



KNOWLEDGE SPACE NO. 2

The Ethical Compass in Palliative Care

A practical guide to medical ethics, cultural sensitivity and spiritual care at the end of life.

The Four Pillars of Holistic Care

Physical

What burdens the body?
(Pain, breathlessness, nausea)

Psychological

What burdens the soul?
(Fear, grief, depression)



Social

Who carries this person?
(Family, friends, loneliness)

Spiritual

What gives life meaning and hope?
(Faith, values, peace)

The Four Principles of Medical Ethics



Autonomy (Self-determination)

"What does the patient want?"

Focus: The will of the patient who is able to consent is decisive.



Beneficence (Care)

"What truly helps this person?"

Focus: Measures that improve quality of life.



Non-maleficence (Do no harm)

"Does my measure cause more harm than benefit?"

Focus: Forgoing burdensome diagnostics without therapeutic benefit.



Justice

"Am I treating this person fairly?"

Focus: Equal care regardless of origin or status.

Navigating Ethical Conflicts

Ethical dilemmas arise when legitimate values stand in tension. There is rarely a perfect solution, but rather a well-founded weighing of considerations.



Prolonging life ↔ Avoiding suffering

Conflict over artificial nutrition at the end of life. Orientation comes from the patient's will and the realistic benefit.



Autonomy ↔ Care (relatives)

Relatives demand therapy against the patient's will. The patient's will takes absolute precedence.



Relieving suffering ↔ Preserving consciousness

Palliative sedation for severe symptoms. Used only when symptoms are refractory to other treatment.

The Rights of Dying People

The dying do not lose their rights – these gain in importance.



Right to self-determination

Decisions are made jointly; advance directives are consistently respected.

Right to freedom from pain

Symptoms are assessed regularly and treated holistically.

Right to honest information

The patient decides how much they want to know.

Right to company and privacy

No one dies alone against their will. Intimacy is protected.

Thinking Ahead: The ACP Cycle

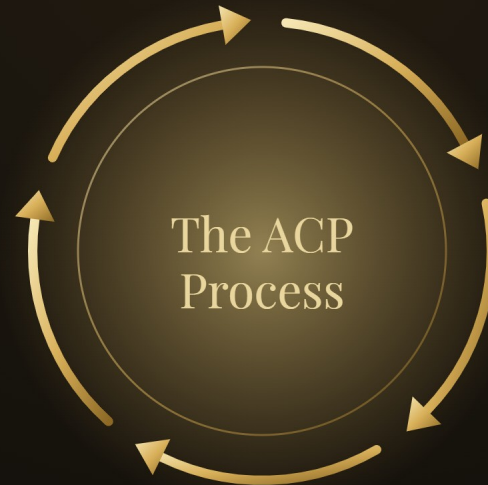
Advance care planning (ACP) is not a form but an ongoing conversation.

Review regularly

Wishes can change. Restart the process.

Discuss values

“What does quality of life mean to you?”



Communicate in the team

Make wishes transparent in the interprofessional team.

Set treatment goals

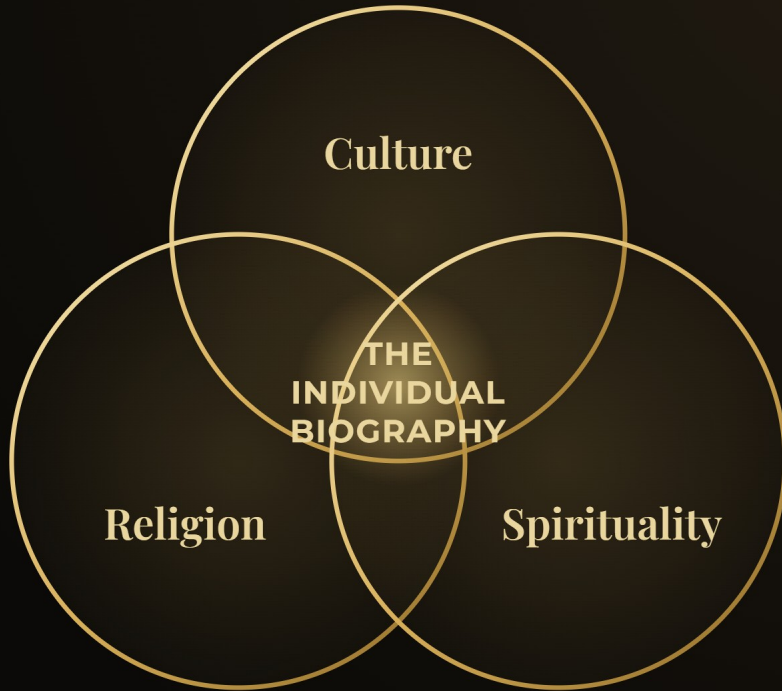
Define limits (e.g. no resuscitation).

Create documents

Record the advance directive and healthcare power of attorney.

The Focus Is on the Individual Biography

Religion does not explain the person – it is only one part of their story.

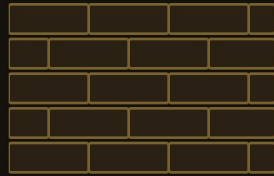


The core message

Knowledge of religions is a tool, not a rulebook.

Not every believer wants religious rituals, and not every person without a faith rejects spiritual support.

Culturally Sensitive Communication in Practice



Barriers / Avoid

- “It’s not worth it any more.” (Devaluing)
- “The tumour in room 4.” (Dehumanising)
- “You don’t need to worry about that.”
(Dismissing feelings)



Bridges / Apply

- “We are guiding our treatment by your wishes.” (Caring)
- “Mr Schneider ...” (Person-centred)
- “What matters most to you right now?”
(Recognising needs)

Understanding Religion and Spirituality

Every religious person has spirituality. Not every spiritual person belongs to a religion.



Recognising Hidden Spiritual Needs

"Why is this happening to me of all people?"

What the patient says

What the patient needs



"I still have something to settle."

"I just want some peace."

Fear & worry

Existential despair and concern for those left behind.

Reconciliation

Unfinished business, guilt or the wish to forgive.

Peace & transcendence

A deep wish for acceptance and letting go.

Worldviews at a Glance: A Practice Guide

Worldview	View of death	Sources of comfort	In practice
Christianity	Death as transition; resurrection	Prayer, anointing of the sick, communion	Offer pastoral care, respect religious symbols.
Islam	God (Allah) determines life and death	Qur'an, orientation towards Mecca, imam	Observe privacy strictly, same-sex care.
Judaism	Life is sacred; death as transition	Rabbi, Psalms	Treat the body per religious requirements.
Hinduism	Rebirth (samsara)	Mantras, sacred symbols	Enable family rituals; give relatives space.
Buddhism	Conscious dying	Meditation, quiet	Strictly avoid unnecessary interruptions.
Humanism	Biological end; meaning through biography	Music, nature, life review	Do not presuppose religious rituals.

Spiritual Care: The Role of the Nurse

Nursing does not have to solve existential questions – it may bear them together.

✓ The nursing toolkit

Presence: sit down at eye level, take time, stay in silence.

Life review: encourage talk about family, work or special events.

Ask openly: “What gives you strength at this time?”

✗ The limits: what nursing is NOT

Not proselytising: never impose one's own beliefs.

Not all-knowing: no need to have answers to all of life's questions.

Not a substitute for specialised psychotherapy in severe crises.

Moral Distress and Self-Care

The downward spiral

Warning signs

Inner conflict & burdened conscience: measures are seen as ethically critical.

Helplessness leads to withdrawal.

Cynicism and emotional exhaustion.



The de-escalation toolkit

Structures that carry the team

Case discussions: understand different perspectives in the team.

Ethics consultation: structured reflection in complex dilemmas.

Team culture: accept one's own limits and communicate openly.

Palliative Care Is an Attitude

“The most important competence in palliative care is not only expertise, but attitude.”



I listen.

(The person feels taken seriously.)

I do not judge.

(Different ways of living are respected.)

I can bear uncertainty.

(Not every question needs an immediate answer.)

The Ethical Compass: Summary



Ethics

Ethical conflicts do not demand perfect solutions, but deliberations oriented to the patient's will.

Culture

Culturally sensitive care begins with genuine interest in the individual, not with stereotypes.

Spirituality

Spiritual care does not resolve existential crises, but bears them together with the patient.

“At the end of our lives, people will probably not remember how perfectly we worked. They will remember how we met them.”