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The Relief of Suffering

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The relief of suffering is considered one of the primary aims of medicine. However, what suffering actually is and what physicians must do specifically to prevent or relieve it is poorly understood. Because of this, the most well-intentioned and best-trained physicians may cause suffering inadvertently in the course of treating disease and may fail to relieve suffering when that might otherwise be possible.

Suffering must be distinguished from pain or other symptoms with which it may be associated. Although physicians, patients, and the medical literature generally link pain and suffering, they are distinct phenomena. For example, patients may tolerate severe pain without considering themselves to be suffering, if they know the source of the pain, that it can be controlled, and that it will come to an end. However, even apparently minor pain or other symptoms may cause suffering if they are believed to have a dire cause (eg, a malignant neoplasm), if they are viewed as never-ending, or if patients consider the symptom (and themselves) to be beyond help, or if their condition is considered hopeless. Suffering may occur in the absence of any symptoms whatsoever, eg, when one is forced to witness helplessly the pain of a loved one. Indeed, helplessness itself may be a source of suffering.

Suffering may occur in relation to any aspect of a person.[1] The word "person," as used herein, refers to all the possible dimensions of an individual. As such, it is larger than and includes the self or personality. A simple topography of person would include personality and character; the lived past; the family's past; associations and relationships with family and others, culture, and society; the person's work and social roles; body image; the unconscious mind; political affiliations; the secret life (which everyone has, whether in reality or in dreams); the perceived future; and the transcendent or spiritual dimension, lending to each person the sense of being greater and more lasting than an individual life.

Sickness, with its pain, dyspnea, weakness, nausea, and the whole panoply of symptoms and disabilities, is important because of what it does to the person, not merely because of its effect on the person's body. Suffering occurs (clinical observation suggests) when the illness or its symptoms threaten not only interference with some aspect of person—virtually any illness does that—but when it destroys or is perceived to destroy the integrity of the person through its effects. Most generally, suffering can be defined as the state of severe distress associated with events that threaten the intactness or wholeness of the person. Suffering continues until the threat is gone or the integrity of the person can be restored in some other fashion. Thus, although pain or other symptoms may, as examples, disrupt a person's relationships with others, interfere with someone's ability to work, or make the patient's usual presentation to the world impossible, the sickness usually does not cause suffering until the patient believes that the changes will continue into the future. Silently or otherwise, patients will continue to suffer until they no longer believe the disruptions to be enduring, come to see the possibility of being whole again, or believe themselves to be total, intact persons, despite the loss of some aspect of themselves or their function. As all physicians know, the capacity of persons and of the human spirit to overcome sickness and loss is wonderful beyond words.

It has always been important for physicians to relieve suffering, but understanding what suffering is and what to do about it has a special urgency in this era. A new category of patients exists for whom the potential for suffering is enormous—the chronically severely sick patient whose life medical technology can now prolong. The most obvious cases involve patients with metastatic disease whose malignant neoplasm and complications are partially controlled. For example, a woman with surgical stage II endometrial cancer with notable myometrial invasion, who had radiation after her hysterectomy, was given cisplatin and doxorubicin hydrochloride therapy, when intestinal obstruction and an abdominal mass heralded recurrence. She had a good response to chemotherapy.

After one year, "second look" laparotomy disclosed a return of the tumor. Postoperatively a small bowel fistula and sepsis developed. Because of total parenteral nutrition and antimicrobial agents, she was discharged from the hospital five weeks after undergoing an operation and she looked well and vigorous. Soon the original fistula reopened, followed by several others, and she died at home six weeks later. With such a patient, the number and severity of symptoms, the quantity and cost of medical care, the toll on the patient, family, and friends, are well known to physicians. These cases are common and are the results of current therapeutic gains. A similar situation pertains to some patients who have end-stage congestive heart disease, chronic obstructive pulmonary disease, neurologic diseases, or multiple coexisting diseases. The essential point is not merely the chronicity, which is not new, but the long duration of severe and demanding sickness previously associated only with acute, short-lived illness.

It is also true that the survivors of such illness, either the

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