Research Sutra

OPEN ACCESS
Journal of Nursing and Holistic Health Care
Vol 1 Issue 1 (2025)

DOI: 10.5281/zenodo.16411264

From Prognosis to Palliation: A Holistic Framework for Heart Failure Management

Ioanna Tsatsou
Cancer Nurse, One Day Clinic, Oncology-Hematology Department, Hellenic Airforce General Hospital, Athens, GR
itsatsou@uniwa.gr, +306983525725

Received 10-05-2025; Revised 16-06-2025; Accepted 18-07-2025

Cite: Tsatsou I. From prognosis to palliation: A holistic framework for heart failure management. JNHH. 2025;1(1):

Abstract

Heart failure (HF) represents a major public health issue globally due to its increasing prevalence, high morbidity and mortality rates, and frequent hospitalizations. Despite advancements in pharmacologic and device-based therapies, HF remains a progressive and incurable condition that significantly impairs patients' quality of life. Palliative care, a multidisciplinary approach focused on alleviating symptoms and improving the quality of life for patients with serious illnesses, offers substantial benefits in the context of HF. This study reviews the integration of palliative care in HF management, exploring its definitions, principles, and application throughout the disease trajectory. A greater focus on holistic care, individualized care planning, education, and healthcare system reforms is essential to enhance the delivery of palliative care to HF patients.

Keywords: Palliative Care; Heart Failure; Symptom Management; Quality of Life; Holistic Care

Introduction

Heart failure (HF) significantly impacts global health, contributing to high rates of morbidity and mortality, with an estimated prevalence of over 64 million individuals globally. The aging population, increasing incidence of hypertension, diabetes, and ischemic heart disease contribute to its growing burden [1]. HF is characterized by frequent hospital admissions, high readmission rates, and significant healthcare costs [2]. In addition to the physical challenges of the disease, patients often experience psychological distress, social isolation, and impaired quality of life. Moreover, caregivers and the whole family endures significant burden in all life aspects [3]. Current clinical guidelines emphasize disease-modifying therapies, yet there remains a substantial unmet need for supportive care interventions that address symptom relief,

emotional wellbeing, and existential concerns [4,5]. Recognizing HF as a life-limiting illness underscores the importance of integrating palliative care early in the disease course to improve holistic outcomes [6].

Heart Failure

Heart failure (HF) is a medical condition characterized by the heart's inability to effectively pump blood to satisfy the body's metabolic requirements [7]. It is typically the end result of various cardiovascular diseases and is classified into three major types:

- **Heart Failure with Reduced Ejection Fraction (HFrEF)**: EF < 40%, commonly due to ischemic heart disease or dilated cardiomyopathy.
- **Heart Failure with Preserved Ejection Fraction (HFpEF)**: EF $\geq$ 50%, often associated with aging, hypertension, and diastolic dysfunction.
- **Heart Failure with Mildly Reduced Ejection Fraction (HFmrEF)**: EF 41%-49%, representing an intermediate phenotype [7,8].

HF can result from systolic dysfunction (impaired contraction), diastolic dysfunction (impaired relaxation), or both. The activation of neurohormonal mechanisms is pivotal in the advancement of disease, encompassing the renin-angiotensin-aldosterone system (RAAS), the sympathetic nervous system, and natriuretic peptides [9].

Common manifestations include dyspnea on exertion or at rest, orthopnea, paroxysmal nocturnal dyspnea, fatigue, edema, and reduced exercise capacity. These symptoms fluctuate and significantly impair daily function and well-being.

Treatments include:

- **Pharmacologic treatment**: Angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs), beta-blockers, mineralocorticoid receptor antagonists, sodium-glucose cotransporter-2 (SGLT2) inhibitors, loop diuretics [11].
- **Device-based treatment**: Implantable cardioverter-defibrillators (ICDs), cardiac resynchronization therapy (CRT), left ventricular assist devices (LVADs) [12].
- **Advanced therapies**: Cardiac transplantation and palliative inotropes in selected patients [13].
- **Non-pharmacologic interventions**: Sodium restriction, fluid management, diet management, exercise training, and cardiac rehabilitation [14].

Despite optimal medical therapy, HF remains a progressive condition marked by repeated hospital admissions, often for volume overload, arrhythmias, or comorbidities. Each hospitalization is associated with increased mortality risk and functional decline, making comprehensive management and timely palliative integration critical [15].

Palliative Care

Palliative care, as defined by the World Health Organization, is a patient- and family-centered approach that aims to improve the quality of life of individuals facing serious illnesses. It encompasses the prevention and relief of suffering through early identification, comprehensive assessment, and effective management of physical, psychological, social, and spiritual symptoms. Palliative care is not limited to end-of-life scenarios; rather, it is applicable at any stage of a serious illness and can be provided alongside curative treatments [16].

Key principles include:

- **Holistic care**: Addressing the full spectrum of patient needs beyond the physical domain.
- **Symptom control**: The fundamental principles of symptom evaluation and diagnosis, as well as pain management (identification, evaluation, the analgesic ladder, methods of administration, and addressing misconceptions surrounding opioids); dealing with emergencies and their management.
- **Emotional support**: Identifying sources of distress, diagnostic methods, pharmacological treatments, psychotherapeutic interventions, and family meetings.
- **Social support**: Financial or employment concerns and role management.
- **Spiritual and existential matters**: Such as manifestations of suffering, anxiety or uncertainty, the function of pastoral care providers, and the quest for meaning, including cultural and religious variances.
- **Individualized goals**: Aligning care plans with patient preferences, values, and life goals.
- **Interdisciplinary collaboration**: Engaging a diverse team of professionals to deliver integrated care.
- **Communication and decision-making**: Facilitating shared understanding and informed choices through ongoing conversations. Establishing objectives and engaging in discussions about achievable targets, methods for accomplishment, and documentation practices.
- **Continuity and coordination**: Ensuring seamless care transitions across settings and time points.
- **Ethical and legal considerations**: Legal obligations, confidentiality, resource distribution, advance directives, do-not-resuscitate orders, research ethics, patient competency, the right to die, and power of attorney [17].

Also, caregiver support and staff well-being are important factors in the provision of palliative care [18].

Palliative Care in Heart Failure

In the context of HF, these principles translate into enhanced symptom control, psychosocial support, and proactive care planning, all of which can improve patient and caregiver outcomes [19].

Integrating palliative care in HF involves a paradigm shift from reactive to proactive management. The disease trajectory of HF is characterized by a pattern of gradual decline punctuated by acute exacerba-

tions. Prognostication is challenging due to this fluctuating course, yet early palliative involvement can provide continuity, preparedness, and symptom stabilization [20]. Palliative care teams provide valuable expertise in complex communication, ethical decision-making, and individualized care planning. Their involvement leads to more consistent documentation of goals, fewer aggressive interventions, and enhanced patient satisfaction [21].

The trajectory of HF and the role of palliative care:

- **Early stage**: Focus on symptom education, psychosocial support, and initiating advance care planning.
- **Middle stage**: Increasing symptom burden, multiple comorbidities, and complex decision-making call for closer palliative involvement.
- **Late stage**: Refractory symptoms, recurrent hospitalizations, and diminishing functional capacity make end-of-life care and appropriate hospice consideration [22].

Palliative care for patients with HF involves a multidimensional approach focused on symptom control, emotional support, and coordinated care planning [23]. Physiological symptoms can originate from HF itself, its treatment, or associated comorbidities. Individuals suffering from HF frequently endure persistent dyspnea, depression, edema, pain, and fatigue, all of which may lead to spiritual distress. Additional symptoms may include nausea, excessive thirst, cognitive decline, weakness, and anxiety. On average, patients with HF report experiencing between 9 to 12 different symptoms [24]. As the condition advances, the severity of these symptoms intensifies, leading to increased distress related to them.

The objectives of treatment are twofold: to alleviate the burden of symptoms and to evaluate the discontinuation of treatments that do not offer symptom relief. Symptom management includes the use of opioids to relieve dyspnea, as well as anxiolytics and sleep aids to address anxiety and insomnia. Fatigue and peripheral edema are managed through appropriate pharmacologic and non-pharmacologic strategies [23–25].

Psychosocial and Spiritual Interventions

Psychosocial interventions target a wide range of challenges, including depression, anxiety, caregiver burden, social isolation, changes in self-identity, loss of autonomy, financial strain, and difficulties in communication within families or with healthcare providers. These interventions aim to enhance quality of life, support informed decision-making, and promote dignified care throughout the disease trajectory [26].

Spiritual support is provided by chaplains or trained clinicians to address existential distress and promote meaning-making [27]. The role of spirituality in HF is increasingly recognized as a vital component of comprehensive care, particularly in advanced stages of the disease. For many patients, HF prompts existential questions about meaning, purpose, suffering, and mortality. Spirituality, whether rooted in religion, personal beliefs, or a sense of connectedness, can be a crucial source of comfort, hope, and resilience. Addressing spiritual concerns helps patients cope with the emotional burden of chronic illness, enhances their ability to find peace amidst uncertainty, and supports overall psychological well-being [28,29].

In clinical practice, spiritual care may involve taking a spiritual history, facilitating conversations about

values and meaning, and connecting patients with chaplaincy services or spiritual counselors. It also includes recognizing and respecting diverse belief systems and incorporating these values into care planning. Importantly, spirituality can influence decisions about goals of care, end-of-life preferences, and advance directives, making it essential for clinicians to engage with patients in a respectful, open, and culturally sensitive manner. When integrated effectively, spiritual care fosters dignity, emotional healing, and alignment between medical interventions and the patient's deeper sense of self [27–29].

Advance Care Planning

Advance care planning (ACP) is integral, including clarification of care goals, completion of advance directives, and discussions regarding the deactivation of implantable cardioverter-defibrillators (ICDs). Seamless coordination of care across inpatient, outpatient, home, and hospice settings is emphasized to ensure continuity and alignment with patient preferences. ACP may enhance the documentation practices of medical personnel concerning their discussions with participants about ACP processes, potentially leading to improvements in individual depression levels [30].

Holistic Framework for Heart Failure Management

A holistic framework for managing HF involves addressing the physical, psychological, social, and spiritual dimensions of patient care. This approach recognizes the interconnected nature of these domains and seeks to deliver person-centered care that transcends disease-specific treatment. By embracing a holistic framework, clinicians can move beyond symptom control to support meaning, dignity, and quality of life for individuals living with heart failure [31].

- **Physical dimension**: Medical management of HF remains the foundation, including evidence-based pharmacologic therapies, device interventions, dietary guidance, and physical rehabilitation. Palliative interventions for symptom relief—such as opioids for dyspnea or diuretics for fluid overload—are integrated to alleviate suffering and improve functional status.
- **Psychological and emotional support**: Depression, anxiety, and emotional distress are common in HF and significantly impact adherence and quality of life. Psychological support, counseling, cognitive behavioral therapy (CBT), and mindfulness practices are incorporated to foster emotional resilience and well-being.
- **Social care and support systems**: Holistic care addresses the social determinants of health, including socioeconomic status, housing stability, caregiver support, and community resources. Involvement of social workers and case managers helps ensure continuity and accessibility of care.
- **Spiritual care**: Patients with advanced HF often seek meaning, purpose, and connection, especially near the end of life. Spiritual assessments and chaplaincy support allow patients to explore existential concerns and strengthen coping mechanisms, fostering peace and acceptance.
- **Communication and shared decision-making**: A holistic approach values transparent communication between providers, patients, and families. Advance care planning, goals-of-care discussions, and shared decision-making ensure that treatment aligns with the patient's values, preferences, and life context.

- **Interdisciplinary collaboration**: Holistic management requires a team-based model involving cardiology, palliative care, nursing, psychology, social work, rehabilitation, and spiritual care. Regular interdisciplinary meetings and coordinated care plans enhance patient safety and satisfaction.

Integration of Complementary Therapies

Complementary therapies have become an essential component of comprehensive HF care, offering valuable support alongside conventional medical treatment to improve symptom control, reduce stress, and enhance the overall quality of life for patients. These therapies, such as acupuncture, massage, mindfulness-based stress reduction, yoga, guided imagery, and music therapy, provide holistic, non-pharmacological options that address both the physical and psychosocial challenges associated with chronic heart failure.

Healthcare professionals are highly advised to ask their patients about the use of complementary and alternative medicine during each clinical appointment. Additionally, they should engage in discussions regarding the interactions, advantages, and potential side effects in conjunction with guideline-directed medical therapy, employing a shared decision-making approach with their patients [32].

The utilization of diverse complementary and alternative medicine agents has been examined through observational studies and clinical trials involving individuals with HF. Certain reports indicate that the use of specific agents correlates with enhancements in HF symptom control, functional capacity, quality of life, and outcomes related to major adverse cardiac events. Although these agents are not intended to substitute for conventional guideline-directed medical therapy, it is crucial for HF clinicians to understand the clinical effects of these agents on patients, as they may be utilized in the management of both HF and non-HF conditions, and patients might choose to use these agents without consulting healthcare professionals [32].

The integration of these therapies into care plans requires careful consideration and collaboration among healthcare providers. Clinicians must ensure that these complementary treatments are evidence-based, safe, and compatible with the patient's overall care regimen. For instance, the American Heart Association (AHA) guidelines recommend a comprehensive approach to HF that includes symptom management, psychosocial support, and patient-centered care [32]. While complementary therapies are not meant to replace conventional medical treatments, they serve as valuable adjuncts that complement pharmacological and interventional strategies, providing a more holistic approach to care [33].

Overall, for HF management, the American Heart Association (AHA) guidelines suggest that alongside guideline-directed medical therapy, the following agents are potentially beneficial: yoga, tai chi, thiamine (with deficiency), vitamin C, D (with deficiency), omega-3 fatty acids, L-carnitine, D-ribose, and coenzyme Q10 [32].

Implications for Healthcare Professionals

Healthcare professionals should possess skills in symptom management, effective communication, and collaboration across disciplines. The incorporation of palliative care in HF necessitates continuous education in palliative care principles and an understanding of holistic and integrative care methodologies. A holistic framework also demands that clinicians consider social and emotional factors, cultural sensitivity, and patient autonomy.

Barriers such as time constraints, prognostic uncertainty, and limited access to palliative specialists must be addressed through institutional support, integrated care models, and the adoption of primary palliative care training for all HF clinicians. Embracing both conventional and integrative methods fosters a more comprehensive, patient-centered approach that aligns medical care with the goals and values of individuals living with HF.

Conclusions

Palliative care represents a vital and underutilized component of comprehensive heart failure (HF) management. As HF continues to impose a growing burden on individuals and healthcare systems, integrating palliative principles throughout the disease trajectory is essential to address unmet needs. Early palliative engagement ensures that symptoms are managed proactively, psychosocial and spiritual distress is acknowledged, and care aligns with patients' values.

The inclusion of integrative and holistic frameworks, counseling, and interdisciplinary collaboration enhances the overall impact of care. For healthcare professionals, embracing a more expansive view of HF care—one that includes palliation, person-centered goals, and continuity across care settings—can significantly improve patient outcomes and quality of life.

Future research and policy must support the systematic implementation of palliative models and training to embed this essential discipline within routine HF practice.

References

1. Shahim B, Kapelios CJ, Savarese G, Lund LH. Global public health burden of heart failure: An updated review. *Card Fail Rev*. 2023 Jul 27;9:e11.
2. Al-Tamimi MA, Gillani SW, Abd Alhakam ME, Sam KG. Factors associated with hospital readmission of heart failure patients. *Front Pharmacol*. 2021 Oct 11;12:732760.
3. McHorney CA, Mansukhani SG, Anatchkova M, Taylor N, Wirtz HS, Abbasi S et al. The impact of heart failure on patients and caregivers: A qualitative study. *PLoS One*. 2021 Mar 11;16(3):e0248240.
4. Tanaka A, Node K. Disease modifying therapies in heart failure: An update. *QJM*. 2025 Mar 1:hcaf060.
5. Beghini A, Sammartino AM, Papp Z, von Haehling S, Biegus J, Ponikowski P, et al. 2024 update in heart failure. *ESC Heart Fail*. 2025 Feb;12(1):8-42.
6. Sobanski PZ, Alt-Epping B, Currow DC, Goodlin SJ, Grodzicki T, Hogg K, et al. Palliative care for people living with heart failure: European Association for Palliative Care Task Force expert position statement. *Cardiovasc Res*. 2020 Jan 1;116(1):12-27.
7. Golla MSG, Hajouli S, Ludhwani D. Heart failure and ejection fraction. [Updated 2024 May 5]. In: *StatPearls* [online]. Treasure Island (FL): StatPearls Publishing; 2025 Jan [Accessed 25 May 2025]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK553115/
8. Khan MS, Shahid I, Fonarow GC, Greene SJ. Classifying heart failure based on ejection fraction: Imperfect but enduring. *Eur J Heart Fail*. 2022;24:1154–7.

9. Buglioni A, Burnett JC Jr. Pathophysiology and the cardiorenal connection in heart failure. Circulating hormones: Biomarkers or mediators. *Clin Chim Acta*. 2015 Mar 30;443:3-8.

10. Ekman I, Cleland JG, Andersson B, Swedberg K. Exploring symptoms in chronic heart failure. *Eur J Heart Fail*. 2005 Aug;7(5):699-703.

11. Rossignol P, Hernandez AF, Solomon SD, Zannad F. Heart failure drug treatment. *Lancet*. 2019 Mar 9;393(10175):1034-44.

12. Boehmer JP. Device therapy for heart failure. *Am J Cardiol*. 2003 Mar 20;91(6A):53D-59D.

13. Masarone D, Melillo E, Gravino R, Errigo V, Martucci ML, Caiazzo A, et al. Inotropes in patients with advanced heart failure: Not only palliative care. *Heart Fail Clin*. 2021 Oct;17(4):587-98.

14. Lancaster JW. Heart failure in older people Part 1: Disease state review and lifestyle interventions. *Sr Care Pharm*. 2024 Sep 1;39(9):325-332.

15. Fraser M, Barnes SG, Barsness C, Beavers C, Bither CJ, Boettger S, et al. Nursing care of the patient hospitalized with heart failure: A scientific statement from the American Association of Heart Failure Nurses. *Heart Lung*. 2024 Mar-Apr;64:e1-e16.

16. World Health Organization. Palliative Care [online]. 2020 [Accessed 269 May 2025]. Available from: https://www.who.int/news-room/fact-sheets/detail/palliative-care

17. Taboada P. Bioethical principles in palliative care. *Textbook of palliative medicine and supportive care*. London: CRC Press; 2016. p. 105-18.

18. Papworth A, Ziegler L, Beresford B, Mukherjee S, Fraser L, Fisher V, et al. Psychological well-being of hospice staff: Systematic review. *BMJ Support Palliat Care*. 2024 Jan 8;13(e3):e597-e611.

19. Kavalieratos D, Gelfman LP, Tycon LE, Riegel B, Bekelman DB, Ikejiani DZ, et al. Palliative care in heart failure: Rationale, evidence, and future priorities. *J Am Coll Cardiol*. 2017 Oct 10;70(15):1919-1930.

20. McConnell T, Blair C, Wong G, Duddy C, Howie C, Hill L, et al. Integrating palliative care and heart failure: The PalliatHeartSynthesis realist synthesis. *Health Soc Care Deliv Res*. 2024 Sep;12(34):1-128.

21. Fendler TJ, Swetz KM, Allen LA. Team-based palliative and end-of-life care for heart failure. *Heart Fail Clin*. 2015 Jul;11(3):479-98.

22. Hupcey JE, Penrod J, Fenstermacher K. Review article: a model of palliative care for heart failure. *Am J Hosp Palliat Care*. 2009 Oct-Nov;26(5):399-404.

23. Bierle RS, Vuckovic KM, Ryan CJ. Integrating palliative care into heart failure management. *Crit Care Nurse*. 2021 Jun 1;41(3):e9-e18.

24. Wilson J, McMillan S. Symptoms Experienced by Heart Failure Patients in Hospice Care. *J Hosp Palliat Nurs*. 2013 Feb 1;15(1):13-21.

25. Ghashghaei R, Yousefzai R, Adler E. Palliative Care in Heart Failure. *Prog Cardiovasc Dis*. 2016 Jan-Feb;58(4):455-60.

26. Chernoff RA, Messineo G, Kim S, Pizano D, Korouri S, Danovitch I, et al. Psychosocial interventions for patients with heart failure and their impact on depression, anxiety, quality of life, morbidity, and mortality: A systematic review and meta-analysis. *Psychosom Med*. 2022 Jun 1;84(5):560-580.

27. Open Resources for Nursing (Open RN). In: Ernstmeyer K, Christman E, editors. *Nursing fundamentals* [online]. Eau Claire (WI): Chippewa Valley Technical College; 2021 [Accessed 29 May 2025]. Chapter 18 Spirituality. Available from: https://www.ncbi.nlm.nih.gov/books/NBK591821/

28. Tobin RS, Cosiano MF, O'Connor CM, Fiuzat M, Granger BB, Rogers JG, et al. Spirituality in patients with heart failure. *JACC Heart Fail*. 2022 Apr;10(4):217-226.

29. Mangolian SP, Nouhi E, Kazemi M, Ahmadi F. Spirituality: A panacea for patients coping with heart failure. *Int J Community Based Nurs Midwifery*. 2017 Jan;5(1):38-48.

30. Nishikawa Y, Hiroyama N, Fukahori H, Ota E, Mizuno A, Miyashita M, et al. Advance care planning for adults with heart failure. *Cochrane Database Syst Rev*. 2020 Feb 27;2(2):CD013022.

31. Duncan A, Cunnington C. A holistic approach to managing a patient with heart failure. *Future Cardiol*. 2013;9(2):189-92.

32. Chow SL, Bozkurt B, Baker WL, Bleske BE, Breathett K, Fonarow GC, et al. Complementary and alternative medicines in the management of heart failure: A scientific statement from the American Heart Association. *Circulation*. 2023 Jan 10;147(2):e4-e30.

33. Institute of Medicine (US) Committee on the Use of Complementary and Alternative Medicine by the American Public. An Ethical Framework for CAM Research, Practice, and Policy. *Complementary and Alternative Medicine in the United States* [online]. Washington (DC): National Academies Press (US); 2005 [Accessed 29 May 2025]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK83792/