Relief of Suffering Is the Business of Every Discipline

The Hippocratic Oath and all other known declarations of medical professional commitment bind and adjure us to care for the sick. They do not stop at requiring attempts to cure; they require care for the suffering that results from sickness. No exceptions. So it is startling that, in an era when we are capable of alleviating so much suffering, much suffering still goes unattended.1-3 Palliative care has never been equipped with such an array of possible pharmacological, technical, and service resources as well as teachable human skills.4,8 It is unfortunate that most practicing physicians today were trained in a medical culture that often assumed it was not the responsibility of the curatively motivated physician to provide comfort or alleviate suffering.9 All of us could have done something to alleviate those problems, and all of us still can. No exceptions.

Palliative care emerged as a discipline through the hospice and end-of-life care movements, but it also belongs as a core skill set to all disciplines that care for people with illness-related suffering. Practicing clinicians are indeed largely united around the goal of integrating palliative care—care directed at quality of life and at symptoms—into routine practice. Examples can make the point among a wide array of specialties. Oncologists today would not consider administering platinum without accompanies antiemetic agents to a patient with cancer. Emergency medicine physicians routinely control pain as a priority along with, rather than after, establishing a diagnosis. Surgeons control postoperative pain. Cardiologists control angina with stents and other interventions for the controllable symptoms among home-dwelling elderly persons, and their loss is one predictor of patient mortality. Caregivers are also often frail or become so. Further research, of the variety that Wilke et al13 have provided for patients, into the epidemiology of caregiver needs would contribute significantly to sound research priorities and hypotheses about underlying causes and possible solutions to the important problems. Large observational databases that encompass the information needed for palliative care research exist, but none are designed for palliative care and information remains fragmented among different, often unlinkable databases. The research by Wilke et al13 reflects a move in that direction and also emphasizes the need for a comprehensive database.

The data by Wilke et al13 also underscore the need for comprehensive competence in palliative care among clinicians from all disciplines that care for frail elderly persons. Education in palliative care is being championed by a number of groups with considerable success; however, the findings by Wilke et al13 also show that the need for these programs is not yet met.

Similarly, the high prevalence of incompletely controlled yet controllable symptoms among home-dwelling, frail elderly persons demonstrated by these data carries an imperative for home care and primary care. Physicians and other clinicians, whether generalists or specialists, must plan their services to take into account the symptom burden of their population. Quality control in these services will need to keep up with these service delivery plans.

Policy needs to allow for sufficient reimbursement for these programs so that patient needs can be met.15 To meet patient needs, it is also essential to take into account the role and needs of family caregivers. Caregivers shoulder a great deal of the burden of care for home-dwelling frail elderly persons, and their loss is one predictor of patient mortality. Caregivers are also often frail or become so themselves. Further research, of the variety that Wilke et al13 have provided for patients, into the epidemiology of caregiver needs would contribute significantly to sound policy. By joining such research with an already developing understanding of patient needs and with ongoing efforts at professional training in palliative care, we might begin to treat medical care with as much dignity and rigor as we treat medical cure.

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REFERENCES


Clinical Trial Registration

In concert with the International Committee of Medical Journal Editors (ICMJE), Archives of Internal Medicine will require, as a condition of consideration for publication, registration of clinical trials in a public trials registry (such as http://ClinicalTrials.gov or http://controlled-trials.com). Trials must be registered at or before the onset of patient enrollment. This policy applies to any clinical trial starting enrollment after March 1, 2006. For trials that began enrollment before this date, registration will be required by June 1, 2006. The trial registration number should be supplied at the time of submission.

For details about this new policy see the editorials by DeAngelis et al in the September 8, 2004 (2004;292:1363-1364) and June 15, 2005 (2005;293:2927-2929) issues of JAMA.