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The BMJ appeal 2025-26: Palliative care is essential humanitarian work

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How to Donate

The BMJ's annual appeal is supporting the work of Médecins Sans Frontières (MSF). Around the world, MSF teams are providing maternity care, containing outbreaks, and performing vital surgeries. In areas overwhelmed by conflicts and natural disasters more lives can be saved when we are in the right place at the right time.

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Every year more than 40 000 people die in Médecins Sans Frontières (MSF) healthcare facilities. The nature or stage of their disease means that most of those deaths are inevitable. They are people who are too sick or severely wounded to survive; people who arrived too late or were born too soon for any curative intervention to be effective. Most are children, which is unsurprising as they make up the largest proportion of our global patient cohort.

Yet descriptions of our work usually focus on life saving—the millions of people we treat each year for injuries, malaria, cholera, or malnutrition in war zones, refugee camps, and after natural disasters. That is not the whole story. Humanitarian medicine is not just about saving lives, it's also about ensuring dignity and providing compassionate, holistic palliative care when cure is no longer possible.

In the 1980s, on the Cambodian Thai border, bombs were falling uncomfortably nearby when MSF doctor and cofounder Xavier Emmanuelli and his colleague Daniel Pavard were treating wounded refugees. One woman had injuries no medical intervention could reverse. Emmanuelli moved on to other victims. When he looked back, Pavard was still with her, cradling her head as she died.

"He was helping her die," Emmanuelli later said. "The bombing continued, and he did this as if he was all alone in his humanity."

That gesture lies at the core of humanitarian medical action. We aim to relieve suffering, not just treat disease. We accompany people facing unimaginable crises through the most vulnerable moments of their lives, including when those moments are their last.

Humanity in the hardest places

In many places where MSF works, healthcare systems are fragile, resources limited, and care is costly and inaccessible. Local clinicians are trained to deliver curative interventions, not to manage dying patients. In highly volatile and violent contexts medics feel pressured to continue with aggressive interventions long after they are clearly futile, as they lack the skills or the training to explain the reality of the situation to families—or members of armed groups—that might react badly. I have seen patients with unsurvivable gunshot wounds or extensive burns arrive intubated, ventilated by hand by a family member who had been told that they would find the specialists to save them at the MSF hospital. In those situations, I would take the lead, aware that, even through a translator, I was more likely to be believed when breaking the bad news, and less likely to be threatened or attacked, than a local colleague.

During an acute crisis such as a conflict or an epidemic, resources are stretched even further. Faced with an overwhelming number of patients, we switch to mass triage mode, but the prioritisation of people whose lives we might be able to save reinforces assumptions that there is nothing to do for the people we can't help.

MSF staff who provide palliative care often contend with misconceptions about their work. The first is the belief that palliative care means stopping active care, rather than adapting care. Adapting care means stopping what harms, focusing on what comforts, and continuing any treatment that might still benefit the patient. Another persistent misconception is that morphine and other opioids cannot be used safely in low resource settings. These drugs are safe, effective, and transformative for patients in severe pain, but fear—and lack of training—too often leads to patients not receiving them and unnecessarily suffering.

Palliative care should not just be the privilege of older adults in high income countries. Where MSF works it is still far too common for newborns and young children to die, but that does not mean that nothing can be done to support them and their families through death. Every culture has its own ways of caring for the dying and grieving, but humanitarian crises can fracture families and communities and disrupt these practices. Good palliative care works with local customs, not against them, restoring dignity and meaning where upheaval has stripped them away.

Bringing structure to compassion

MSF collects data on mortality and morbidity in all our medical structures. Although we extensively analyse these data to help improve the curative treatment that we offer, there have been until recently too few attempts to improve the experience of dying for patients and their families. For years, our clinicians have been working with limited guidance.

This is why we developed the MSF palliative planner, a new digital tool designed specifically for medics working in humanitarian contexts with varying levels of experience. It offers clinical guidelines for managing symptoms, communication strategies for discussing prognosis and supporting families, cultural and ethical guidance tailored to specific

regions, and mortality data analysis to help teams anticipate needs.

The tool does not replace clinical judgment, nor does it add to already overstretched workloads. Instead, it provides targeted, context specific support. Our teams report that once they gain confidence in using the tool, their entire approach to patient care changes. As one colleague put it, "I used to think telling families the truth would break them. Now I know it is what helps them survive it."

The measure of our humanity

As the world seems ever more volatile, and as countries like the UK turn their backs on international solidarity, the work of medical humanitarian organisations like MSF to provide assistance to populations in distress continues to be as relevant as ever.

Humanitarian medicine, like emergency medicine, is often portrayed in stark terms: who lives, who dies. But the measure of our work is not only how many lives we save but also how we care for the people we cannot save.

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