# International Palliative Care: Middle East Experience As a Model for Global Palliative Care

Ramzi R. Hajjar, MD, AGSF[a], Haris A. Charalambous, BM, MRCP, FRCR[b], Lea Baider, PhD[c], Michael Silbermann, DMD, PhD[d,*]

**KEYWORDS**

• Palliative care • Family • Illness • Treatment • Middle East • Cancer care • Aging • Culture

**KEY POINTS**

- With the global shortage of palliative care (PC) specialists, it has become clear that care for elderly people with life-limiting illness cannot be delivered primarily by geriatricians or PC practitioners.
- In a culture in which family ties run deep, the offer of PC from an outsider is likely to be met with suspicion and distrust. The family bond in the Middle East may be stronger than in Western countries, but in contrast the emotional response to terminal illness may push families to request futile treatments, and physicians to comply. When PC is well developed and well understood, it provides a viable alternative to such extreme terminal measures.

## INTRODUCTION

Palliative care (PC), as a specialty and model of care, is a recent construct in global health care, although the principle of alleviating suffering of the infirm is not novel. Modern medicine has seen great advances in diseases management and prevention, but until recently little attention had been given to supportive care of patients with cancer. This year alone, it is estimated that more than 8.2 million deaths will occur globally, of which 5.3 million (64.6%) will be in developing countries.[1] Moreover, in the near future, the number of elderly in developing countries is expected to increase dramatically, and with it the number of people needing PC. Experts estimate that 60%

[a] Geriatrics Medicine and Palliative Care Service, American University of Beirut Medical Center, Riad El Solh, Beirut 1107 2020, Lebanon; [b] Clinical Oncologist, The Bank of Cyprus Oncology Centre, 32 Acropoleus Avenue, Strovolos, Nicosia 2006, The Republic of Cyprus; [c] Psycho-Oncology Services, Assuta Medical Center, 20 Habarzel Street, Tel Aviv 69710, Israel; [d] The Middle East Cancer Consortium, 15 Kiryat Sefer str, Haifa 3467630, Israel
* Corresponding author.
*E-mail address:* cancer@mecc-research.com

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of all deaths could benefit from PC at some stage of the disease progression, but very few receive it.[2]

Over the past few decades, great progress has been made in the provision of PC in most parts of Europe, Canada, and Australia, and more recently a similar push was seen in the United States, where PC has been integrated into mainstream medicine. In contrast, PC in most developing countries remains underappreciated and poorly established, if available at all. The deficit is of such far-reaching impact that Singer and Bowman,[3] among others, argue that the quality end-of-life care should be viewed as a global public health and health systems problem. With an aging global population, this crisis is expected to worsen unless decisive steps are taken.

This article draws from our collective experience in introducing and promoting PC in the Middle East (ME). It examines the reasons why PC provision lags behind in most of the region's countries, and the challenges involved in overcoming this deficit. Real-life clinical vignettes are used to describe the cultural milieu that simultaneously hinders and welcomes PC, and the all-encompassing spiritual component present in most developing countries is examined. The Middle East and Northern Africa (MENA) region is used as a proxy model for global PC, because the generic parameters are grossly similar for most traditional families, even as specifics vary in style, solutions, resources, and constraints across different values and belief systems.[4] This article also favors the term PC rather than hospice in order to emphasize the need for symptom management throughout the trajectory of illness.

### *Palliative Care and the Developing World*

Over the past century the world witnessed a demographic shift that has had profound impact on the practice of medicine and the delivery of health care. Toward the end of the nineteenth century, miasma theory gave way to the germ theory of disease, and micronutrient deficiencies were discovered as the cause of several debilitating illnesses. The introduction of aseptic surgery under general anesthesia, and the advancement of primary and preventive care, further played a major role in shaping the modern view of illness and health. These changes were the result of public health measures based on a deeper understanding of the pathophysiology of body structure and function, and the era of mechanization of medicine commenced.

As a result, many illnesses that were life limiting in the early 1900s became routinely treatable or preventable, and the number of elderly adults grew at an unprecedented rate. Life expectancy in westernized countries nearly doubled over the span of a century, and currently stands at around 80 years in most developed countries. Diseases that people used to die from last century became conditions they live with, and the medical establishment was not prepared to deal with the sequelae that chronic disease entails. Modern medicine not only prolonged life, but prolonged the dying trajectory as well. The proliferation of structured PC programs in parallel with aging societies in developed countries was not coincidental. The model of care that emerged to address the quality of life of patients with life-limiting illness served well the aging populations. Moreover, end-of-life palliation took on a renewed sense of urgency as causes of mortality shifted from acute illnesses (eg, infections, myocardial infarctions, nutritional deficiencies) to chronic degenerative disorders occurring late in life (eg, heart failure, dementia). The unintended consequence of longevity (mainly chronic illness) was a significant force in the evolution of PC conceptualization over the past 2 decades. Although the initial model of PC was based on patients with terminal cancers, it now embraces a broad spectrum of nonmalignant conditions.

In contrast, developing and low-income countries have not benefited from advances in medical sciences to the same extent as westernized countries. In some developing