Palliative Care Initiative for the Eastern Mediterranean Region: A Proposal

Mohammad Zafir Al-Shahri, MD*; Stuart Brown, MD*; Adnan Ezzat, MD*; Oussama Khatib, MD†

Summary: The Eastern Mediterranean Region (EMR), with 22 countries and about half a billion people, has scarce palliative care services that are far from meeting the needs of the region. The authors of this paper believe that the resources and international influence of the World Health Organization could be combined with the excellent palliative care expertise of King Faisal Specialist Hospital and Research Center, Riyadh, Saudi Arabia to establish a collaborative initiative for promotion of palliative care services in the region. This proposal is based on the major components of professional training, development of regional guidelines, integration of palliative care into health plans and polices, and ensuring availability of essential medications. Investment in developing palliative care in the EMR would be expected to relieve the suffering of hundreds of thousands of patients and families in this part of the world.

*From the *King Faisal Specialist Hospital and Research Center, Riyadh, Saudi Arabia; and the †World Health Organization, East Mediterranean Regional Office, Cairo, Egypt.*

Correspondence to:
Dr. Mohammad Z. Al-Shahri
P. O. Box 365636
Riyadh 11393
Saudi Arabia
Email : malshahri@kfshrc.edu.sa

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The Eastern Mediterranean Regional Office (EMRO) based in Cairo, Egypt, is a World Health Organization (WHO) office that promotes health in the 22 member states that occupy a vast area in which about half a billion people live.[1] Most of the member states have sparse data about population censuses, cancer incidence and cancer mortality. However, in the year 2000, the estimated number of cancer patients in the member states of EMRO approached 400,000 while cancer deaths exceeded 250,000.[2] Table 1 shows the area, total population, estimated number of cancer cases and deaths in one year for EMRO member states.[1-2] Unfortunately, most cancer patients in developing countries present in advanced stages when diseases are beyond any curative options and the best option is palliative care.[3] Even more unfortunate is the fact that palliative care services in the EMR are extremely underdeveloped, with only a few exceptions.[4] This undoubtedly entails tremendous suffering of patients and their families, while their suffering could be relieved by relatively easy-to-acquire and readily affordable measures.[5-9] Palliative care is defined as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual".[10] The definition emphasizes the fact that palliative care is meant to be for all patients with life-threatening illnesses. However, the great majority of the palliative care population has cancer, with non-cancer patients comprising 4% to 20% of the total patient load.[11-12]

Published reports on palliative care in the EMR suggest that the most developed palliative care program in the region is the one based at King Faisal Specialist Hospital and Research Center (KFSHRC) in Riyadh, Saudi Arabia.[4,13-14] This program started in the early 1990s and is now run by an interdisciplinary team of health professionals who provide care for patients and families in the hospital and in the community within Riyadh city. The program consists of an inpatient unit with a 10-bed capacity, an outpatient clinic, a consultation service for patients admitted in different units in the hospital, and a home health care service covering Riyadh city.

This paper suggests that the EMRO might be able to utilize the established palliative care program in KFSHRC as a regional center of excellence that can act as the core of an EMR palliative care initiative.

Organizational structure

The EMRO and KFSHRC shall form a steering committee that will be responsible for detailed planning and management of the initiative. This committee will be responsible for governing all technical and administrative aspects related to this initiative. The steering committee will report to the Regional Director of EMRO, or his designee.

Program content

Training

Fellowship program. A structured one-year training program leading to a WHO-accredited fellowship degree in palliative care will enable the candidates to lead the pioneer palliative care teams in the participating countries. The cur-

riculum for the fellowship will include theoretical and clinical components related to palliative care. The candidates will also receive training in medical education, health management, and research. Candidates eligible for the fellowship should be graduates from accredited medical colleges and be board certified in a major specialty, preferably family medicine, internal medicine, anesthesiology or general surgery. The candidates for the fellowship shall be carefully selected and rigorously assessed throughout their training as they are expected to lead palliative care in their countries.

Advanced course. A structured three-month course will be designed for physicians who will receive theoretical and clinical palliative care training that enables them to manage routine palliative care patients mostly on a primary care level. The eligible candidates should have completed two years of experience after their bachelor degree in medicine and surgery. In addition to a continuous assessment process, the trainees in this course need to pass a written examination towards the end of their training. A certified physician at the end of this course will be competent in diagnosis and management of common palliative care clinical problems and prescription of opioids.

Annual workshop. A palliative care workshop shall be held annually to refresh fellows, advanced certificate holders and others. It will also serve to increase awareness about palliative care. These workshops may also help potential candidates for the training program to develop their interest. The workshops will be organized and delivered by the trainers and the graduates of the training program in different countries. The trainers may interview interested attendees of the workshops for possible enrollment in the training program.

Palliative care guidelines

The palliative care trainers shall draft a palliative care guidelines manual to help palliative care workers in EMR standardize the management of common clinical problems and to avoid major deviations in practice whenever possible. The manual shall be printed by EMRO and distributed to all concerned professionals and institutions.

Table 1. Area and population for the member states in the East Mediterranean Region, World Health Organization.

Country	Area in square kilometer	Population in thousands	Estimated number of cancer cases in year 2000[2]	Estimated number of cancer deaths in year 2000[2]
Afghanistan	65225	22140	18382	11893
Bahrain	710	672	481	323
Djibouti	23000	751	754	480
Egypt	1001450	66794	55003	34429
Iran	1648000	65201	52542	35243
Iraq	435052	25127	15764	10251
Jordan	91100	5329	4409	2859
Kuwait	17818	2331	1131	721
Lebanon	10452	4260	3439	2346
Libya	1775500	5484	4264	2718
Morocco	710850	29637	24357	15311
Oman	309500	2538	1359	912
Pakistan	796095	145500	136719	85872
Palestine	6162	3465	–	–
Qatar	11493	616	542	373
Saudi Arabia	2250000	21368	15090	10237
Somalia	637657	7852	9663	6104
Sudan	2506000	32718	21324	13172
Syria	185180	17130	11489	7694
Tunisia	154530	9780	7835	4892
UAE	83600	3754	2145	1476
Yemen	460000	19607	11077	7290
Total	13179374	492054	397769	254596

Governmental policies

The EMRO, in collaboration with the steering committee, shall be able to encourage ministries of health in the member states to improve current policies so as to integrate palliative care into their national health plans. Policies should reflect clearly that palliative care is always on the health needs agenda for all member states.

Essential medications

Table 2 shows a suggested list of essential medications that shall be made available for palliative care teams. The responsibility of ensuring the availability of medications lies on the Ministry of Health (MOH) in every member state. However, EMRO can help to facilitate the process by providing logistic and advisory support. Although diverted use of medical stock of opioids and controlled medications has not been a problem, an inventory system shall be designed by the steering committee of the program and implemented in collaboration with the MOH in respective countries.[15] Support from religious scholars shall be sought in order to clarify to the communities the permissibility of using opioids when medically indicated.

Resources

The training center. The palliative care training center shall be optimally resourced in preparation for the major EMRO initiative. Before the EMRO initiative can be launched, the necessary arrangements shall be undertaken in the following areas:

Staffing. The medical staffing level shall be upgraded to eight consultant physicians (trainers) and four assistant physicians. A full time clinical pharmacist shall be assigned to the program. Two secretaries, one administrative assistant and one research assistant shall be dedicated to the program.

Service setup. The tertiary palliative care unit shall be expanded to 14 beds to allow for accommodating the expected rise in the number of patients based on the improved staffing level. The larger unit, being the core area for clinical training, will allow for ensuring enough clinical material for trainees. The number of palliative care outpatient clinics shall increase to 10 per week. Palliative care physicians shall substantially expand the home health care component of the program, with activation of home visits by physicians. The palliative care team shall continue to consult on patients admitted under other services throughout the hospital.

Physical environment. This major initiative will require allocation of appropriate space to accommodate staffing and various program-related activities. There needs to be a classroom and a family conference room available solely for palliative care use. Offices will be needed for all physicians, secretaries, research assistants, the clinical pharmacist, and the administrator.

Table 2. Essential palliative care drug list

Analgesics	
– Non-opioids	AcetaminophenIbuprofen Ibuprofen
– Opioids	Codeine Morphine Hydromorphone Methadone
Opioid antagonists	Naloxone
Corticosteroids	Dexamethasone Prednisone
Laxatives	Bisacodyl Docusate sodium Senna Magnesium citrate
Anti-depressants	Amitriptyline Citalopram
Psychostimulants	Methylphenidate
Anti-epileptics	Gabapentin Phenytoin Diazepam
Sedatives	Midazolam
Neuroleptics	Haloperidol Methotrimeprazine
Anticholinergics	Hyoscine butylbromide Glycopyrrolate
Gastric protection	Omeprazole
	Ranitidine
Diuretics	Spirinolactone
	Furosemide
Anti-fungal	Nystatin Fluconazole
Anti-emetics	Metoclopramide Prochlorperazine

Funding. The trainees shall be fully sponsored by EMRO. This financial sponsorship should cover monthly salaries, airline tickets, accommodation and medical coverage. An agreed upon tuition fees shall be paid by EMRO to the training center on a per-candidate monthly basis.

Demonstration projects. The initiative shall be piloted in two areas selected by the steering committee. One pilot project shall be in Saudi Arabia and the other shall be in a nearby country, with preferably limited area and population. Five candidates shall be selected from each piloted center, two for the fellowship program and three for the advanced course. All trainees shall start their training at the same time. By the end of the first month of training, all candidates will be formally evaluated for suitability to complete the training.

Before starting the training of the candidates, one of the trainers shall visit the demonstration project centers to prepare the setup for the execution of the program once the first group of advanced course trainees completes the course. Before executing the program, proper establishment of the infrastructure in the piloted centers shall be ensured. This includes ensuring availability of essential drugs, securing a control drug inventory system, ensuring enough supply of symptom assessment forms, prescription forms, referral forms, and the necessary registry books.

In each demonstration project area, a referral hospital (RH) and a referral primary health care center (RPHCC) shall be designated as the piloted health facilities for the program. Although the palliative care program should eventually target terminally ill non-cancer patients, the piloting phases will be limited to cancer patients for feasibility reasons. Cancer patients in the piloted regions shall be identified with the help of cancer registry programs or alternative bodies in the piloted countries. A register of those patients shall be kept in both the RH and RPHCC. With the help of RH authorities, the visiting trainer shall nominate two or more physicians in the RH with interest in looking after terminally ill patients. The nominated physicians are expected to collaborate with the palliative care physicians in managing patients during hospitalization.

The candidates who successfully complete the advanced course shall be based in the RPHCC and liaise with the designated physicians in the RH when needed. The palliative care physicians will assess all registered patients and address their palliative care needs. Newly diagnosed cancer patients will be added to the palliative care register only when their primary physicians refer them to the palliative care program. When a patient's condition necessitates admission to the RH, the physician in RPHCC shall make the necessary arrangements with the RH physicians to facilitate the process. The palliative care trainers can be consulted by phone or email to help in managing complex cases.

There will be no candidates under training for the next three months following the graduation of the first group of the advanced course. This period will be utilized to evaluate the pilot projects and, if needed, modify the original plan according to the needs. Once this evaluation period is completed, the next group for advanced course shall commence training. Demonstration projects shall be started in the rest of the member states according to a planned schedule. This proposal will allow 18 physicians to complete the advanced course and 4 physicians to complete the fellowship program in the first year. Within 3 years of implementing the program, all member states are supposed to have their demonstration projects established. The fellowship graduates will preferably be based in RHs and are supposed to start establishing palliative care units and training programs in their localities, with support from the training center in Riyadh.

Conclusion

The palliative care services in most of the EMR countries are underdeveloped or non-existent. As a result, terminally ill patients and their families suffer tremendously. Health policy-makers, local and international health organizations, cancer centers, and palliative care experts have a moral obligation to establish palliative care services in the region. Delay in taking the initiative for pursuing this noble task would mean allowing hundreds of thousands of people (patients and families) to continue enduring extreme suffering, when they can be helped. The authors believe that the establishment of palliative care in the region should be mainly based on three pillars, namely, training of professionals, incorporation of palliative care into the regional health systems, and ensuring availability of essential medications. The palliative care center of excellence in KFSHRC and the EMRO, with its international weight and influence, shall be able to play a pivotal role in establishing palliative care in the EMR.

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