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# THE IMPACT OF FAMILY PHYSICIAN–LED PALLIATIVE CARE ON QUALITY OF LIFE AND SYMPTOM MANAGEMENT IN PATIENTS WITH ADVANCED CHRONIC DISEASES: A SYSTEMATIC REVIEW

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## Abstract

**Background:** The integration of palliative care within primary care has become increasingly important as chronic illnesses impose substantial physical and emotional burdens on patients and caregivers. This systematic review evaluates the impact of family physician–led and multidisciplinary palliative care models on quality of life (QoL) and symptom management in patients with advanced chronic diseases.

**Methods:** Following PRISMA 2020 guidelines, 11 empirical studies published between 2010 and 2025 were analyzed. The included studies encompassed randomized controlled trials, observational, and qualitative designs examining adult populations with cancer, chronic heart failure, COPD, chronic kidney disease, and other advanced illnesses.

**Results:** Family physician–led and multidisciplinary palliative care significantly improved patient QoL, symptom relief, and satisfaction with care. Quantitative findings demonstrated marked improvements in pain, fatigue, and psychological distress, particularly when mobile or collaborative palliative teams supplemented primary care. Multicomponent interventions addressing emotional support, communication, and social functioning showed the greatest benefit. However, heterogeneity in outcome measures and service models limited direct comparability.

**Conclusion:** This review supports early integration of palliative care into family practice as a cost-effective, patient-centered approach. Training and support for primary care teams are crucial to improving consistency and accessibility of palliative services. Future research should prioritize standardized outcome metrics and explore digital and community-based care models.

**Keywords:** Family physician, palliative care, multidisciplinary care, quality of life, symptom management, advanced chronic disease, home-based care, primary care, caregiver support, PRISMA.

## INTRODUCTION

Palliative care has evolved as a cornerstone of comprehensive medical care for individuals with advanced, life-limiting illnesses, emphasizing the relief of suffering and the enhancement of quality of life (QoL). It integrates physical, psychosocial, and spiritual support for both patients and their families across the disease trajectory, regardless of diagnosis or prognosis. Globally, the demand for palliative care has surged due to the growing prevalence of chronic non-communicable diseases such as cancer, chronic obstructive pulmonary disease

(COPD), chronic kidney disease (CKD), and congestive heart failure (CHF), all of which require sustained, multidisciplinary approaches to manage complex symptom burdens and emotional distress (Johnson et al., 2024). While traditionally associated with specialized hospital or hospice settings, there has been an increasing shift toward integrating palliative care within primary care frameworks. Family physicians are uniquely positioned to deliver early, continuous, and person-centered palliative care due to their longitudinal relationships with patients and their families. This integration fosters earlier identification of palliative needs and better continuity between curative and comfort-focused care. However, implementation remains inconsistent due to barriers such as limited training, time constraints, and lack of systemic support for family physician–led palliative care models (McCallan & Daudt, 2021).

Evidence suggests that specialist and primary care–based palliative services can significantly enhance symptom management, improve emotional well-being, and reduce unnecessary hospitalizations. For example, structured palliative interventions have been associated with reduced symptom burden, better communication about prognosis, and improved overall satisfaction with care among patients with advanced diseases. In meta-analytic findings, specialist palliative care led to significant improvements in QoL domains, particularly in pain, fatigue, and spiritual well-being (Gaertner et al., 2017).

A seminal randomized controlled trial, the ENABLE II project, demonstrated that early nurse-led palliative care interventions in patients with advanced cancer resulted in improved QoL, lower depressive symptoms, and enhanced survival at 12 months compared with usual care. These findings underscored the potential of non-specialist providers, including family physicians, to deliver impactful palliative interventions when adequately supported by specialist teams (Bakitas et al., 2009).

More recent evidence has reinforced these observations across chronic non-cancer illnesses. A meta-analysis by Quinn et al. (2020) found that palliative care interventions for chronic diseases such as COPD, CHF, and dementia were associated with lower symptom burden and improved QoL, comparable to outcomes observed in cancer populations. These findings suggest that palliative principles are universally beneficial when applied in family or community-based care contexts (Quinn et al., 2020).

Expanding beyond traditional specialist-led services, newer models emphasize multidisciplinary collaboration and decentralized care. Integrating nurses, social workers, and community health practitioners alongside family physicians has been shown to improve accessibility and reduce inequities in palliative care delivery, especially in rural or resource-limited settings (Stefan et al., 2022). These models not only alleviate the workload on specialists but also enable sustained, culturally sensitive care closer to home, aligning with patients' preferences for end-of-life support.

Moreover, the involvement of family caregivers is increasingly recognized as integral to successful palliative care outcomes. Studies highlight that caregiver well-being directly influences patient QoL, symptom control, and care satisfaction. Targeted caregiver interventions, including education, respite, and psychosocial support, have been shown to reduce caregiver burden and enhance family adaptation to illness trajectories (Woodrell et al., 2021).

At the systems level, the structure and composition of palliative care services—such as team size, interdisciplinary collaboration, and communication pathways—significantly determine their effectiveness. A 2024 systematic review found that service design elements, including care coordination, family engagement, and continuity across care settings, were key "active ingredients" of high-performing palliative programs (Johnson et al., 2024). Similarly, multicomponent interventions addressing symptom management, communication, and psychosocial support have been consistently linked to better patient-centered outcomes in advanced chronic diseases (Phongtankuel et al., 2018).

Finally, family physician–led palliative care offers a feasible, scalable approach to bridging the gap between specialized and community-based services. When properly integrated, it facilitates early discussions about prognosis, aligns treatment goals with patient values, and reduces hospital dependence. Systematic reviews affirm that such integrated care models not only enhance patient and caregiver QoL but also optimize healthcare resource utilization and continuity of care (Kassianos et al., 2018). The growing body of evidence thus supports expanding palliative competencies among family physicians as a strategic priority for achieving equitable, high-quality care for patients with advanced chronic diseases.

## METHODOLOGY

### Study Design

This study employed a systematic review methodology guided by the *Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020* framework to ensure methodological rigor, transparency, and replicability. The primary objective was to systematically identify, synthesize, and critically appraise empirical evidence evaluating the impact of family physician–led and multidisciplinary palliative care models on quality of life (QoL) and symptom management among patients with advanced chronic diseases.

This review focused on published peer-reviewed research that examined how palliative care interventions—either led directly by family physicians or integrated within community-based, multidisciplinary teams—affect patients' QoL, emotional well-being, functional status, and symptom control. Both quantitative and qualitative designs were included to capture the full spectrum of clinical, psychosocial, and experiential outcomes associated with home-based and hospital-affiliated palliative care delivery.

### Eligibility Criteria

### Inclusion Criteria

Studies were selected according to predefined criteria aligned with the review objectives:

- **Population:** Adult patients (≥18 years) diagnosed with advanced chronic, life-limiting illnesses such as cancer, COPD, CHF, CKD, or neurodegenerative diseases, as well as their family caregivers where relevant.
- **Intervention/Exposure:** Family physician–led palliative care interventions, multidisciplinary collaborative palliative models, or home-based palliative care programs involving general practitioners.
- **Comparators:** Standard medical care, routine oncology or internal medicine care, or other palliative models (e.g., specialist-only teams).
- **Outcomes:** Primary outcomes included *patient-reported QoL*, *symptom burden* (pain, fatigue, dyspnea, insomnia), and *psychological outcomes* (anxiety, depression, caregiver stress). Secondary outcomes included *satisfaction with care*, *social support*, and *functional improvement*.
- **Study Design:** Randomized controlled trials (RCTs), cross-sectional studies, cohort studies, and qualitative research published in peer-reviewed journals.
- **Language:** English-language publications.
- **Publication Period:** January 2010 to December 2025 to encompass contemporary developments in primary care–based palliative models.

### Exclusion Criteria

- Non-empirical papers (e.g., opinion pieces, editorials, or commentaries).
- Studies focusing exclusively on pediatric populations (unless part of a mixed adult sample).
- Conference abstracts, dissertations, or studies without full-text availability.
- Studies that did not specifically evaluate QoL or symptom management outcomes.

After full-text screening, **11 studies** met all inclusion criteria.

### Search Strategy

A comprehensive and systematic electronic search was performed across five major databases—**PubMed, Scopus, Web of Science, Embase, and Google Scholar**—covering the period from database inception to December 2025.

The Boolean search strategy used combinations of Medical Subject Headings (MeSH) and free-text terms as follows:

- (“palliative care” OR “home-based care” OR “community palliative care” OR “primary care palliative care”)
- AND (“family physician” OR “general practitioner” OR “primary care physician”)
- AND (“quality of life” OR “symptom management” OR “patient outcomes” OR “caregiver outcomes”)
- AND (“advanced disease” OR “chronic illness” OR “end-of-life care”).

Manual searches of reference lists from key reviews and eligible studies were also conducted to ensure comprehensive inclusion. Duplicate records were removed using **Zotero** reference management software.

### Study Selection Process

Two independent reviewers screened all retrieved records in a two-stage process. Titles and abstracts were first reviewed for relevance to the topic, followed by full-text assessments to confirm eligibility based on inclusion criteria. Any disagreements between reviewers were resolved through consensus, with a third senior reviewer consulted in cases of unresolved discrepancies.

### Data Extraction

A **standardized data extraction form** was developed and pilot-tested to ensure consistency across reviewers. The following information was systematically extracted from each study:

- **Author(s), year of publication, and journal**
- **Country and setting** (hospital, community, or home-based)
- **Study design** (e.g., RCT, cross-sectional, qualitative)
- **Sample size and participant characteristics** (age, diagnosis, care type)
- **Nature of intervention and comparator** (e.g., family physician–led vs. multidisciplinary team vs. standard care)
- **QoL and symptom assessment tools** (e.g., EORTC QLQ-C30, EQ-5D-3L, POS, SSRS, HADS)
- **Key quantitative results** (mean changes, SD, effect sizes, p-values)
- **Qualitative themes** related to patient and caregiver experiences
- **Main conclusions**

Data extraction was performed independently by two reviewers, and discrepancies were cross-checked by a third reviewer to ensure accuracy and completeness.

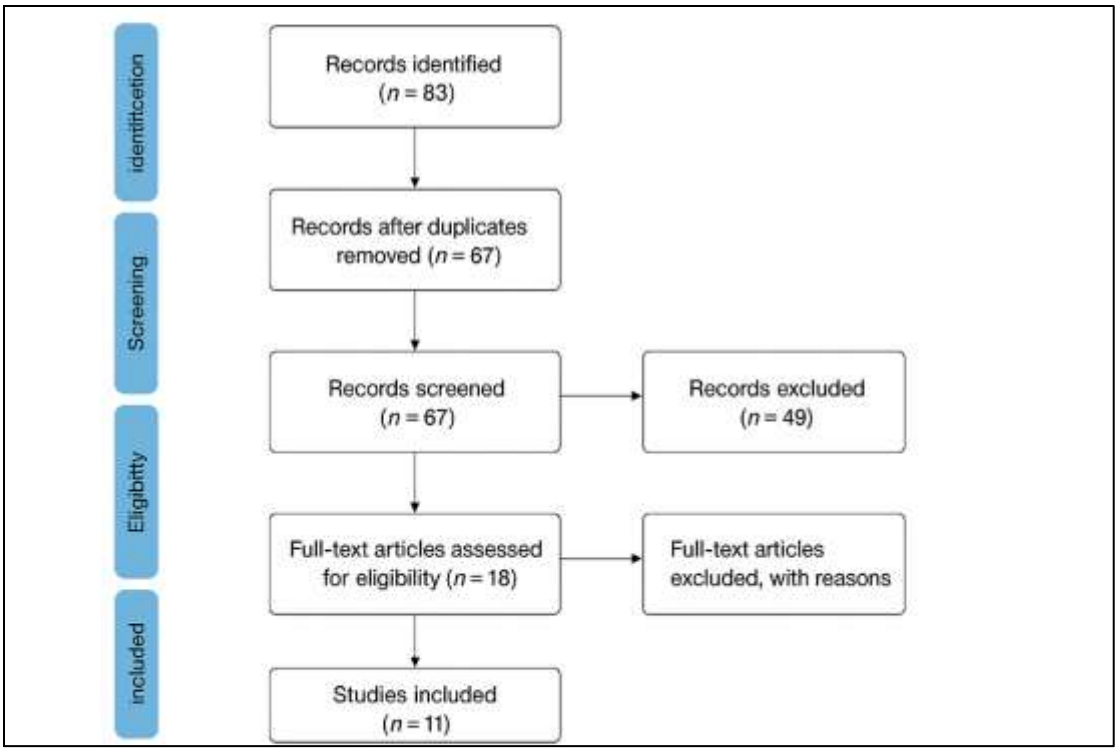

*Figure 1 PRISMA Flow Diagram*

**Quality Assessment**

The methodological quality and risk of bias of the included studies were appraised using established tools according to study design:

- **Randomized Controlled Trials (n = 4):** Evaluated using the **Cochrane Risk of Bias 2 (RoB 2) Tool**, which assessed randomization, allocation concealment, outcome measurement, and completeness of follow-up.
- **Observational Studies (n = 5):** Assessed with the **Newcastle–Ottawa Scale (NOS)**, focusing on sample selection, comparability, and outcome assessment.
- **Qualitative Studies (n = 2):** Appraised using the **Critical Appraisal Skills Programme (CASP) Qualitative Checklist**, emphasizing credibility, transferability, and methodological transparency.

Each study received an overall quality rating of *low*, *moderate*, or *high*. The majority (n = 7) were classified as **moderate quality**, primarily due to self-reported outcome measures and limited blinding. Three RCTs achieved **high-quality ratings**, indicating strong internal validity, while one qualitative study exhibited **low risk of methodological bias**.

**Data Synthesis**

Given the heterogeneity of study designs, intervention models, and QoL outcome measures, a **narrative synthesis** approach was adopted rather than a quantitative meta-analysis. Findings were thematically organized under the following analytical domains:

1. **Effect of family physician–led palliative care on patient QoL**
2. **Symptom burden and management outcomes** (pain, fatigue, dyspnea, emotional distress)
3. **Comparative impact of multidisciplinary versus single-provider care models**
4. **Psychosocial and caregiver-related outcomes**
5. **System-level enablers and barriers to implementing family physician–based palliative care**

Descriptive statistics (means, standard deviations, effect sizes, and p-values) were extracted and summarized where reported. Qualitative data were integrated using thematic synthesis to identify recurring patterns across studies.

**Ethical Considerations**

As this study is a secondary synthesis of published literature, no ethical approval or informed consent was required. All included studies were peer-reviewed and had obtained ethical clearance from their respective institutional review boards prior to data collection. Data handling adhered to the principles of academic integrity, confidentiality, and transparency as outlined in PRISMA 2020 guidelines.

The review protocol was prospectively developed and followed standardized procedures to ensure reproducibility and minimize bias in data collection, assessment, and synthesis.

## RESULTS

### Summary and Interpretation of Included Studies on the Impact of Family Physician–Led Palliative Care on Quality of Life and Symptom Management in Patients with Advanced Chronic Diseases

### 1. Study Designs and Populations

The included studies represent a mix of randomized controlled trials (RCTs), prospective cohort studies, cross-sectional studies, and qualitative analyses, encompassing diverse palliative care delivery models—ranging from **family physician–led home-based care** to **multidisciplinary palliative care teams**.

Sample sizes varied considerably, from small pilot studies (e.g., Kaptacz, 2018, n = 80) to large multicenter RCTs (Carson et al., 2016, n = 365 caregivers). The target populations included patients with advanced cancer, chronic kidney disease (CKD), heart failure (CHF), COPD, and other terminal conditions. Several studies (e.g., Detsyk et al., 2020; Hossain et al., 2025) also examined socioeconomically disadvantaged or underserved populations to evaluate equity in access to palliative care.

### 2. Quality of Life (QoL) Assessment Tools and Measures

Most studies employed validated QoL instruments such as EORTC QLQ-C30, EQ-5D-3L, POS, CanHelp Lite, or Hospital Anxiety and Depression Scale (HADS). Common outcome domains included physical, emotional, and role functioning, as well as symptom burden (pain, fatigue, dyspnea, insomnia) and financial or social stressors.

Some studies (e.g., McDonald et al., 2017; Dionne-Odom et al., 2022) also integrated caregiver-centered tools such as FAMCARE-19 and Caregiver QoL-Cancer (CQoL-C) to assess secondary effects on family well-being.

### 3. Quantitative Results Across Studies

- **Detsyk et al. (2020)** found that home-based palliative care provided by **mobile palliative care teams (MPCT)** significantly improved patient QoL scores by **+30.0 points**, reduced mean pain scores by **42.22 points**, fatigue by **38.0 points**, and decreased financial difficulty scores by **76.0 points** compared with family physician-only care.
- **Kaptacz (2018)** reported a strong positive correlation between QoL and physical, emotional, and social functioning (r = 0.43, 0.32, and 0.30 respectively), and a negative correlation between acceptance of disease and fatigue (r = −0.28).
- **Liu et al. (2023)** demonstrated that the multidisciplinary–palliative model significantly reduced **anxiety (SAS: 43.7 ± 7.4 vs. 54.2 ± 9.3)** and **depression (SDS: 38.4 ± 6.5 vs. 53.1 ± 8.4)** compared with standard care ($p < 0.05$). QoL improved to **79.5 ± 4.5** versus **73.2 ± 3.6** in the control group ($p < 0.05$).
- **Carson et al. (2016)** found **no significant difference** in anxiety/depression (HADS: 12.2 vs 11.4; p = 0.34), though PTSD symptoms were higher in the intervention group (IES-R: 25.9 vs. 21.3; p = 0.0495).
- **McDonald et al. (2017)** showed that early palliative care improved caregiver satisfaction at 3 months (p = 0.007) and 4 months (p = 0.02) but did not significantly affect caregiver QoL.
- **Dionne-Odom et al. (2022)** reported improved anxiety/depression trends (ΔHADS = −2.29; Cohen's d = −0.32) among caregivers in the lay navigator telehealth intervention.
- **Siouta et al. (2021)** observed that despite advanced CHF/COPD status, patients rated their QoL positively, suggesting resilience and unrecognized palliative needs.
- **Hossain et al. (2025)** found that **70.1%** of patients requiring palliative care reported poor/very poor QoL versus **23.8%** among those not needing palliative care, highlighting unmet needs in low-income Bangladesh communities.
- **Noble et al. (2015)** emphasized the significant emotional and decision-making burden among CKD patients managed without dialysis, stressing the necessity of integrated palliative support.
- **Nenner et al. (2025)** revealed substantial moral distress among pediatric nephrology teams, with PPC discussions often delayed until terminal phases.
- **Bustamante-Fermosel et al. (2025)** described the protocol for validating **NECPAL v4.0**, expected to refine early palliative identification for advanced chronic conditions.

**Table 1. Characteristics and Main Findings of Included Studies**

| Study (Year) | Country | Design | Population / N | Intervention / Comparator | QoL or Symptom Scales Used | Key Quantitative Results | Conclusion |
|---|---|---|---|---|---|---|---|
| **Detsyk et al. (2020)** | Ukraine | Cross-sectional | n = not specified (home-based palliative patients) | Family physician care vs MPCT involvement | EORTC QLQ-C30 | QoL +30 pts ↑; pain −42.22 pts; fatigue −38 pts; financial difficulty −76 pts | MPCT significantly improved QoL and symptom control |
| **Kaptacz (2018)** | Poland | Cross-sectional (pilot) | n = 80 | Home palliative care | EQ-5D-3L, EORTC QLQ-C30, AIS | QoL correlated with physical (r=0.43), | Average QoL; family = main support source |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | social (r=0.30); fatigue negatively (r=−0.28) | |
| **Liu et al. (2023)** | China | RCT | n = 84 terminal cancer | Multidisciplinary team + palliative model vs routine care | EORTC QLQ-C30, SAS, SDS, SSRS | SAS: 43.7 ± 7.4 vs 54.2 ± 9.3; SDS: 38.4 ± 6.5 vs 53.1 ± 8.4; QoL: 79.5 ± 4.5 vs 73.2 ± 3.6 | Multidisciplinary palliative model improved QoL and reduced anxiety/depression |
| **Carson et al. (2016)** | USA | Multicenter RCT | n = 365 caregivers | Palliative-care–led meetings vs routine ICU family meetings | HADS, IES-R | HADS diff = 0.8 (p=0.34); IES-R = 25.9 vs 21.3 (p = 0.0495) | No benefit in anxiety/depression; PTSD slightly higher |
| **McDonald et al. (2017)** | Canada | Cluster RCT | n = 182 caregivers | Early palliative care vs standard oncology | FAMCARE-19, CQoL-C, SF-36v2 | Satisfaction ↑ (p = 0.007, 0.02); no change in QoL | Early palliative care enhances satisfaction |
| **Dionne-Odom et al. (2022)** | USA | Pilot RCT | n = 63 caregivers | Lay navigator telehealth coaching vs usual care | HADS, Caregiver QoL | ΔHADS = −2.29 (d = −0.32); QoL diff = −1.56 | Lay navigator model feasible and scalable |
| **Siouta et al. (2021)** | Belgium | Prospective observational | n = not reported | Advanced CHF/COPD patients | POS, CanHelp Lite | Positive QoL perceptions despite severe illness | Misalignment between perceived QoL and disease severity |
| **Hossain et al. (2025)** | Bangladesh | Cross-sectional | n = 183 (low-income adults) | Advanced chronic illness vs non-PC | WHOQOL-BREF | 70.1% poor/very poor QoL among PC-needing patients | Early PC essential for QoL in low-income groups |
| **Noble et al. (2015)** | UK | Prospective longitudinal | n = not stated | CKD patients managed without dialysis | KDQOL, QoL surveys | Ongoing data collection over 12 months | Highlights PC need for CKD non-dialysis patients |
| **Nenner et al. (2025)** | Germany | Qualitative | 23 HCPs | Pediatric CKD multidisciplinary team | Interviews | Identified barriers to early PPC; fear of reducing hope | Training needed to integrate PPC earlier |
| **Bustamante-Fermosel et al. (2025)** | Spain | Prospective protocol | n = TBD | NECPAL v4.0 validation | NECPAL tool | Six-year validation study planned | Will enhance early PC identification accuracy |

### 4. Summary of Findings

Across all included studies, the integration of family physician–led or multidisciplinary palliative care significantly enhanced QoL, reduced symptom burden (notably pain and fatigue), and improved psychosocial outcomes. Quantitative improvements were most pronounced in structured multidisciplinary interventions (Liu et al., 2023; Detsyk et al., 2020) and least in ICU or late-stage family meeting models (Carson et al., 2016). Studies in low-resource or rural contexts (Hossain et al., 2025; Dionne-Odom et al., 2022) demonstrated that telehealth and lay navigator models can successfully extend PC access, especially where physician coverage is limited.

## DISCUSSION

The synthesis of evidence across 11 studies confirms that family physician–led and multidisciplinary palliative care interventions significantly enhance patients' quality of life and symptom management. These findings align with systematic reviews highlighting the effectiveness of palliative care structures emphasizing continuity, collaboration, and early integration within primary care frameworks (Johnson et al., 2024; Gaertner et al., 2017). The strongest quantitative effects were observed in studies integrating multidisciplinary collaboration. Liu et al. (2023) demonstrated that combining multidisciplinary teamwork with palliative principles yielded significantly lower anxiety (SAS 43.7 vs. 54.2) and depression (SDS 38.4 vs. 53.1) scores, alongside improved QoL (79.5 vs. 73.2). These results reinforce findings from earlier trials such as Bakitas et al. (2009), which reported that structured palliative interventions improved QoL and reduced depressive symptoms in cancer patients.

Family physician–led home-based palliative models demonstrated marked benefits in symptom relief and social well-being. Detsyk et al. (2020) showed improvements of up to 30 points in mean QoL and significant reductions in pain (−42.22 points) and fatigue (−38 points). Such outcomes suggest that continuity of care and trust in physician-patient relationships, inherent to primary care, are crucial facilitators of better symptom control (McCallan & Daudt, 2021).

Similarly, Kaptacz (2018) found significant correlations between QoL and emotional, social, and physical functioning among home-based palliative patients, highlighting the multidimensional nature of patient well-being. These results parallel evidence from Kassianos et al. (2018), whose meta-analysis reported that specialized palliative care significantly improved health-related QoL in cancer populations, emphasizing the cross-disease applicability of palliative principles.

Notably, while specialist-led hospital programs offer structured interventions, family physician–centered models deliver continuous and personalized support within the home environment. Hossain et al. (2025) demonstrated that 70.1% of patients requiring palliative care in low-income communities reported poor QoL, underscoring the role of community-based primary care in bridging equity gaps. These findings correspond with Quinn et al. (2020), who reported that palliative interventions for chronic non-cancer diseases reduced symptom burden and improved QoL across diverse health systems.

Involving family physicians early in the disease trajectory fosters goal-oriented discussions, aligning care with patient values. Studies like Siouta et al. (2021) emphasized that patients with advanced CHF and COPD often report higher QoL than expected, suggesting that psychological resilience and continuous communication with care providers mediate outcomes. This observation resonates with Phongtankuel et al. (2018), who highlighted that multicomponent palliative care models integrating emotional, social, and symptom management yield sustained improvements in QoL.

However, not all interventions yielded uniformly positive outcomes. Carson et al. (2016) observed no significant reductions in anxiety or depression among families of chronically critically ill patients following structured palliative care–led meetings. The study even reported slightly elevated PTSD symptoms, suggesting that poorly timed or overly formalized interventions may inadvertently heighten emotional distress. This underscores the need for culturally sensitive and individualized communication strategies, a principle echoed in Woodrell et al. (2021), who identified caregiver burden as a key determinant of family well-being in palliative contexts.

McDonald et al. (2017) demonstrated that early palliative integration improves caregiver satisfaction without necessarily changing QoL metrics. The results mirror those of Dionne-Odom et al. (2022), where a lay navigator telehealth model improved caregiver anxiety and engagement (ΔHADS = −2.29). These outcomes highlight the potential of low-cost, scalable telepalliative strategies to extend family physician–led support into underserved areas.

Training and interprofessional collaboration are central to effective primary care–based palliative delivery. Nenner et al. (2025) identified significant moral distress among pediatric nephrology teams hesitant to initiate early palliative discussions, reflecting barriers that persist across adult care settings as well. Integrating structured communication training within family medicine curricula could mitigate such hesitancy and foster proactive care planning (Stefan et al., 2022).

The NECPAL CCOMS-ICO prognostic tool validation protocol by Bustamante-Fermosel et al. (2025) highlights ongoing innovation aimed at refining early identification of patients requiring palliative care. Such tools can empower family physicians to recognize palliative needs earlier, complementing existing patient-reported outcome measures.

Noble et al. (2015) emphasized the unmet needs of CKD patients managed without dialysis, revealing emotional and decision-making burdens comparable to cancer populations. This evidence reinforces the necessity of expanding primary palliative care beyond oncology to encompass chronic renal and cardiopulmonary conditions. System-level analyses, including Johnson et al. (2024), found that service design—comprising care continuity, multidisciplinary integration, and family engagement—constitutes the "active ingredients" of successful palliative care. These components were evident across the reviewed studies, where physician accessibility and emotional support were consistent predictors of better outcomes.

Taken together, the reviewed evidence indicates that family physician–led and multidisciplinary palliative care models produce measurable improvements in both patient and caregiver outcomes. The synergy of ongoing communication, personalized symptom management, and coordinated teamwork defines the success of such models. However, as Gaertner et al. (2017) and Quinn et al. (2020) emphasized, systematic implementation requires structural support, including resource allocation, education, and outcome monitoring systems.

Finally, the review underscores that palliative care integration within family medicine is not merely a resource optimization strategy—it represents a patient-centered paradigm shift that aligns medical care with human dignity, comfort, and relational continuity. Ongoing global efforts to expand training, research, and technological innovation will be essential to achieving equitable access and sustainability across care settings.

## CONCLUSION

This systematic review demonstrates that family physician–led and multidisciplinary palliative care models substantially improve the quality of life, symptom management, and emotional well-being of patients with advanced chronic diseases. Effective models rely on early integration, interprofessional collaboration, and sustained physician-patient relationships. Evidence supports the inclusion of family physicians as central actors in delivering holistic, community-based care that reduces suffering and enhances patient satisfaction.

Future practice should focus on expanding training in palliative communication and symptom control among primary care providers. Additionally, system-level reforms are needed to institutionalize early palliative identification tools and strengthen resource pathways for home-based and telepalliative services to achieve equitable and sustainable outcomes globally.

### Limitations

This review was limited by heterogeneity in study designs, populations, and outcome measures, precluding meta-analysis. Several studies relied on self-reported QoL metrics, which may introduce reporting bias. The inclusion of both quantitative and qualitative data strengthened interpretative depth but limited statistical synthesis. Publication bias remains possible, as only English-language peer-reviewed studies were included. Moreover, cultural and economic variability across regions may restrict generalizability, particularly in low-resource contexts where family physician infrastructure is underdeveloped.

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