Palliative geriatrics and dementia: key issues and challenges

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Abstract

Palliative care enhances the quality of life for patients and families facing life-threatening illnesses by addressing physical, psychosocial, and spiritual needs. Dementia, characterized by its progressive and terminal trajectory, presents unique challenges due to its unpredictable course and the difficulty of identifying the terminal phase. This manuscript aims to explore the integration of palliative care into the management of advanced dementia, emphasizing patient-centered approaches and timely, appropriate interventions. We discuss early intervention strategies and tailored approaches for managing nutrition, infections, symptoms, pain, and medication in advanced dementia. Key issues include ethical considerations surrounding artificial nutrition, the role of assisted feeding, cautious opioid use, and deprescribing of non-essential medications. The manuscript also addresses systemic barriers, including limited awareness, ageism, and inadequate professional training. Emphasis is placed on shared care planning, caregiver support, and continuity of care. Future directions underscore the importance of telemedicine, community-based services, and enhanced professional education to address the growing needs of an aging population. Integrating palliative care into dementia management promotes dignity, improves quality of life, and supports individuals and families throughout the course of the disease.

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Introduction

The World Health Organization (WHO) defines palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems—physical, psychosocial, and spiritual".[1] Among these life-threatening conditions, dementia occupies a significant place due to its progressive and incurable nature. Dementia is defined by the WHO as "a syndrome – usually of a chronic or progressive nature – in which there is deterioration in cognitive function (*i.e.*, the ability to process thought) beyond what might be expected from normal ageing. It affects memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement".[1] The clinical dementia rating (CDR) scale is a standardized tool used to assess the severity of cognitive impairment in individuals with dementia.[2] It classifies dementia into stages, ranging from 0 (no dementia) to 3 (severe dementia), based on performance in six domains: memory, orientation, judgment and problem-solving, community affairs, home and hobbies, and personal care. CDR 4-5 indicate very severe and terminal dementia. This staging helps clinicians align care interventions with disease progression, facilitating timely and appropriate palliative strategies tailored to the patient's functional and cognitive status.

Mortality projections for England and Wales (2006-2014) show dementia driving a surge in palliative care needs, with annual deaths expected to increase from 59,199 to 219,409 by 2040.[3] However, predicting the end of life in people with dementia remains challenging.[4] Dementia's unclear terminal stage complicates the transition to end-of-life care, often delaying palliative care until hospitalization. Clear clinical criteria are needed to identify end-stage patients and optimize care pathways. Dementia shortens life expectancy, especially in women and younger individuals, yet awareness of this among patients and caregivers is often insufficient.[5] Communicating a dementia diagnosis is challenging due to its progressive nature. Early care planning is crucial but often hindered by variable progression, leading to "prognosis paralysis", inappropriate interventions, and underutilized palliative care.[6] Healthcare providers vary in viewing dementia as a terminal illness, influencing clinical decisions. Patients with advanced dementia and a life expectancy under 6 months are less likely to receive interventions like feeding tubes, catheters, or parenteral therapies.[7] The challenge of predicting 6-month survival underscores the need to prioritize patient preferences, focusing on comfort and quality of life. Some medical teams avoid terms like "palliative care" or "hospice" to preserve hope.[8]

A small proportion of people with dementia receive palliative care, often only during a crisis or at the very end of life. Many spend their final days in hospitals or undergoing intensive, disproportionate treatments.[9] In a review of dementia survival times, the median ranged from 3.3 to 11.7 years from the onset of symptoms, with predictors of mortality including advanced age, increased disease severity, and functional impairment.[10] In some cohort studies, mortality risk rose with age, cognitive decline, and complexity of the diagnosis, especially when made in specialized memory clinics rather than primary care settings. Although dementia often progresses gradually, death can occur suddenly, particularly in neurological conditions associated with severe disabilities, such as multisystem atrophy, where sudden death is a recognized outcome.[11] Collectively, dementia poses significant challenges for palliative care, requiring a shift in focus from prognosis-driven care to patient-centered approaches that prioritize quality of life (Figure 1). Early palliative recognition, effective communication, individualized care, and research into therapies and access are vital to meeting dementia care needs and ensuring dignity.

Palliative care in dementia: current perspectives and advances

A 2016 Cochrane review on dementia palliative care found only two studies, with intervention variability preventing meta-analysis and providing insufficient evidence on effectiveness in advanced

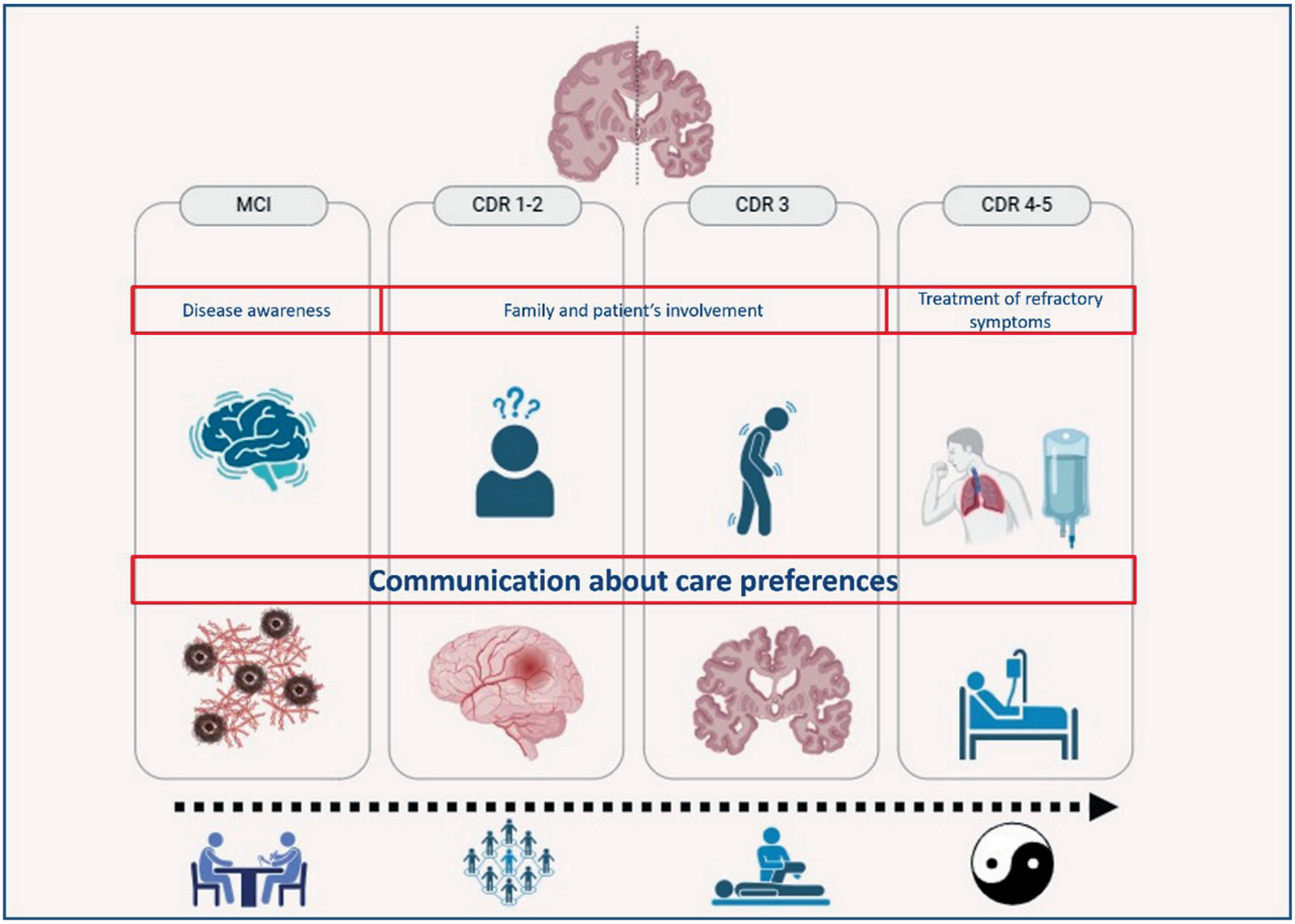

Figure 1. Progression of cognitive decline and key considerations in patient care. These visual outlines the progression of cognitive decline, from mild cognitive impairment (MCI) to advanced stages [clinical dementia rating (CDR) 4-5], emphasizing critical aspects of care at each phase: i) MCI stage: focus on disease awareness and early interventions; ii) CDR 1-2: highlight family and patient involvement to plan care effectively; iii) CDR 3: address functional decline while ensuring communication about care preferences; iv) CDR 4-5: prioritize treatment of refractory symptoms and palliative care approaches. The bottom section underscores the importance of ongoing communication, collaborative decision-making, and holistic care, aligning patient needs with clinical strategies across all disease stages.

dementia.[12] A systematic review of qualitative studies on nutrition and hydration strategies near the end of life identified various approaches, though in the context of dementia, these were rarely explored in depth.[13] Additionally, a systematic review of clinical tools to improve communication and decision-making for serious illnesses demonstrated improvements in patient knowledge and preparedness for treatment choices, including palliative care and feeding options in dementia.[14] Medicare hospice eligibility for dementia requires complications like aspiration pneumonia, pyelonephritis, septicemia, advanced pressure ulcers, recurrent unresponsive fever, significant weight loss, or low serum albumin (<2.5 g/dL).[15] The European Association for Palliative Care issued a consensus with 57 recommendations across 11 domains to optimize palliative care for dementia patients.[16]

The Italian legal framework and shared care planning

Italy's Law 219/2017 highlights informed consent and advance directives, introducing "Shared Care Planning" (Article 5) for chronic or disabling illnesses.[17] This collaborative process aligns care with patients' values and goals, guiding treatment decisions and ensuring adherence when patients cannot consent. People with dementia are often excluded from discussions about their care preferences.[18] Their involvement varies along a continuum, from full participation to substituted decision-making. While the ability to make decisions independently is important, dementia often interferes with this process, leading to anxiety. Shared decision-making, supported by families and physicians, can alleviate feelings of isolation and fear of making mistakes. However, being informed does not always equate to being ready to make choices, underscoring the need for a dynamic process based on trust and familiarity with healthcare providers.

Barriers to advance care planning and decision-making

Many patients with dementia lose the opportunity to participate in care decisions when their diagnosis is not disclosed or obtained during the early stages of the disease. Decision-making is more likely when dementia is newly diagnosed, the patient has insight into their condition, and the disease stage is mild. Factors such as higher education levels and male gender are positively associated with involvement in decision-making, while older age is negatively associated.[19] Family caregivers often experience stress and guilt about making decisions for their loved ones. Studies show that involving patients in decisions alleviates caregiver burden and improves alignment with the patient's wishes.[20] However, caregivers may experience ambiguous grief and a sense of failure, particularly when decisions conflict with perceived patient desires. The tendency of some physicians to withhold a dementia diagnosis or avoid discussing bad news, a paternalistic approach, may unintentionally deprive patients of the ability to understand their condition and prepare for its progression. Truthful communication, even when difficult, has been shown to reduce emotional distress more effectively than ambiguous or evasive communication, as highlighted in oncological literature.

Palliative care approach

A palliative geriatric approach involves addressing dementia patients' needs in a holistic, patient-centered manner. This includes exploring the progression of the disease, discussing treatment goals, and fostering open communication between patients, families, and healthcare teams. Physicians play a crucial role in guiding proxies to clarify the patient's goals and translate them into specific care interventions, ensuring alignment with the patient's values.[21]

Key elements of palliative care for dementia include: i) timely communication – early and clear communication about the diagnosis and prognosis allows patients to express their preferences before significant cognitive decline; ii) family involvement – engaging families in decision-making reduces caregiver stress and ensures that care aligns with the patient's values; iii) personalized care – avoiding a purely medical model, care should incorporate the bio-psycho-social-spiritual dimensions of the patient;[22] iv) addressing emotional needs – palliative care should provide emotional and psychological support for both patients and caregivers.

Key decision points include symptom onset, diagnosis, therapy, loss of independence, institutionalization, and advanced-stage treatments. Early, proactive care planning ensures patient input, addresses needs, avoids delays, and ensures continuity of care, mitigating conflicts and supporting patient well-being. Table 1 provides a stage-based overview of palliative care strategies aligned with the CDR scale. It outlines appropriate interventions, such as advance care planning, symptom monitoring, nutrition strategies, hospitalization criteria, and end-of-life sedation, tailored to each phase of cognitive and functional decline. The matrix facilitates practical clinical decision-making across the dementia continuum.

Table 1. Key palliative care interventions across dementia stages.

Dementia stage (CDR)	Core characteristics	Palliative strategies
MCI (CDR 0.5)	Mild cognitive deficits, mostly preserved independence	• Advance care planning (ACP) introduction • Patient and family education • Legal and ethical discussions (*e.g.*, advance directives)
Mild (CDR 1)	Noticeable memory issues, mild functional impairment	• Continued ACP • Baseline symptom monitoring • Discussing goals of care • Initiating supportive services
Moderate (CDR 2)	Clear cognitive decline, dependence in daily activities	• Reassessment of goals of care • Management of behavioural and psychological symptoms • Nutrition planning (assisted feeding)
Advanced (CDR $\geq$3)	Severe impairment, non-verbal, full care dependency	• Focus on comfort and quality of life • Avoidance of burdensome interventions • Pain and symptom control • End-of-life sedation when appropriate

MCI, mild cognitive impairment; CDR, clinical dementia rating.

Practical challenges and ethical considerations

Advanced dementia demands a balance between intervention and maintaining dignity and comfort. Key concerns include nutrition, infections, refractory symptoms, pain, and medication optimization, shifting focus from curative to palliative care. An interdisciplinary approach, guided by evidence and ethics, addresses patient and caregiver needs to ensure compassionate, patient-centered care.

Nutrition and hydration

Early dementia patients often experience unintentional weight loss or wasting, potentially due to a hypermetabolic state exacerbated by behavioral disturbances or altered hypothalamic regulation. Mechanisms include appetite dysregulation, inflammation, β-amyloid and tau burden, impaired insulin and glucose homeostasis, mitochondrial dysfunction, and oxidative stress. However, dementia-related wasting remains less studied than in cancer or other end-stage diseases.[23-26] The ethics of artificial nutrition in dementia are debated, seen by some as life-sustaining and others as burdensome. Italy's Law 219/2017 upholds patients' autonomy to refuse treatments, including artificial nutrition, defining them as medical interventions requiring consent. The European Society for Clinical Nutrition and Metabolism guidelines provide detailed recommendations for managing nutrition in dementia:

- Recommendation 22: appetite-stimulating drugs or weight-gain therapies should not be used in dementia patients [grade of recommendation good practice point (GPP), consensus 89%].
- Recommendation 34: decisions regarding enteral or parenteral nutrition and hydration should be individualized, considering the patient's clinical situation, prognosis, and preferences (GPP, strong consensus 100%).
- Recommendation 35: enteral and parenteral nutrition should not be initiated in patients with dementia in the terminal phase of life (GPP, strong consensus 96%).
- Recommendation 36: temporary enteral nutrition may be considered in mild or moderate dementia if low nutritional intake results from a reversible condition (GPP, strong consensus 100%).
- Recommendation 39: parenteral fluids may be temporarily administered during periods of insufficient intake to manage acute crises (GPP, strong consensus 100%).[27]

Artificial nutrition should be considered only when death from malnutrition is expected before the underlying disease progresses. It should not be initiated if life expectancy is limited to weeks and may be discontinued if no clinical benefit is evident. Currently, there are no randomized clinical trials or Cochrane Reviews demonstrating significant benefits of enteral tube feeding in dementia patients regarding survival, quality of life, or nutritional outcomes. On the contrary, risks such as aspiration pneumonia, infections, and surgical complications are well-documented, with decisions often influenced by clinical pressures or ethical conflicts.[28]

Assisted oral feeding prioritizes comfort and enjoyment over caloric intake, preserving taste and social interactions while reducing discomfort. It involves strategies like minimizing distractions, using adaptive tools, optimizing positioning, and aligning meals with alertness. This approach, requiring 45-90 minutes daily, does not preclude medical care for other conditions. Persistent feeding challenges often emphasize assisted feeding over tube feeding. The National Institute for Health and Care Excellence guidelines recommend encouraging drinking, addressing swallowing issues, ensuring oral hygiene, and weighing the benefits and risks of assisted hydration, with regular reassessment to ensure clinical benefit. The decision to initiate artificial nutrition or hydration in dementia patients must balance ethical considerations with clinical realities.[29] Key factors include the patient's prognosis, preferences, and overall quality of life. Effective communication with patients and caregivers is essential to navigate these complex decisions, reduce caregiver guilt, and ensure alignment with patient values. Oncological literature emphasizes that truthful communication about prognosis reduces emotional distress more effectively than ambiguous or evasive discussions. This principle also applies to dementia care, where openness allows patients and families to plan, access appropriate services, and make informed decisions.

Management of recurrent infections and hospitalizations in advanced dementia

Recurrent infections are the second most common clinical complication in advanced dementia, following eating difficulties. These infections often include respiratory and urinary tract infections, which are prevalent due to compromised immunity, reduced mobility, and other comorbidities. Despite their frequency, there is excessive use of antimicrobials in this patient population, frequently without adherence to appropriate clinical guidelines. This overuse underscores the need for judicious prescribing practices to balance the risks and benefits of treatment.[30] Physicians must ensure that the minimum diagnostic criteria are met before initiating antimicrobial treatment. Criteria include clinical signs and symptoms suggestive of infection, alongside diagnostic confirmation where possible. The decision to use antibiotics should align with the patient's and family's treatment goals, which may prioritize comfort over curative intent. The use of antibiotics in advanced dementia can sometimes prolong life but may also increase discomfort, expose patients to further suffering, or delay death without improving the quality of life. For instance, antibiotic treatment for pneumonia may extend survival but at the cost of side effects, such as gastrointestinal upset, secondary infections, or drug resistance. Therefore, physicians should evaluate each episode of infection on a case-by-case basis and consider withholding antibiotics if the goal is solely palliation.[30,31] Antibiotics may be appropriate in cases of acute infections that destabilize the patient's overall condition or exacerbate dementia-related symptoms. However, decisions should be made with careful review and discussion with the patient's caregivers or proxies, considering the patient's overall prognosis, treatment preferences, and risks of further suffering.

Hospitalizations are often traumatic for patients with advanced dementia, causing distress due to disorientation, unfamiliar surroundings, and invasive procedures. Many hospitalizations are unnecessary and should be avoided unless they clearly support the patient's care goals. For example, hospital treatment may be justified in cases of severe pain, uncontrollable symptoms, or specific interventions that cannot be provided in other settings.

Healthcare providers should conduct a thorough risk-benefit analysis before recommending hospitalization, particularly in end-stage dementia. Key considerations include: i) patient comfort – does hospitalization contribute to comfort or increase distress?; ii) goals of care – does hospitalization align with the patient's and family's desired outcomes, such as palliation or specific treatments?; iii) quality of life – will the intervention improve or compromise the patient's quality of life?

Alternative approaches, such as palliative care provided in the home or long-term care facility, should be prioritized whenever possible. These settings allow for symptom management and comfort measures without subjecting the patient to the physical and emotional toll of hospitalization.[32]

Management of refractory symptoms

Refractory symptoms are those that cannot be adequately controlled despite efforts to identify and implement effective treatments that preserve the patient's state of consciousness. These symptoms include dyspnea, delirium, vomiting, pain, psychological distress, status epilepticus, and massive bleeding. Managing dyspnea begins with identifying and addressing its underlying causes where possible, complemented by non-pharmacological interventions such as providing fresh air or using a fan directed at the face, employing breathing techniques, and optimizing patient positioning. Routine oxygen therapy is not recommended, as it may cause irritation and exacerbate xerostomia; however, in cases of hypoxemia (oxygen saturation <90%) or agitation, a trial of oxygen may be appropriate. Pharmacological options include low-dose oral morphine (starting at 2.5 mg and titrated upwards) and benzodiazepines, such as oral lorazepam (500 micrograms every 4-6 hours as needed), oral diazepam (2-5 mg for continuous anxiety), or subcutaneous midazolam (2-5 mg every 4-6 hours as needed). While anticholinergic agents like hyoscine butylbromide (20 mg subcutaneously) are sometimes used to reduce end-of-life secretions, their effectiveness is limited, and they may exacerbate delirium. Opioids remain the treatment of choice for severe symptoms, administered orally or *via* continuous infusion when necessary.[33-35] Terminal delirium, a distinct clinical entity, requires distinguishing between reversible and non-reversible causes. Its management in dementia varies by stage, with moderate stages (*e.g.*, CDR scale 2) focusing on reversible factors, while advanced stages prioritize comfort. A combination of non-pharmacological and pharmacological strategies is often most effective, including sedatives for sleep disturbances or psychomotor agitation and low-dose antipsychotics for psychotic symptoms.[34,36]

Pain management

Pain, often referred to as the "fifth vital sign", should be evaluated with the same rigor as other vital signs, such as blood pressure, heart rate, and body temperature. In patients with severe dementia who can no longer verbally communicate, pain transitions from being a symptom to a clinical sign. Pain assessment and management in individuals with dementia are complex due to communication and cognitive impairments. Several pain assessment tools have been developed to systematize this intuitive process by making explicit the information or evidence used. These include both verbal intensity rating scales for patients with preserved communication and observational tools for non-verbal or advanced-stage patients.[37-40] Table 2 summarizes commonly used tools for assessing and managing pain in individuals with dementia, highlighting their main characteristics.

Typical expressions of pain in advanced dementia include facial indicators such as sadness, fear, grimacing, closed or semi-closed eyes, furrowed brows, and frequent blinking, as well as vocalizations like sighing, moaning, complaining, grumbling, singing, screaming, or calling for help. Italian Law No. 219 of December 22, 2017, addresses pain management and dignified end-of-life care. Article 2 explicitly mandates that physicians, leveraging appropriate means, must strive to alleviate patient suffering, even when the patient refuses or withdraws consent for other healthcare interventions.[41] The law ensures the availability of effective pain therapies in collaboration with general practitioners and guarantees access to palliative care, as established by Law No. 38 of March 15, 2010. Furthermore, it instructs physicians to avoid disproportionate or futile treatments in cases of poor short-term prognosis or imminent death and allows for continuous deep palliative sedation when suffering becomes refractory to other treatments, with the patient's consent.

Barriers to effective pain management in older patients with dementia include misconceptions that pain is a normal part of aging, insufficient training in pain assessment and management, and difficulty recognizing pain in nonverbal individuals. Behavioral and psychological symptoms of dementia are often misinterpreted, and there is hesitation to use opioids due to fears of addiction, side effects, or stigmatization of chronic non-malignant pain. Healthcare providers and families may also harbor misconceptions about analgesics, further complicating pain management. In patients with limited verbal communication, pain-related behaviors during activities such as medical examinations, position changes, or spontaneous movement should be carefully observed as potential indicators of discomfort. Opioid therapy is a viable option for patients with moderate to severe pain, especially when pain significantly impairs function or quality of life. To minimize risks in older adults with dementia, opioids should be started at the lowest effective dose and titrated cautiously, considering polypharmacy and comorbidities.[42] Regular monitoring for side effects, including sedation, respiratory depression, and constipation, is essential to ensure the safety and effectiveness of treatment. Adopting a multidisciplinary approach to pain management, along with proper education and training for caregivers and healthcare professionals, can significantly improve the quality of life for patients with dementia.[43]

Medication use in advanced dementia

Medication management in advanced dementia should be firmly rooted in the overarching goals of care, which prioritize maximizing quality of life, ensuring comfort, and minimizing the burden of adverse effects. As dementia progresses, the utility of many medications diminishes, necessitating a careful evaluation of their appropriateness in the context of the patient's current condition and prognosis. Several classes of medications commonly pre-

Table 2. The main structured pain assessment tools for patients with dementia.

Tool	Description	Reference
PAINAD (Pain Assessment in Advanced Dementia)	Assesses five domains (breathing, negative vocalization, facial expression, body language, consolability) to infer pain level in non-verbal patients with advanced dementia	[37]
Abbey Pain Scale	Uses a scoring system based on vocalization, facial expression, change in body language, behavioral changes, physiological changes, and physical changes	[38]
DOLOPLUS-2	Evaluates somatic, psychomotor, and psychosocial behaviors across 10 items to assess pain in older patients, particularly those with communication difficulties	[39]
WHO Pain Ladder	Stepwise approach for pharmacological treatment of pain, escalating from non-opioids to strong opioids based on severity.	[40]

WHO, World Health Organization.

Table 3. Symptom management strategies and corresponding treatments in advanced dementia.

Symptom	Non-pharmacological interventions	Pharmacological treatments (with dosage examples)
Pain	Observation of facial expressions, posture, and behavior; gentle touch; positioning	• Paracetamol (500-1000 mg every 6-8 hours) • Morphine (starting at 2.5 mg orally, titrate as needed)
Dyspnea	Fan to face, open windows, upright positioning, calming environment	• Oral Morphine (2.5-5 mg every 4 hours) • Lorazepam (0.5 mg orally every 4-6 hours as needed)
Delirium	Reduce stimuli, provide orientation cues, caregiver presence	• Haloperidol (0.5-1 mg orally or intramusculevery 8-12 hours) • Quetiapine (12.5-25 mg at bedtime)
Agitation	Reassurance, routine structuring, music therapy, massage	• Risperidone (0.25-0.5 mg twice daily) • Trazodone (25-50 mg at bedtime)
Infections	Preventive hygiene, hydration, avoid unnecessary catheterization	• Antibiotics per site and pathogen
Swallowing disorders	Upright feeding, food texture modification, pacing meals	• No pharmacologic standard; consider anticholinergics for secretions if needed • Avoid benzodiazepines

scribed earlier in the disease course, such as lipid-lowering agents, calcium supplements, and cholinesterase inhibitors, often provide limited benefit in advanced stages of dementia. For instance, lipid-lowering agents, while effective in managing cardiovascular risk factors in younger or healthier populations, are unlikely to meaningfully improve outcomes in patients with limited life expectancy. Similarly, calcium supplements may not offer significant protection against fractures in patients with advanced dementia, where immobility and frailty predominate, and cholinesterase inhibitors may no longer provide cognitive benefits when neurodegeneration is severe. These medications can often be safely discontinued, reducing the pill burden and the risk of side effects, such as gastrointestinal distress or drug interactions.[44,45] Medications that enhance comfort and quality of life, such as analgesics for pain and antibiotics for infections, should be carefully maintained, prioritizing symptom relief over disease modification. Regular medication reviews and proactive deprescribing address polypharmacy, drug interactions, and patient burden, simplifying regimens to improve quality of life and caregiver focus. A patient-centered approach, involving caregivers in decisions and interdisciplinary collaboration, ensures treatments align with patient goals, supporting a dignified and comfortable end-of-life experience.

Conclusions

Effective symptom control is central to palliative care in advanced dementia. Table 3 summarizes the main symptoms encountered in this population, such as pain, dyspnea, delirium, agitation, infections, and swallowing disorders, along with evidence-based pharmacological and non-pharmacological management strategies, including dose recommendations where applicable. Geriatric palliative care integrates principles of geriatric medicine and palliative care to address the needs of older adults with chronic illnesses and cognitive decline.[46] It emphasizes informed decision-making, including end-of-life care preferences, and ensures that withholding or withdrawing interventions is viewed as compassionate care. Early implementation, rather than restricting care to advanced dementia stages, is crucial for maximizing benefits.[47] Barriers include limited awareness, inadequate physician training, delayed symptom recognition, and structural challenges such as insufficient nursing resources, ageism, and a weak palliative care culture in geriatrics. The oldest old, often unable to express preferences, require thoughtful planning that incorporates family input influenced by socioeconomic, cultural, and geographic factors. Continuity of care, seamless communication, and collaboration between geriatricians and palliative specialists are essential, supported by tools like prognostic scales and Shared Care Planning.[30] Efforts should focus on enhancing provider training, expanding services beyond oncology, and addressing systemic gaps. Prioritizing patient-centered, interdisciplinary approaches can better meet the complex needs of older adults and ensure dignified end-of-life care. To translate these findings into everyday clinical practice, training, and health policy, the following priorities should be considered.

- Clinical practice: i) integrate early palliative assessments and advance care planning at the point of dementia diagnosis; ii) utilize structured tools for symptom monitoring, ethical guidance, and deprescribing protocols; iii) foster interdisciplinary collaboration among geriatricians, palliative care teams, and primary care providers.
- Training and education: i) include dementia-focused palliative care modules in the curricula of medical, nursing, and allied health programs; ii) provide continuous professional development in communication skills, end-of-life care, and ethical decision-making.
- Policy and systems-level strategies: i) support legislation and institutional policies that enable shared care planning and access to palliative services; ii) allocate resources to strengthen caregiver support, expand community-based care, and integrate telemedicine; iii) address structural barriers such as ageism, inadequate staffing, and the limited presence of palliative care in geriatrics.

These steps are vital to meeting the complex needs of individuals with dementia, enhancing dignity and comfort, and ensuring equitable, quality-oriented care at the end of life.

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