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Strategies for Establishing Palliative Care – Perspectives from Multidisciplinary Discussions

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ABSTRACT

Background: Access to palliative care is limited in many low-resource settings, despite being a fundamental component of universal health coverage. This paper presents a practical perspective on initiating and scaling up palliative care services, based on the collective experiences of healthcare professionals from diverse regions.
Methods: Structured multidisciplinary group discussions were conducted during a Fellowship in Palliative Care program and thematically analyzed. Insights were informed by institutional experiences, regional models, and supporting literature.
Results: There were experiential perspectives from ten clinicians and 36 supporting publications. To cultivate awareness and competence, the integration of palliative care into health sciences curricula and continued professional education is recommended. Nurse-led palliative care clinics, community volunteer training, and telemedicine services are identified as scalable, context-sensitive models to extend care beyond traditional settings. Initiatives such as Hope Cafes are proposed to normalize conversations around serious illness and dying and offer supportive environments for patients, caregivers, and the public. Challenges such as limited manpower, inadequate funding, medico-legal constraints, and sociocultural barriers are acknowledged. Solutions suggested include cross-sector partnerships, targeted training, use of digital platforms, and alignment with existing health and social systems. The role of bereavement support and palliative care research is highlighted as essential to holistic palliative care service delivery.
Conclusion: This paper offers a roadmap for institutions and regions aiming to introduce or strengthen palliative care services. Through leveraging available human resources, community structures, and innovative delivery models, a compassionate, culturally sensitive, and scalable palliative care framework can be achieved, even in resource-constrained environments.

Keywords: Bereavement; Community health; Palliative care; Program development

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INTRODUCTION

Palliative care services are provided to patients with progressive diseases that generally have limited possibility of obtaining remission or modifying the course of the disease (1). Palliative care focuses on improving the quality of life for patients and their families facing life-threatening illnesses, through early identification, assessment and management of symptoms causing suffering, such as pain. It utilizes a holistic approach taking into account the physical, psychosocial, and spiritual needs of an individual (2). Despite its recognized importance, the implementation of palliative care services is limited in many parts of the world. A study identified significant disparities in palliative care access; 80% of the global palliative needs are in low-middle income countries, which has only 30% of the palliative services (3).

Palliative care models especially home-based interventions have also been shown to be cost-effective, providing significant savings to health systems through decrease in healthcare costs with an associated improvement in patient and caregiver outcomes (4). There has also been recent interest in a public health palliative approach to scale up the provision of palliative care through community empowerment, participation and compassion for those needing palliative and supportive care (5).

Although many countries have introduced national palliative strategies, practical guidance on how to initiate and scale up services, especially in resource-limited contexts remain sparse. As reviews often focus on high-income settings or specific interventions rather than comprehensive, experience-based strategies, this paper aims to fill the gap by synthesizing multidisciplinary perspectives to guide implementation in diverse regional contexts.

This paper is based on multidisciplinary discussions among clinicians during a Fellowship in Palliative Care programme and provides suggested strategies to initiate and develop palliative care services within healthcare institutions, nationally and regionally. It is hoped these perspectives can stimulate discussions encompassing models of care, resource allocation, training, education and community engagement strategies towards actionable steps that can be taken to integrate palliative care into healthcare systems.

METHODS

As part of a Fellowship in Palliative Care organised collaboratively by the Institute of Palliative Medicine, India (also the WHO Collaborating Centre for Building Country Capacity in Palliative Care and Long-Term Care), St Christopher's hospice London, Sanjeevan Palliative Care Project Pondicherry and Bangabandhu Sheikh Mujib Medical University of Bangladesh, participants were required to discuss practical ways to implement ideas for starting or establishing palliative care services in their localities, identify possible obstacles and suggest how these may be overcome. The group authors are ten clinicians from six different institutional settings who practice palliative care, with varying backgrounds in terms of specialties ranging from orthopedics, anesthetics, community medicine and geriatrics, and countries including India, Bangladesh, Iran, Thailand, Myanmar and Brunei. Each author shared strategies for initiating services in their institutions, which were transcribed. Thematic synthesis was conducted collaboratively to identify recurrent strategies, challenges, and solutions. As the primary purpose of the paper was to document and analyze shared professional experiences rather than evaluate all available experience, a systematic search was not performed, rather literature cited was identified purposively to support key points. This paper is not a systematic or scoping review; it adopts a narrative synthesis approach, integrating personal experiences, institutional models, and relevant literature to develop a comprehensive and pragmatic perspective for institutions seeking to establish and strengthen palliative care services.

RESULTS

Experiential perspectives were obtained from ten clinicians, with 36 peer-reviewed publications cited to support and contextualize the insights derived from the multidisciplinary discussions. The following sections outlines suggested strategies to initiate and develop palliative care services, with possible obstacles and solutions for each approach.

Palliative Care Awareness, Education and Training Within Universities

Integrating palliative care into health sciences education requires a multifaceted approach to raise awareness of future healthcare professionals and enhance competencies in palliative care practices. Regular sensitization initiatives to raise awareness and understanding of palliative care principles to medical and nursing students, allied health sciences, and hospital staff within teaching hospitals are essential. Informative posters around health campuses would also raise awareness among students and faculty members, supporting palliative care education.

Palliative care pioneers from each site may be engaged to conduct seminars and workshops for Continuing Medical Education (CME) to share valuable insights and updated knowledge. Interactive health talks and panel discussions may serve as platforms for dialogue, learning and sharing experiences to improve receptiveness to the palliative approach. Mandatory palliative care modules for medical and nursing students may be introduced to ensure all graduates have a basic understanding of palliative care. These modules can be integrated into existing curricula and tailored to different levels of education. Open courses on basic palliative care may also be developed, which may be online or hybrid format to improve accessibility. These courses should include assessments to ensure competencies are achieved. Internship opportunities for final-year students allows them to acquire hands-on experience and apply theoretical knowledge in real-world settings. Students should also be encouraged to volunteer in palliative settings to enhance community engagement and work with grassroots healthcare workers (6).

Obstacles and solutions:

There may be a shortage of qualified educators to deliver palliative care training. Financial constraints may hinder curriculum development and the sustainability of educational programs. Prevailing knowledge and attitudes among staff and students may resist the integration of palliative care, and moving from theoretical knowledge to practical application can be challenging.

Leveraging the expertise of trained doctors, nurses, and volunteers for capacity building and training of trainers can mitigate the shortage of educators. Inviting experts from other institutions or overseas, accessible through online platforms, can provide high-quality training and broaden the educational scope. Offering free training sessions and workshops and providing certificates may incentivize students to participate in palliative care training.

Community Volunteer Training in Palliative Care

Community volunteers are essential in the delivery of care to patients at home and are an essential component for developing a compassionate community. This requires community palliative training and education sessions for various segments of civil society, including village volunteers, village heads, students, community nurses, spiritual leaders, governmental and non-governmental organizations, and retirees. These sessions can help build a network of informed and capable volunteers to provide holistic care and support. Community meetings serve as valuable opportunities to raise awareness, recruit volunteers, and survey community needs while promoting self-reliance and ownership of palliative care (7).

Training programs should be tailored to the different groups and provide knowledge on essential aspects such as pain management, dyspnea, pressure sores, spiritual care, and bereavement support. Volunteer management requires establishing clear criteria for volunteer selection, such as neighbors and individuals known to patients, along with mandatory police checks and security clearances to ensure patient safety. Additionally, identifying and linking volunteers to available services, such as spiritual support and recreational activities from elderly clubs are required for support and reducing burnout (8).

Obstacles and solutions:

The sustainability of volunteer programs requires effort. Limiting factors include budgets for recruitment and administration costs, and

volunteer retention with high turnover rates. The unpaid and informal nature of volunteer roles may deter individuals from taking on responsibilities, especially with an unclear scope of roles, ranging from nursing, spiritual support, or medication management. There may also be a lack of awareness about volunteer opportunities or a perceived lack of skills which hinders volunteer recruitment (9).

It is useful to obtain support and funding from governments and spiritual organizations for financial support and volunteer recruitment. Clear volunteer guidelines and orientation programs to define roles and responsibilities ensures volunteers know what is expected from them. Regular recruitment drives and interviews to match volunteers' skills to appropriate roles can improve retention and effectiveness. Encouraging caregivers and patients to share their stories can advocate for volunteer support and enhance recruitment and orientation efforts (10). Incentives such as badges, certificates, and credit hours, as well as events to acknowledge volunteer contributions may improve motivation among volunteers.

Nurse-Led Palliative Clinics

Nurse-led palliative clinics are a potential way to scale up palliative specialty clinics, especially in low- and middle-income countries (11). This approach has been shown to improve patient symptoms and decrease utilization of emergency department services for patients with life-limiting illnesses (12). The implementation of such clinics requires systematic planning to develop nurse specialist roles. Identified nursing champions with basic palliative knowledge and expertise are required to undergo advanced palliative training to lead palliative initiatives and mentor other nurses. It is necessary to secure formal permissions from institutions for nurses to run clinics, with clear information on requirements, responsibilities and scope of practice. Access to reference materials, guidelines and specialties, such as oncology and geriatrics should also be facilitated to provide nurses with the necessary guidance and support.

A scoping review identified successful nurse-led palliative clinics mainly from India and sub-Saharan Africa, where trained palliative care nurses provide outpatient services under institutional oversight. The minimum recommended training includes certification in basic and advanced palliative care, clinical experience under supervision, and additional training in communication, symptom management, leadership, and mentoring. Clinics operate under established protocols, with regular supervision from senior palliative care specialists to ensure safe practice and adherence to standards (11).

Obstacles and solutions:

There is a shortage of palliative trained nurses and overloading of skilled nurses to take on additional palliative roles such as clinics is unsustainable. Institutional support must be obtained, as under-recognition of nurses' roles and abilities may lead to skepticism towards nurse-led clinics. There may also be an absence of standardized guidelines or protocols for palliative treatment and the operation of nurse-led clinics, which must be developed beforehand.

Strong institutional support is paramount, including granting nurses decision-making authority and limited medication prescribing rights within their scope of practice. Providing incentives such as adequate facilities, competitive salaries, and career advancement opportunities can attract and retain skilled nurses. Specialized palliative training programs for nurses may need to be developed to include leadership, management, and mentoring skills so they are equipped to lead clinics effectively (13). Collaboration with allied health professionals, such as paramedics and physiotherapists to develop comprehensive palliative care plans may also improve patient outcomes. Information may also need to be disseminated to the public regarding nurse-led clinic services to improve public awareness, access and acceptance.

Palliative Telemedicine Services

Palliative telemedicine services can significantly enhance the accessibility and continuity of care for patients requiring home-based palliative care (14). This involves setting up a telephone helpline and providing online follow-up consultations to support patients and their families at home. Staff training for teleconsultation practices may be required, and additional staff, such as paramedics or nurses may be engaged to handle routine enquiries and provide 24/7 availability of palliative support.

***Obstacles and solutions*:**

For clinicians, it is important to ensure medico-legal protection and indemnity cover for managing patients who are not seen physically.

Clear documentation is important, as it can be difficult to make accurate diagnoses without face-to-face or physical examinations and prescribe controlled drugs remotely. Privacy and data security concerns must be managed, given the risks associated with storing patient data in the cloud. Additionally, barriers to telemedicine include access from remote areas, varying levels of digital literacy, and language barriers (15).

In regions with poor internet connectivity, telemedicine services may not be feasible. Hybrid models combining telephone helplines, home visits, and digital platforms can help bridge gaps. Addressing digital literacy among patients and caregivers through simple instructions, caregiver training, and use of local languages may also help narrow the accessibility divide.

Pilot Palliative Care in Areas of Need

Palliative services may be established through a pilot initiative in a specialty with high palliative needs, such as intensive care units (ICUs) (16). This may improve buy-in from other specialties and significantly enhance the quality of care for critically ill patients. Palliative care consultation services (PCCS) provide a valuable service in acute healthcare settings, particularly for those with advanced life-limiting diseases or requiring symptomatic improvement. The ideal specialty to select for this pilot initiative may vary depending on the burden of palliative care needs, readiness, clinician interest, and relatedness to local clinical practices such as oncology. For example, a tertiary hospital from Germany found that PCCS requests were highest from internal medicine, gynaecology and radiotherapy (17). Another hospital study providing palliative care consultations focusing on pain received referrals predominantly from internal medicine, general surgery and radiotherapy (18).

A scoping review should be conducted to better understand the specific palliative care needs, for example, by gathering insights from ICU staff. Prognostic indicators may be used to identify patients who would benefit from palliative care. A trigger-based model may also be used to identify those who require palliative care consultations; triggers may include ICU admission stay for ten days or greater, multisystem organ failure in three systems or more, stage IV malignancy, status post-cardiac arrest, and intracerebral haemorrhage requiring mechanical ventilation (19). Palliative care specialists should regularly attend handovers and participate in multidisciplinary team meetings and family meetings to provide holistic care plans. Developing collaborative ICU-palliative clinical care pathways ensures that palliative care is systematically integrated into the ICU workflow, providing a seamless approach to patient management (20).

***Obstacles and solutions*:**

There may be a lack of trust and rapport between ICU and palliative teams initially, with a need to determine patient ownership and optimal involvement of each team. Potential conflicts regarding goals of care or miscommunication with families may occur. ICU teams may feel obliged to carry out invasive procedures due to legal concerns, which may conflict with palliative care principles. Limited palliative care staffing and the additional workload may strain resources, especially if there is an increased number of patients from the pilot (21).

Initially, it is advisable to observe how the specialty operates to understand how best to integrate palliative care. Ground rules should be set at the start of the pilot to manage expectations. Shared patient goals should be discussed during case conferences and handover meetings, ensuring consistent communication with family members. A palliative-ICU nurse specialist may have a role in bridging the gap between the two disciplines (22). Joint projects such as developing information materials for patients regarding intubation, ventilation and advance care planning may facilitate team building and improve informed decision making for staff and patients.

Set Up Hope Cafés

Hope Cafés are dedicated community spaces where individuals can access resources, network, find support and solace, and exchange ideas on caregiving while promoting palliative care initiatives. Hope cafés play an important advocacy role by raising public awareness about palliative care, educating communities, and serve as a bridge to connect individuals and families with local palliative care services. They can also promote advance care planning, normalize conversations about serious illness, and foster community involvement in care initiatives. These cafés are strategically located in places such as hospitals, educational institutions, and community gathering areas to maximize their reach and impact (23). A central organization can spearhead the initiative, promoting the branding and mechanisms needed to set up Hope Cafés.

Creating strong links between volunteers, providers, franchisers, and charities is crucial for opening and maintaining these cafés. They can be used as educational opportunities for students to learn about life, death and palliative care (24). Hope cafes may also be opportunities for vocational rehabilitation by hiring unemployed individuals, family members, and disabled persons, with funds redirected to assist people facing socioeconomic difficulties or palliative needs.

***Obstacles and solutions*:**

Effective branding, through creation of logos, stickers, and pamphlets, is necessary to establish a recognizable and cohesive identity. Ensuring quality control and brand compliance across different cafés can be challenging, as can creating a relaxed ambiance in typically busy places such as hospitals. Securing permission from café owners to incorporate palliative care awareness, coordinating daily operations and volunteers, and obtaining financial support are additional hurdles.

It is beneficial to learn from and showcase evidence from successful Hope Cafés and market the concept within community palliative movements. This requires buy-in from hospitals and institutions, which can also use Hope Cafés for promotional events, integrating them into broader healthcare initiatives. There is a need for frequent check-ins by coordinators to ensure the smooth running of cafés. Donations may be obtained to support the provision of free coffee, meals, and basic care for those in need, making the cafés accessible and welcoming to all community members. With strategic planning and community engagement, Hope Cafés can become vital hubs for palliative care support, offering resources, solace, and a sense of community to individuals and families navigating the complexities of palliative care (25).

Palliative Home-Based Care

Home-based care is an essential component of a comprehensive palliative service to support patients with life-limiting illnesses within the comfort of their homes. Before embarking on this initiative, it may be useful to conduct a survey to identify and locate areas of need. For example, in Bangladesh, palliative care was provided in Korail slums due to an identified need (26). Liaising with local leaders and forming a supportive group or network can facilitate community engagement, ownership and investment in the project. Skilled personnel may be acquired through hiring palliative nurses and nurse assistants and providing palliative training to volunteers (27). A mobile van equipped with a palliative inventory enables healthcare providers to deliver essential medications and supplies to patients' homes. Maintaining accurate records using standardized templates will facilitate efficient patient management and monitoring.

Regular surveys to determine patient and family satisfaction can provide valuable feedback for the ongoing evaluation and improvement of home-based care services. It is suggested that this initiative should aim to empower and hand over operations to the community within a specified timeframe, such as three to five years.

***Obstacles and solutions*:**

Inadequate trained multidisciplinary manpower, with the need to coordinate teams and volunteers may make this a challenging initiative to implement. There may already be potential unaddressed inequities in access to care based on socioeconomic status and geographic location. Cultural taboos and social stigma surrounding end-of-life care may also affect acceptance and utilization of services.

Thus, it is essential to conduct a thorough needs assessment and engage in active planning and engagement of caregivers. Emphasizing advance care planning, end-of-life care, and after-death burial planning helps address cultural sensitivities and ensure patient-centered care. Ongoing learning and reflection during the roll-out phase, coupled with the sharing of success stories, will enable continuous improvement and community support for palliative home-based care services (28).

Bereavement Support Services in the Community

Bereavement support services in the community are an essential yet often neglected component in providing holistic palliative care to individuals and families coping with loss. This requires a collaborative approach involving healthcare professionals, community volunteers, and social workers to bridge the gap in clinician support before and after patients pass away (29).

Once community volunteers and social workers are recruited, they should receive training on providing encouragement, support, and identifying grief complications. Volunteers can express condolences through various means such

as telephone calls, sympathy cards, and attending funerals, offering tangible support during the grieving process. They also play a crucial role in identifying complicated grief and referring individuals for counseling when necessary (30).

'Palliative Care Partners' acting as liaisons between hospitals and communities ensures continuity of care and support closer to families. These partners often comprise of primary care physicians, nurses and community support groups who received training in communication skills and grief counseling from palliative care specialists. Information exchange and handover protocols may facilitate seamless transitions between hospital and community care settings, with referral systems for distributed tasks and responsibilities.

***Obstacles and solutions*:**

Working in silos and poor handovers between hospitals and community providers may affect a seamless bereavement support service. There may also be poor bereavement acceptance due to misconceptions or family attitudes towards death, avoidance behavior in discussing death and dying, family conflicts, language and cultural barriers, and emotional overwhelm in volunteers and bereaved families.

It is essential to define clear roles, responsibilities, and referral guidelines between professionals involved in bereavement support. Identifying a dedicated bereavement team comprised of individuals who have built relationships and empathy with families can enhance support provision. Screening tools to identify those with complicated grief in need of counseling may facilitate effective targeted support for these individuals (31).

Palliative Care Research

Promoting palliative care research will help advance knowledge, improve patient care, and shaping policy decisions. A comprehensive framework of research topics may be developed as a roadmap, which should encompass epidemiological studies, observational research, interventional trials, randomized controlled trials, and case reports. Collaborations between faculties, departments, institutes, and international partners can enrich research endeavors and facilitate knowledge exchange (32).

Integrating research components into degree and postgraduate qualifications encourages students and clinicians to engage in research activities. Grants and research support services, such as assistance with data collection, analysis, writing, publication, and collaboration with clinical specialties, should be considered to boost research quality and impact. Opportunities to regularly showcase palliative research findings through conferences and publications will also raise awareness and inform policymakers and service providers about evidence-based practices.

***Obstacles and solutions*:**

There are limited funding opportunities for nurses and allied health professionals, in addition to the overall scarcity of funds for palliative research. Staff may lack interest or time for research due to their clinical workload. Lengthy processes for obtaining institutional and ethical permissions, and limited experience in research methodology and academic recognition may also discourage participation in research endeavors (33).

Establishing research teams or partnerships with other better funded specialties, such as cardiology or oncology, may open up funding opportunities. Interdepartmental collaborations may foster a collaborative research culture. A research office can be set up to disseminate information on available scholarships and grants and provide assistance to researchers. Workshops and research "clinics" are also helpful to enhance basic research skills and troubleshoot difficulties during projects. Recognizing research contributions through awards and accolades within institutions also motivates researchers and enhances their professional recognition.

National Palliative Policies and Guidelines

The introduction of national palliative policies and guidelines will ensure consistent, evidence-based practices to improve the quality of care for patients facing serious illnesses. This requires collaboration among stakeholders, adaptation to local contexts, and strategies to address potential obstacles. The implementation process begins with the formulation of national evidence-based guidelines covering various aspects of palliative care, including the design of care settings (hospital, community, homecare), program models, and clinical management, including end-of-life care (34). Existing policies, guidelines, and standards from international palliative authorities and countries with developed palliative services can provide valuable insights and inform the development of tailored guidelines.

Round-table discussions between national multidisciplinary stakeholders and experts in palliative care will facilitate the adaptation of guidelines to the local context, ensuring relevance and feasibility (35). A formal launching of policies and guidelines can raise awareness of their availability and importance among healthcare professionals, policymakers, and the public. Standardized algorithms, proformas, screening tools, and consultation templates can be developed to streamline implementation for consistent application to clinical practice, while voluntary audits help identify areas of improvement to maintain palliative care standards.

***Obstacles and solutions*:**

Clinicians and service providers may be unaware or reluctant to follow clinical guidelines. This will require ongoing education and training, taking into account regional variations in practice. Knowledge gaps should be identified and addressed, with regular reviews to ensure guidelines are updated evidence-based practices. It is also important to identify implementation barriers, such as opioid availability, which need to be addressed, or guidelines tailored to the local contexts (36). Policies and guidelines may also be socialised through community engagement, involving small group activists, political leaders, officials, and other stakeholders; this ensures that palliative care is supported as an integral component of national healthcare systems.

DISCUSSION

The strategies outlined reflect a need for adaptable and scalable approaches to palliative care, especially in resource limited settings. Common themes identified include the importance of integrating palliative care education in health professional training, identifying and capitalizing existing community and institutional resources, as well as developing cross-sectoral partnerships. Innovative models, such as nurse-led clinics and telemedicine, offer potential to extend the reach of palliative care. These findings align with the literature emphasizing the need for context-sensitive palliative models, especially nurse-led models (11,12) and a public health approach to community-based palliative care (5). Implementation must be tailored to local needs, taking into account workforce capacity, community engagement, cultural norms, and available resources.

This current synthesis extends these frameworks by integrating experiential insights from multiple regions, with an approach foregrounding practitioner-driven strategies adaptable to low-resource areas. While practical, contextually grounded recommendations are provided, limitations include its reliance on participant reflections and selected literature, which may not capture the full range of approaches to establish palliative care.

CONCLUSION

It is hoped that these discussions offer a potential roadmap for institutions and regions aiming to introduce or strengthen palliative care services. Through leveraging available human resources, community structures, and innovative delivery models, a compassionate, culturally sensitive, and scalable palliative care framework can be achieved, even in resource-constrained environments.

CONFLICT OF INTEREST

The authors have no conflicts of interest to declare.

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AUTHOR CONTRIBUTIONS

All authors were involved in conceptualization, drafting and finalizing the manuscript.

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