The Ethos And Essence Of Palliative Medicine: A Comprehensive Review

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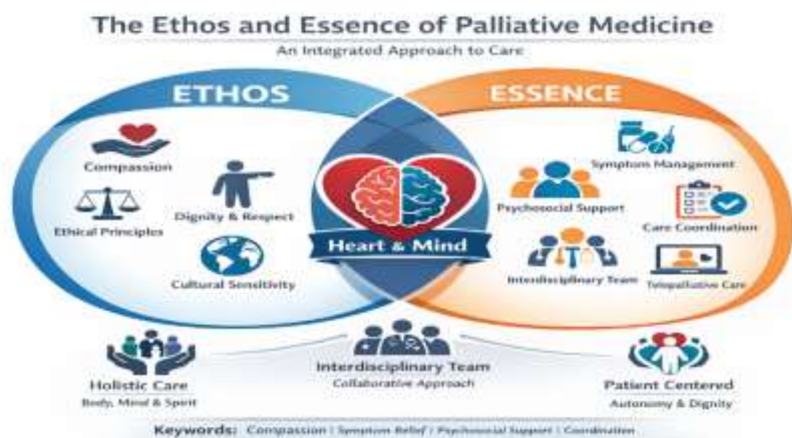
Abstract

Palliative medicine (PM) is an approach that merges professional knowledge with ethical and emotional sensibility to help patients dealing with a serious illness. This review highlights two related features essence and ethos that influence palliative practice. The essence refers to the commitment to reducing suffering and the willingness to embrace life itself, while the ethos reflects the moral and humanistic ideals compassion, dignity, and respect for autonomy that shape how care is rendered. This paper does not suggest a dualistic framework; rather, it uses Cicely Sanders's Heart and Mind idea to suggest that they are mutually reinforcing and correspond closely with each other. The analysis shows that ethos and essence are not opposing tensions, but rather complementary features of a unified philosophy of care. After reviewing historical developments, ethical principles, and clinical models, the review illustrates how values and practices reinforce each other, leading to palliative care that is more equitable, responsive, and person-centered. The integrated approach creates technically good care systems, while being deeply humane to ensure patients receive care in ways that honour their physical, emotional, and existential needs. Overall, the research suggests that the values of palliative care delivery are in congruence with clinical realisation of care in numerous settings.

Graphical Abstract:



1. Introduction

While the principles of palliative care are gaining recognition, their adoption in mainstream healthcare is still quite inconsistent, which hampers the growth of the field [1]. The World Health Organization (WHO) (2020) points out that palliative medicine (PM) stands apart from curative care by prioritizing pain relief, enhancing quality of life, and providing family support across physical, emotional, and spiritual aspects [2]. As a comprehensive approach, palliative care offers holistic assistance to patients facing serious illnesses [3,4], whereas PM specifically tackles complex symptoms using advanced therapies [5,6]. With the rise of chronic diseases and an aging population, along with predictions that nearly half of global deaths by 2060 will involve serious health-related suffering (SHS), the demand for these services is becoming increasingly urgent [7,8]. However, to effectively integrate PM into healthcare systems that primarily focus on curative methods, a deeper understanding of its philosophical and practical aspects—its core values and essence—is essential [9,10].

The core values of palliative care are grounded in ethical principles that guide practice, emphasizing humanitarian values, dignity, compassion, and respect for patient autonomy [11,12]. Its ethical framework is built on concepts like beneficence, non-maleficence, justice, and respect for individuals, specifically applied to those with serious illnesses [13]. Autonomy is seen as relational, highlighting the importance of shared decision-making and compassionate communication to uphold dignity and enhance quality of life [14-16].

In practice, PM merges symptom management with psychological and medical care, addressing issues like pain, shortness of breath, and emotional distress [17]. Patients truly feel its impact through various interventions, such as opioid prescriptions, nurse monitoring, family meetings led by social workers, and guidance from chaplains [18].

The flexibility of this approach enables quick responses to how diseases progress, allows for treatments that are directed by patients, and helps manage symptoms throughout the course of an illness [19,20].

While ethos and essence are different concepts, they are closely connected: ethos provides the moral compass, while essence shows how those principles are applied in a clinical setting. Understanding this distinction makes it clear that palliative care is about more than just end-of-life support [3] and resonates with Cicely Saunders' vision of blending "heart and mind" through compassionate, holistic practices [21,22]. This article explores how ethos influences patient-centered and culturally sensitive care, linking philosophical ideas to practical strategies for clinicians, educators, and policymakers.

2. Historical Context of Palliative Care

This section explores the historical development of palliative care, focusing on how early practice was guided by the spirit of compassion and gradually evolved into a clinical focus on symptom control.

2.1. Ancient Roots and Religious Foundations

Palliative care has deep roots in ancient religious and cultural traditions, like the Asklepieia temples in Greece, various Buddhist and Hindu texts, and the hospices of medieval Europe. These early influences helped shape the ethical and institutional foundations of what we now recognize as modern palliative care [23-27]. Fast forward to the early 19th century, and we see trailblazers like Madame Jeanne Garnier and the Irish Sisters of Charity blending medical care with compassion. They focused on managing symptoms, providing supportive care, and ensuring dignity, rather than just pushing for aggressive treatments [28-30]. Later, Dame Cicely Saunders took this concept further by formalizing a multidisciplinary model that brought together the core values and essence of modern PM [31].

2.2. The Pioneering Work of Dame Cicely Saunders
In the mid-20th century, Dame Cicely Saunders changed the game in terminal care. While training as a physician at St. Joseph's Hospice in London, she developed her groundbreaking philosophy [32,33]. Her doctoral research revealed that giving patients regular analgesics could prevent their pain from getting worse, which challenged the common practice of delaying treatment [34]. In 1967, she took a monumental step by founding St. Christopher's Hospice, where she combined clinical care with education and research [31,35]. Her innovative "total pain" approach tackled not just physical pain but also psychological, social, and spiritual distress, utilizing multidisciplinary teams that set a new global standard [36]. Thanks to Saunders' efforts, palliative care saw rapid growth through improved policies, training, and international collaboration.

2.3. Expansion and PM (1970s-1990s)
Back in the 1970s, palliative care really started to take off around the world, thanks to Florence Wald opening the first American hospice in 1974 and Dr. Balfour Mount introducing the term "palliative care" in Montreal in 1975. This was all about helping doctors who were focused on curing patients [37,38]. Then came the 1980s AIDS epidemic, which pushed for more services due to the need for complex symptom management and the stigma surrounding the disease [39]. By the 1990s, palliative care was gaining professional recognition: the WHO defined it in 1990, and it became a recognized specialty in the UK in 1987 and in Australia in 1999. Textbooks and academic programs started popping up, and research began to back up effective symptom management practices [40-42]. This global evolution really underscored the ongoing challenge of balancing ethical principles with clinical practice.

2.4. Ethical Foundations vs. Clinical Practice in Historical Context
PM has come a long way, shaped by fundamental ethical values like compassion and dignity, along with effective management of symptoms. Its roots can be traced back to the 13th century, where religious hospices blended spiritual care with early medical practices, setting the stage for the holistic approach to palliative care that would later be formalized by Saunders [43-46]. Fast forward to the 19th century, and we see advancements in pain management, but it was Saunders who truly merged ethical principles with clinical expertise, introducing regular pain relief and a holistic care model inspired by Anglican nursing nuns [33]. The 1970s brought about heated discussions on euthanasia versus symptom management and the importance of home-based care, highlighting the ongoing struggle between ethical values and clinical practices [32,47-52]. These historical milestones show how PM has developed its identity by intertwining moral values with practical care, focusing on autonomy, dignity, and a compassionate approach to end-of-life care [53]. In the next section, we'll dive into the ethos of PM, exploring its moral principles, humanitarian commitments, and ethical responsibilities in caring for patients facing serious illnesses.

3. Understanding the Ethos of PM

3.1. Philosophical Foundations of Palliative Ethics
PM is rooted in ethical principles that emphasize compassionate, patient-centered care. Kantian deontology highlights our responsibility to alleviate suffering and maintain dignity, while Bentham's consequentialism focuses on actions that reduce distress and enhance quality of life [54,55]. Virtue ethics emphasises the moral character of caregivers, including compassion, integrity, and humility, as crucial qualities in end-of-life care. Feminist care ethics has an element of relationship, as it places emotional presence and mutual respect in clinical interactions [56].

Instead of sticking to one of these views, palliative care incorporates them to develop a holistic spirit. This moral pluralism enables clinicians to be responsive to unique needs, and this approach balances moral values and cultural sensitivity with professional judgement. The aim is not to cure illness but to take care of the individual, not only physically but also ethically, emotionally, and spiritually [31].

As the PM ethos serves as the profession's moral compass, the nature of this practice exposes how these values are implemented in clinical practice. This practical aspect is discussed in the following section because it revolves around the therapeutic plans, interdisciplinary care, and responsive interventions, which actualise ethical principles.

4. Delving into the Essence of PM

The heart of PM is all about taking practical steps to ease suffering and improve the quality of life for patients facing serious illnesses. It embodies the hands-on aspect of palliative care, concentrating on clinical techniques and protocols that bring ethical principles to life in various healthcare environments.

4.1. Symptom Management

PM focuses on easing suffering by tackling symptoms such as anxiety, insomnia, nausea, and shortness of breath. Care teams skillfully combine carefully measured doses of opioids and psychotropic medications with breathing exercises to help manage both physical and emotional distress [57,58]. Pioneers such as Cicely Saunders developed research on scheduled analgesia, which demonstrated proactive symptom control as a preventive measure against distress escalation, thus establishing new compassionate clinical practice standards [33,59]. PM provides individualized treatment and approaches directly to patients who need physical comfort support alongside illness dignity preservation.

4.2. Psychosocial and Spiritual Support

The essential underpinning of PM, therefore, also incorporates psychosocial and spiritual support, addressing the emotional, social, and existential aspects of suffering. Patients receive assistance with distress management, gain a meaningful perspective, and benefit from family support coordination through psychological counselling, social work, and chaplaincy services.

Dignity therapy is a structured psychotherapeutic intervention developed initially by Chochinov et al. (2002), which enables terminally ill patients to re-examine their life stories, validate their dignity, and create a legacy document to share with their loved ones [60]. This intervention is designed to enhance dignity, autonomy, and meaning at the end of life.

This model illustrates the holistic approach of palliative care wherein emotional and existential well-being is recognized as being part of clinical support.

Dignity therapy creates structured sessions that help terminally ill patients revisit their life experiences while strengthening their life meaning and relieving their emotional strain [61,62]. A comprehensive care system operates through seamless teamwork among nurses, physicians, and chaplains, who collaborate to provide personalized support to each patient [63,64]. Palliative care provides comprehensive, compassionate support by treating physical concerns alongside the mind and spirit of patients.

4.3. Care Coordination and Communication

Effective communication stands as the central practice element within the interdisciplinary team, the patient, family, and in PM, since it enables clinicians to implement advanced care planning, conduct family discussions, and preserve cultural patient-centered care standards [65]. The COVID-19 pandemic introduced tele-palliative care as a novel approach to demonstrate

how providers can maintain critical support through remote services, ensuring uninterrupted patient care. [66].

4.4. Flexibility Across Illness Trajectories

PM delivers treatment options before end-of-life care to manage conditions such as cancer and organ failure, or frailty, to advance both patient life quality and treatment results. Studies show that early integration services prevent avoidable hospital admissions and bring about increased satisfaction among patients and their families [67,68]. The staff at palliative care services provides bereavement assistance to families as part of the ongoing commitment to complete care after the patient's death [69].

After discussing the practical aspects characteristic of PM, it is important to distinguish between these clinical actions and the guiding ethical values. The following section explores the parallel relationship between ethos and essence to explain their functions in creating identity and providing palliative care.

5. Ethos and Essence in PM

PM is built on two fundamental aspects: ethos, which refers to the ethical values that shape the care we provide, and essence, which encompasses the practical actions, skills, and systems that bring that care to life. Modern literature delves into these interconnected themes to gain a deeper understanding of how palliative care is structured and experienced.

PM is based on the ethical principles of compassion, dignity, and respect towards patient autonomy [70,71]. These values are rooted in the ethos of care, grounded in feminist care theory and virtue ethics, and focus on alleviating holistic suffering as a moral obligation [72]. On the contrary, the nature of palliative care is conveyed through evidence-based interventions, i.e., scheduled analgesia, psychosocial support, and coordinated care models [20,73]. As much as ethos provides the moral compass, essence transforms these ideals into clinical action, forming a two-facet concept in which delivery provides the source of essence and value offers the source of ethos [3].

This dynamic is all about finding the right balance between universal ethics and the need to adapt to specific contexts. While core values like dignity are important, principles must align with cultural and family norms. In collectivist societies, for instance, the consent of the family can sometimes take precedence over individual autonomy [12]. To accommodate such nuances, the essence is met with such innovations as telepalliative care or pharmacological innovations, which ensure care is sensitive to technological and cultural changes [7,19,74].

In palliative care, there's an interesting interplay between ethos and essence during assessments. Ethos is looked at through the lens of patient stories and the moral judgments of clinicians, while essence is gauged with numbers—like pain scores, hospital admissions, and feedback from caregivers [62,75]. The combination of these methods guarantees that the subjective significance and the objective effectiveness underlie the development of palliative care [10].

Palliative care teams beautifully embody a balance: while they all share a common mission, each member brings their unique skills to the table. Chaplains focus on addressing spiritual needs, oncologists help navigate treatment options, and nurses expertly handle opioid management and advance care planning [18,76]. The core of these competencies is the ability to create an interdisciplinary model that is structured and respects the unique contribution of each specialty [77].

The journey of palliative care reveals a changing philosophy and core values throughout the course of an illness. Ethical support is provided from the moment of diagnosis all the way through to bereavement, while the focus of care transitions from managing symptoms in the early stages to resolving crises as life comes to an end [33]. Such flexibility is what indicates the emergence of the caring spirit to adapt to the constantly evolving needs of patients, and ethos is what guarantees the persistence of the caring spirit at all levels [20,78].

Modern conflicts, including debates over assisted dying, indicate the multifaceted, mutually dependent character of ethos and essence. One of the ethical principles is autonomy, which can conflict with medical directives or the policies of the institution [32]. Likewise, cultural dignity demands a delicate compromise between the principles and practices of ethics and clinical practice to align the pain protocols [12]. The identification of these tensions helps to avoid reductionist perceptions of palliative care and supports its applicability in a larger context, even when it is not the end of life [3].

6. Practical Implications in Palliative Care Practices

Grasping the difference between ethos (the ethical core) and essence (the professional foundation) in PM is crucial for healthcare, education, and policy professionals. It enables them to create care systems that truly reflect the fundamental principles of nursing.

6.1. Clinical Practice: Connecting Ethics and Action

Medical professionals use the combination of ethos and essence to make ethically sound, scientifically appropriate clinical decisions. Medical practitioners need to handle opioid prescriptions by weighing pain reduction against medication misuse hazards [74]. The essential aspect of advance care planning requires healthcare providers to preserve patient autonomy through strong communication skills [79]. Team-based care models demonstrate this combination through physician, nurse, and chaplain collaboration to treat the physical, emotional, and spiritual needs of patients [76]. The concept of opioid stewardship also demonstrates the role of such an ethical principle as non-maleficence in the treatment of pain. Such a procedure as morphine titration protocols is influenced by the U.S. Palliative Care Quality Collaborative, which incorporates ethics standards that decrease misuse and increase relief [80]. The additional tool of patient autonomy is the so-called Four-Quadrant Approach, which is used to manage addiction [81].
In addition, Oncology dignity therapy shows the healing effect of affirming a patient's worth. Structured life review interventions at MD Anderson Cancer Center allow patients with advanced cancer to validate their sense of value (ethos), which reduces depressive symptoms by 30% [62].

6.2. Education and Training: Cultivating Competence and Compassion

Training programs must dedicate equal attention to developing both ethical reasoning competencies and technical medical competencies of their students. Students who experience narrative medicine through reflective exercises in medical schools develop stronger empathy skills, along with clinical competency gained through simulation-based programs [70,77]. The "Compassionate Care Initiative" at MGH employs mindfulness training to help medical staff combat burnout, thereby maintaining their ethos and essence when working under high-stress conditions [82]. Practicality in ethics training regarding simulation is taught. A Serious Illness Care Program at Harvard Medical School uses role-playing to enhance and empower end-of-life care communication, resulting in a 25-point increase in patient satisfaction scores [77]. Clinician mindfulness-based interventions can be used to show how ethical self-care practices can be instituted. The Compassionate Care Initiative (essence) combines mindful training and reflective diary practice to develop self-compassion ethics among staff, leading to reduced burnout and long-term compassionate care [70]. Such activities showcase the care provided to the professionals caring for patients, which is truly instrumental through good medicine and compassion.

6.3. Policy and Healthcare Systems: Building Equitable Frameworks

Public officials need to develop operational frameworks that translate the two pillars of palliative care. Funding for timely palliative integration represents the essence, but ethical mandates

regarding dignity-preserving protocols represent the ethos [7]. Telehealth policies during the COVID-19 pandemic needed to address access inequities (justice principle of ethos) among rural and marginalised people [19]. The Lancet Commission on Palliative Care promotes worldwide access to care by aligning clinical practices with human rights policies [8]. The national palliative care program in Rwanda is a good example of culturally embedded ethical practice. Community health workers provide pain relief (essence), and cultural fit (ethos) is ensured by the village councils, resulting in a locally based model of compassionate care [83]. Ethical innovation in crisis telepalliative care in California during the COVID-19 pandemic. Long-distance practices of compassionate presence enabled patients and providers to manage symptoms without violating relational ethics, even when they were physically apart [66].

6.4. Research Priorities: Measuring What Matters

Future investigations should develop measurement methods to assess both patient-reported outcomes and symptom reduction resulting from essential interventions. Mixing research methods enables investigators to address this gap because studies by Vuksanovic measured psychological distress subjectively (qualitative) and quality-of-life scores objectively (quantitative) [62]. The results of comparative effectiveness research demonstrate which health care models achieve the best ethical outcomes in practice [20]. Dignity measurement is critical towards ethical appraisal of care environments; a U.K. case study of a hospice revealed that increased distress scores of caregivers were less related to higher dignity-preservation scores [84]. The incorporation of palliative care into COPD in early adulthood indicates the changing nature of the ethical practice: the long-established models at the Addenbrooke Hospital and Kaiser Permanente have minimized emergency visits, which have been confirmed by 2024 trials, and facilitated patient autonomy by decision-making tools [85,86].

6.5. Cultural Adaptation: Localizing Universal Principles

Palliative care in the global community has to be culturally sensitive and maintain the main principles; in a society that values family, the practice of advance care planning should be agreed upon by all the members of the family [12]. According to Tripodoro et al. (2025), the WHO-endorsed training programs for under-resourced areas combine fundamental health worker education (essence) with preservation of local traditions (ethos) [87]. Japanese family-based advance care planning: To illustrate it, Japanese healthcare systems adhere to Western ACP models by making the family agreement the centre of decision-making for a terminal patient and by convening group meetings [88,89].

As the practical uses of ethos and essence have advanced palliative care across the clinical, educational, policy, and cultural spheres, various challenges remain. The discussion below identifies significant challenges and outlines a future perspective for enhancing PM in a changing global health environment.

7. Challenges and Future Directions

Even though PM is becoming more accepted, it still grapples with some significant challenges. One major issue is the common misconception that it’s only about end-of-life care, when in fact, it can play a crucial role in managing chronic diseases early on [3,20]. There are also ethical concerns surrounding access to opioids, particularly with restrictive policies like India’s licensing system. On the flip side, nurse-led initiatives, such as Uganda’s morphine program, show that there are ethical and effective ways to address these issues [7,74].

Workforce disparities add another layer of complexity, with shortages in low-resource areas and burnout affecting high-resource settings. However, Rwanda’s community health worker model is a great example of how shared responsibility can help maintain both ethical and clinical standards [12,42].

Emerging technologies like AI and predictive algorithms hold promise for improving early referrals and clinical efficiency, but it's essential to ensure they respect patient autonomy and dignity, especially in end-of-life situations [79,90]. Policy changes, such as incorporating pediatric palliative care into Kenya's national insurance, show how clinical effectiveness can go hand in hand with ethical fairness [7,41].
Education and research should weave ethical inquiry into clinical training, using models like Australia's relational ethics approach to nurture compassionate and culturally competent professionals [62]. Innovations like telehealth need to strike a balance between digital equity and efficient care delivery. Ultimately, the future of PM hinges on blending ethical principles with clinical practice to uphold its core values.

8. Conclusion

The ethical precepts of compassion, justice, autonomy, and dignity serve as both moral underpinnings and useful guidelines for care in PM. This review demonstrates that the essence of PM—clinical expertise in symptom management, advanced care planning, and interdisciplinary collaboration—and ethos—its ethical orientation toward human dignity, relational ethics, and holistic compassion—are not distinct domains, but rather an integrated and dynamic whole. Instead of being in opposition to one another, clinical practice and ethical intent work together to produce a very humane model of medicine that reflects Dame Cicely Saunders' goal of fusing compassionate care with scientific excellence. The evidence demonstrates that ethical principles and clinical components of PM are closely related, despite difficulties resulting from conflicts between technical expertise and emotional intelligence, especially for practitioners trained in curative models and for patients navigating traditional expectations of medical intervention. When combined, ethos and essence provide a coherent framework for comprehending, bolstering, and improving palliative care theory and practice.

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