles of palliative care. A good death does not happen by chance; it requires honest and comprehensible communication, empathy, adaptation of medical procedures to the patient's condition, and family education and teamwork (12,13).

Spiritual care is also an integral part of the palliative approach. This does not refer exclusively to religious support, but the ability to listen, reduce anxiety, connect with meaning, and forgive. The role of priests, spiritual guides, and empathetic healthcare professionals is invaluable in this regard (14).

A good death can be considered one in which a person is clearly informed about their condition, respected and accepted in their full identity, strengthened by the sacraments, and reconciled with themselves and others. At the moment when a person can no act for themselves, respecting their will becomes crucial. As physicians, we cannot accept the decision to forcibly end a person's life – palliative care is neither euthanasia nor dysthanasia. It is a response to humanity.

7. Conclusion

Death is not the opposite of life – it is an integral part of it. Through palliative care, we reduce suffering, restore human dignity, and affirm the value of every human life and every moment. Regardless of where the care is provided – at home, in a hospital, or in a hospice – the goal remains the same: to enable a person to die as a person.

Ars moriendi should be transformed into *ars vivendi* – the art of living to the end.

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