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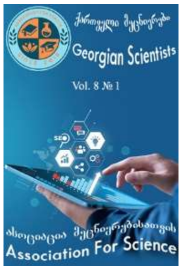

From Suffering to Dignity: Redefining Palliative Care Through Biopsychosocial, Spiritual, and Family-Centered Approaches

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Abstract

The modern healthcare landscape, shaped by high technology and commercialization, often reduces patients to biological entities in need of repair, neglecting their multidimensional needs. In response, the biopsychosocial model emphasizes holistic care that addresses physical, psychological, social, and spiritual dimensions, recognizing patients as persons with inherent rights. Palliative care exemplifies this approach, integrating symptom management with psychological, spiritual, and family-centered support from diagnosis through the end of life. Spiritual well-being, dignity, and family involvement are central to improving quality of life, coping with illness, and mitigating suffering. Despite evidence of its effectiveness, spiritual and family-centered care remains systematically underdeveloped, particularly in low- and middle-income countries. Conceptualizing palliative care as a public health priority highlights ethical obligations, equitable access, and the societal responsibility to uphold human dignity. This article argues that embracing biopsychosocial, spiritual, and family-centered approaches transforms palliative care from a clinical service into a humanizing practice that affirms patient autonomy, alleviates suffering, and strengthens the resilience of healthcare systems.

Introduction

The introduction of high technologies and the commercialization of healthcare in the modern world have, in turn, contributed to the perception of the patient primarily as a biological organism that requires “repair” by the healthcare system in the event of “malfunction.” In response to this reductionist approach, initiatives aimed at the rehumanization of medicine have emerged, emphasizing that healthcare professionals (physicians, nurses) should be regarded as persons with rights, and that patients should not be viewed merely as biological entities, but rather as persons endowed with multidimensional needs and fundamental rights (David R. Kopacz, MD, 2013; Biopsychosocial Approach, 2020).

It is also important to note that well-being is essential not only for improving quality of life but also for coping with illness itself. An effective healthcare system, therefore, implies an approach oriented not toward disease, but toward the human being as a person (Saad et al., 2017).

Following the end of World War II, during a period of profound reassessment of global values, the World Health Organization adopted a definition of health according to which well-being represents “a dynamic state of physical, mental, social, and spiritual integrity, and not merely the absence of disease” (WHO Constitution, 1948). Three decades later, in 1977, American psychiatrist George Engel laid the foundation for the biopsychosocial holistic approach in medicine.

Illness and disease disrupt the normal course of life and often alter it radically. In chronic and incurable conditions, in addition to physical symptoms, patients frequently experience existential challenges such as questions concerning the meaning and purpose of life, which are directly associated with fear, anxiety, and depression. Gradually, individuals may become socially isolated. This process not only affects patients’ quality of life but, alongside the physical suffering caused by illness, also leads to profound psychological and spiritual distress.

According to Engel, biopsychosocial factors determine vulnerability to disease, while the biomedical model that dominates modern medicine focuses exclusively on disease treatment and fails to address the spiritual needs of the individual. Human beings must also be understood within their social context as persons with complex, multidimensional needs (Engel, 1977).

Within the biomedical healthcare model, physicians focus primarily on a specific disease, striving to establish a diagnosis based on etiological and pathogenetic components and to develop treatment strategies accordingly. While this approach is undoubtedly important, it remains insufficient. In contrast, the biopsychosocial model is holistic and provides a comprehensive understanding of disease, taking into account the patient’s physical, spiritual, social, and psycho-emotional needs. Most importantly, this model shifts the primary focus from the disease itself to the patient as a person with inherent rights. As such, the biopsychosocial model is both more humane and more cost-effective (Biopsychosocial Approach, 2020).

Notably, the biopsychosocial model seeks to broaden the understanding of disease causation, health, and well-being (Havelka et al., 2009). The development of this philosophy has made a significant contribution to medicine, as the perception of the patient has shifted from that of an “object” to a “subject”—a person living with disease and possessing rights (Biopsychosocial Approach, 2020).

Palliative Care and Human Rights

“You matter because you are you, and you matter until the last moment of your life. We will do all we can, not only to help you die peacefully, but to help you live until you die.” —Dame Cicely Saunders, founder of the modern hospice movement

In antiquity, illness was perceived as a disruption of harmony with the cosmos. Similarly, modern biomedicine recognizes that disease involves a disturbance of homeostasis—a breakdown of coordination among organ systems—and treatment aims to restore this balance. However, chronic and incurable illnesses affect not only patients but also their families and broader social environments, leading to disruptions in both intrapersonal and extrapersonal relationships. A holistic approach seeks to restore psychological, spiritual, and social connections, while at the end of life—when restoration of homeostasis is no longer possible—extrapersonal connections may still be repaired (Sulmasy, 2002).

The essence of the biopsychosocial holistic model is particularly well reflected in the discipline of palliative care. The term “palliative care” derives from the Latin word *pallium*, meaning “cloak” or “mantle,” symbolizing protection and relief. The emergence of this field is closely linked to global population aging and the increasing prevalence of incurable chronic diseases. Patients living with such conditions experience profound suffering and require a comprehensive, multidimensional approach (Kordzaia et al., 2005).

Palliative care should begin at the time of diagnosis and continue alongside curative or life-prolonging treatment. It must be adapted to patients’ evolving needs and include psychological and spiritual support to help patients prepare for death, as well as support for family members both during disease progression and following bereavement.

In palliative care, the biopsychosocial model gains particular significance through the explicit inclusion of the spiritual dimension. In 1967—ten years before Engel’s theoretical framework—Cicely Saunders, the founder of the first modern hospice, emphasized not only the management of pain and physical symptoms but also the psychological suffering of patients and the need to support their families. She and her colleagues observed that, near the end of life, patients’ value systems often change, with spiritual concerns—such as the meaning of life, the purpose of suffering, and fear of death—coming to the forefront.

During this period, patients frequently seek to reconcile relationships and resolve matters of personal importance. This underscores why palliative care must extend beyond symptom control to encompass multidisciplinary, holistic care that includes spiritual, psychological, and social support. Within this model, the patient’s values, preferences, and autonomy are central to care planning.

Spiritual needs become particularly salient in the final days and moments of life. Spiritual well-being, hope, personal dignity, and the preservation of a sense of worth directly influence patients' quality of life, disease trajectory, and treatment outcomes. By its very nature, palliative care is holistic, and respect for the patient as a person reduces suffering at the end of life (Chochinov & Cann, 2005).

The effectiveness of palliative care is greatest when it is integrated into healthcare systems across all stages of treatment and can be delivered both in clinical settings and at home, in accordance with patients' and families' preferences (Biopsychosocial Approach, 2020). The goals of palliative care include:

- adequate pain relief and symptom management;
- improvement of quality of life for patients and their families;
- psychological support for families during illness and after death;
- assistance with social and legal issues;
- promotion of a philosophy of dignified living and recognition of death as a natural and lawful process.

The biopsychosocial model of palliative care fully embodies the humanization of healthcare, person-centered practice, respect for human rights, and the protection of human dignity (Biopsychosocial Approach, 2020). Palliative care must be equally accessible to all who suffer. Every state bears the responsibility to ensure equitable access to palliative services for its citizens and to strengthen such care, as the right to a dignified life constitutes a fundamental human right (Gauri, 2012).

Palliative Care as a Public Health Responsibility

Palliative care should not be understood solely as a clinical or end-of-life service but rather as a fundamental public health responsibility of healthcare systems toward the population. From a public health perspective, palliative care addresses population-level suffering, health inequities, and the ethical obligation to ensure dignity and quality of life for individuals living with life-limiting illnesses (World Health Organization (WHO, 2014).

Global demographic shifts, particularly population aging and the increasing prevalence of chronic non-communicable diseases, have significantly expanded the need for palliative care services worldwide. According to the World Health Organization, more than 56 million people require palliative care annually, yet only a small proportion have adequate access, especially in low- and middle-income countries (WHO, 2014). This gap in access represents not only a clinical deficiency but also a public health failure, as unmet palliative care needs contribute to avoidable suffering, caregiver burden, and systemic health inequalities.

The integration of palliative care into public health frameworks aligns closely with the principles of Universal Health Coverage (UHC), which emphasizes equitable access to essential health services without financial hardship. Both the WHO and the European Association for Palliative Care (EAPC) recognize palliative care as an essential component of UHC and a marker of health system maturity and social justice (WHO, 2014; EAPC, 2017). When palliative care is excluded from national health strategies, vulnerable populations—particularly older adults, patients with advanced cancer, and individuals with chronic progressive illnesses—are disproportionately affected, reinforcing existing health disparities.

From a public health ethics perspective, the lack of accessible palliative care violates the rights to health and to live with dignity. Health systems that prioritize curative and high-technology interventions while neglecting palliative services implicitly devalue the needs of individuals for whom a cure is no longer possible. Such an imbalance reflects a narrow biomedical orientation and contradicts the biopsychosocial model of health, which recognizes suffering as a multidimensional phenomenon encompassing physical, psychological, social, and spiritual domains (Engel, 1977; Havelka et al., 2009).

Moreover, evidence suggests that early integration of palliative care within healthcare systems is not only ethically justified but also cost-effective. Palliative care has been shown to reduce unnecessary hospitalizations, improve symptom management, support family caregivers, and optimize resource allocation—outcomes that are directly relevant to public health planning and sustainability (Chochinov & Cann, 2005; WHO, 2014). As such, palliative care represents a high-value intervention that simultaneously contributes to individual well-being and system-level efficiency.

In this context, palliative care must be conceptualized as a core public health priority rather than a marginal or optional service. Governments and health authorities bear a responsibility to integrate palliative care into national health policies, ensure workforce training, establish regulatory frameworks, and guarantee equitable access across regions and care settings. Upholding access to palliative care ultimately affirms the principle that dignity, relief from suffering, and holistic care are not privileges, but fundamental human rights that persist throughout the entire life course, including its final stages (Gauri, 2012).

Spiritual Care as a Neglected Component of Palliative Care

Despite growing international recognition of palliative care as a holistic, person-centered approach, spiritual care remains one of its most systematically neglected components. This neglect largely stems from the persistent misconception that spiritual care is synonymous with religious care. While religious support may be relevant for some patients, spirituality in healthcare encompasses a broader existential domain, including the search for meaning, the preservation of hope, the experience of dignity, and the need for connection in the face of serious illness and mortality (Puchalski et al., 2014; Ferrell et al., 2018).

Cicely Saunders' foundational concept of "total pain" provides a critical theoretical framework for understanding spiritual suffering as an integral dimension of patient distress. According to this model, suffering is multidimensional and arises from the complex interaction of physical, psychological, social, and spiritual factors. Saunders emphasized that unrelieved spiritual distress can amplify physical pain, deepen emotional suffering, and erode patients' sense of self and worth, particularly at the end of life (Saunders, 1964; Saunders et al., 2010). Consequently, the omission of spiritual care compromises the effectiveness of palliative interventions and undermines the goal of alleviating suffering in its totality.

Spiritual distress is highly prevalent among patients with advanced and life-limiting illnesses and is strongly associated with adverse psychosocial outcomes. Empirical studies consistently demonstrate that unmet spiritual needs are linked to higher levels of depression, anxiety, fear of death, hopelessness, and social isolation, as well as poorer health-related quality of life (Balboni et al., 2007; Chochinov & Cann, 2005). Moreover, patients who perceive their spiritual concerns as ignored by healthcare professionals report lower satisfaction with care and reduced trust in the healthcare system, while their family caregivers experience increased emotional burden and complicated grief (Balboni et al., 2010).

From a systems-level perspective, the marginalization of spiritual care reflects the enduring dominance of the biomedical model, which prioritizes disease-centered diagnosis and symptom control while inadequately addressing existential suffering. This imbalance is particularly evident in health systems where multidisciplinary palliative care teams are underdeveloped or poorly integrated. The absence of structured spiritual assessment tools, limited professional training, and unclear role definitions further contribute to the invisibility of spiritual care in routine practice (EAPC, 2017; WHO, 2014).

Importantly, spiritual care does not require healthcare professionals to engage in religious counseling. Rather, it involves recognizing patients as meaning-making beings, acknowledging their values and beliefs, and creating space for conversations about purpose, fears, hopes, and dignity. Such care affirms the patient as a subject rather than an object of treatment and aligns with contemporary human rights–based and dignity-centered models of care (Chochinov et al., 2002; Gauri, 2012).

Integrating spiritual care into palliative care is therefore both a clinical necessity and an ethical obligation. International guidelines increasingly identify spiritual care as a core domain of quality palliative care and call for its systematic integration into health systems through education, policy development, and interdisciplinary collaboration (EAPC, 2017; WHO, 2014). Addressing spiritual suffering not only improves quality of life but also reinforces the fundamental principle that every person retains intrinsic dignity and worth until the end of life.

The Role of the Family in Palliative Care: The Concept of the “Invisible Patient”

In palliative care, the patient’s family constitutes an indispensable yet frequently overlooked component of the care continuum. Serious and life-limiting illness affects not only the individual diagnosed but also profoundly disrupts the psychological, social, emotional, and economic well-being of family members who assume caregiving roles. Consequently, contemporary palliative care literature increasingly conceptualizes the family as the “invisible patient,” whose unmet needs significantly influence patient outcomes, quality of care, and the overall effectiveness of palliative interventions (Hudson & Payne, 2011; Ferrell & Wittenberg, 2017).

Family caregivers often provide extensive physical care, symptom monitoring, emotional support, and decision-making assistance, frequently with minimal preparation or professional support. This sustained responsibility exposes caregivers to substantial psychological distress, commonly referred to as caregiver burden, which encompasses emotional exhaustion, anxiety, depression, sleep disturbances, financial strain, and social isolation (Schulz & Sherwood, 2008). Empirical evidence consistently demonstrates that high caregiver burden is associated with poorer mental health, reduced quality of life, and increased morbidity among caregivers themselves (Adelman et al., 2014). Importantly, caregiver distress has a reciprocal effect on patients, exacerbating symptom burden, impairing communication, and diminishing perceived quality of care (Given et al., 2012).

From a biopsychosocial perspective, caring for the family is inseparable from caring for the patient. Family members serve as primary interpreters of patients' needs, mediators between patients and healthcare professionals, and custodians of patients’ values and preferences, particularly as illness progresses and functional decline limits patients' autonomy. When families are inadequately supported, their capacity to fulfill these roles deteriorates, resulting in fragmented care, moral distress, and increased reliance on acute healthcare services (Ferrell et al., 2018).

Bereavement care represents a critical yet often neglected extension of palliative care for families. The period following a patient’s death is associated with heightened vulnerability to complicated grief, depression, anxiety disorders, and long-term health consequences among surviving relatives (Prigerson et al., 2009). International palliative care standards emphasize that support for families should not cease at the moment of death but should extend into the bereavement period through structured follow-up, psychosocial counseling, and community-based support mechanisms (EAPC, 2017; WHO, 2014). Failure to provide bereavement care not only undermines family well-being but also contradicts the ethical foundations of palliative care, which prioritize continuity, compassion, and dignity.

Recognizing the family as a unit of care necessitates a multidisciplinary approach that integrates psychosocial professionals, social workers, psychologists, and spiritual care providers alongside medical teams. Such integration facilitates early identification of caregiver distress, timely intervention, and the development of individualized care plans that address both patient and family needs (Hudson et al., 2012). Evidence suggests that family-centered palliative care models improve patient satisfaction, reduce caregiver burden, enhance coping capacity, and contribute to more sustainable healthcare delivery (Ferrell & Wittenberg, 2017).

In this context, family-centered palliative care is not an optional adjunct but a core ethical and clinical requirement. Supporting families affirms their intrinsic role in the patient's lived experience of illness and reinforces the principle that dignity, compassion, and holistic care extend beyond the individual to encompass the relational networks in which patients exist. Ultimately, integrating family care into palliative services strengthens both patient outcomes and the resilience of health systems facing the growing burden of chronic and life-limiting diseases.

Conclusion: Palliative Care as a Humanizing and Social Responsibility Framework

Palliative care embodies the humanization of medicine, the protection of human dignity, and a societal commitment to those facing life-limiting conditions. Beyond symptom management, it represents a deliberate ethical and professional stance that prioritizes the person over the disease, integrating physical, psychological, social, and spiritual dimensions into care delivery (Chochinov & Cann, 2005; Sulmasy, 2002). By addressing the holistic needs of patients and their families, palliative care reinforces the principle that every individual retains intrinsic worth and rights, even in the context of incurable illness (Engel, 1977; Kopacz, 2013).

Moreover, palliative care challenges healthcare systems to confront fundamental questions about equity, access, and social justice: how societies care for those who cannot be cured reflects the moral and structural humaneness of their health systems. Ensuring universally accessible palliative care not only alleviates suffering but also affirms a shared responsibility to uphold dignity at the end of life (Gauri, 2012; Ferrell & Wittenberg, 2017). As such, palliative care functions simultaneously as a clinical practice, a moral imperative, and a public health strategy, compelling both policymakers and practitioners to integrate compassion, ethics, and patient-centered approaches into systemic healthcare delivery.

"How we care for those who can no longer be cured defines the humanity of our healthcare systems."

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ტანჯვიდან ღირსებამდე: პალიატიური მზრუნველობის ხელახალი გააზრება ბიოფსიქოსოციალური, სულიერი და ოჯახზე ორიენტირებული მიდგომების მეშვეობით

აბსტრაქტი

თანამედროვე მსოფლიოს ჯანდაცვის სისტემაში მაღალი ტექნოლოგიების დანერგვამ და კომერციალიზაციამ, თავის მხრივ შეუწყო იმას, რომ პაციენტი აღიქმება როგორც ბიოლოგიური ორგანიზმი, რომელიც „დაზიანების“ დროს ჯანდაცვის სისტემის მხრიდან „შეკეთება“ სჭირდება, ამის საპასუხოდ, ბიოფსიქოსოციალური მოდელი მისი ჰოლისტური ბუნებიდან გამომდინარე მოიცავს დაავადების „სრულყოფილ გაგებას“, პაციენტის როგორც ფიზიკური ასევე სულიერი, სოციალური და ფსიქოემოციური საჭიროებების გათვალისწინებას და, რაც მთავარია, მთავარ სუბიექტად არა დაავადების, არამედ პაციენტის როგორც პიროვნების წარმოდგენას, რომელსაც უფლებები გააჩნია. პალატიური ზრუნვა წარმოადგენს ამ მიდგომის ყველაზე თვალსაჩინოდ გამოხატულ დისციპლინას, რომელიც ემსახურება არა მხოლოდ სიმპტომების მართვას, არამედ ფსიქოლოგიურ, სულიერ და ოჯახის მხარდაჭერას დიაგნოზის დადგენის მომენტიდან სიცოცხლის ბოლომდე. სულიერი კეთილდღეობა, ღირსება და ოჯახის ჩართულობა უმნიშვნელოვანესია ცხოვრების ხარისხის გაუმჯობესებისა, დაავადების მართვისა და ტანჯვის შემსუბუქებისთვის. მიუხედავად მისი ეფექტურობის მრავალმხრივი მტკიცებულებისა, პაციენტის ფსიქოემოციური და სულიერი და ასევე ოჯახის წევრების მხარდაჭერის ელემენტები ხშირად არ არის განვითარებული, განსაკუთრებით დაბალ და საშუალო შემოსავლიან ქვეყნებში. პალატიური ზრუნვის აღქმა როგორც საზოგადოებრივი ჯანმრთელობის პრიორიტეტი ხაზს უსვამს ეთიკურ ვალდებულებებს, სამართლიან და თანასწორ ხელმისაწვდომობას და საზოგადოებრივ პასუხისმგებლობას. ბიოფსიქოსოციალური, სულიერი და ოჯახის წევრებზე ორიენტირებული მიდგომების დანერგვა გარდაქმნის პალატიურ ზრუნვას მხოლოდ კლინიკური სერვისიდან ჰუმანურ პრაქტიკად, რომელიც აღიარებს პაციენტის ავტონომიას, ამცირებს ტანჯვას და ამყარებს ჯანდაცვის სისტემების მდგრადობას.